

**An Najah National University
Faculty Of Graduate Studies**

**Assessment of the Actual Treatment
Abroad Department at Palestinian
Ministry of Health (MOH)**

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Declaration

No portion of this work referred to in this thesis has been submitted to an application for another degree or qualification of this or any other university or institute of learning.

List of Abbreviations

ASQC	American Society of Quality Control
BPR	Business Process Re- engineering
CABG	Coronary Artery Bypass Grafting
CTS	Computer Tomography Scan
ERCP	Endoscope Retrograde Cholangiopancreatography
GDP	Gross Domestic Product
GNP	Gross National Product
GP	General Practitioner
GS	Gaza Strip
HIID	Harvard Institute for International Development
ICD	International Classification of Diseases
ICU	Intensive Care Unit
ID	Identifier
IVF	In Vitro Fertilization
MOH	Ministry of Health
MOP	Ministry Of Planning
MRI	Magnetic Resonance Imaging

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NGOS	Non Governmental Organizations
NPHP	National Palestinian Health Plan
NIS	New Israeli Shekel
NPA	National Palestinian Authority
PHA	Private Hospital Association
PICU	Pediatric Intensive Care Unit
QIP	Quality Improvement Project
RTA	Referral Treatment Abroad
SMC	Superior Medical Committee
TAO	Treatment aboard Office
TAP	Treatment Abroad Patients
TQM	Total Quality Management
UNFP	United Nation Funds for Population Activities
UNICEF	United Nation International Children Emergency Fund
UNRWA	United Nation for Relief and Works Agency
USA	United States of America
USD	United States Dollars

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Abstract

Based on the policy of "Health for all in the twenty-first century adopted by the world community in may 1998, to realize the vision of the World Health Assembly at the Alma-Ata conference in 1978, World Health Organization (WHO) had develop the World Health Survey (WHS) as a mean of providing low-cost, valid, reliable and comparable information. (WHS) served as an evidence base to monitor the efficiency of different health systems in meeting the desired goals. Thus providing policy makers with the evidence they might need to adjust their policies, strategies, and programs as necessary.

This study aims to assess the performance of treatment abroad department in the Ministry of Health (MOH), to rationalize spending cost and to find options to decrease this cost by providing alternatives for replacing treatment abroad by treatment in Palestinian health care facilities to demonstrate the importance of having centers of excellence and comprehensive health care services in Palestine.

The study was conducted during the period of January-May, 2006. To achieve our goal and objectives, data was collected through structured interviews utilizing a questionnaire for five key informants, one for decision maker of MOH, another for chair person of treatment abroad department, physicians and policy makers in public sector (governmental),

physicians and administrative persons in private sector, NGOS and UNRWA, and the last one for patients who receive treatment abroad inside Palestine (in private sector, NGOS, UNRWA hospitals), and outside Palestine (in Jordan and Israel).

The sample of the study was (191) patients, (92) collected from Jordan hospitals, (99) patients from west bank, (40) employees from private and public sector, one for decision maker and one for chair person of treatment abroad department.

Quantitative collected data was analyzed using SPSS while other qualitative data was analyzed manually.

Several hypotheses were formulated and tested, the results of the current study showed the highest percent of reason for referral abroad have been tumor disease with 33%, then cardiac disease with 17%, organs transplantation with 5.8% and 1.6% invitro fertilization. In relation to reason of referral cases abroad, the highest cause that the treatment not available in Palestine with percent 43.6%, second because services were not of good quality 26.7%, the third reason there was a long waiting list for intervention 14.1%, 4.7% no trust for medical team in Palestine. From analysis of patient questionnaire there was relationship between disadvantages of referral abroad and suggestions to avoid referral treatment abroad, ministry of health should provide an inclusive medical health system.

The result also showed that questionnaire for other key informant illustrate the importance and need of integration between all health care providers sectors in Palestine and encourage treatment abroad inside Palestine rather than outside Palestine .

Chapter One

(Introduction)

1.1 General Background

Despite the fact that Palestinian Ministry of Health (MOH) has developed advanced diagnosis and treatment facilities in West Bank and Gaza strip, it is necessary to refer patients who are in need of special diagnosis and care which are not available in MOH institutions to institutions outside the Palestinian MOH facilities.

The patients who are in need of particular diagnosis or treatment outside MOH institutions are referred for consultations or hospitalization at nongovernmental specialized hospital, tertiary care private health institutions in West Bank, Gaza Strip & East Jerusalem or to public or private health providers in Israel, Jordan, Europe, USA and Egypt. These patients are labeled "Treatment Abroad Patients" (TAP).

It is important to stress that the term "treatment abroad" embraces all patients who receive treatment consultation (outpatient) or hospitalization (inpatient) outside the Palestinian MOH institutions, either in health facilities in West Bank, Gaza Strip, East Jerusalem, or in hospitals in Israel, Jordan and Egypt or elsewhere, (MOH,2003).

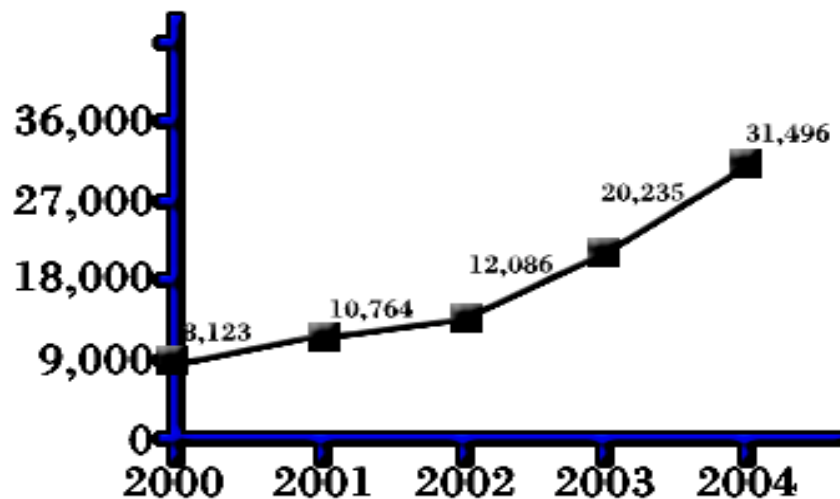
In Palestine the total number of patients referred for hospitalization and consultation increased from 8,123 in 2000, to 10,764 in 2001 to 12,086 in 2002, to 20,235 in 2003, and 31,493 in 2004 in the West Bank and Gaza. (MOH-2004).

1.2 Cost of treatment abroad

From 2002 to 2003 with an increasing percentage of 194.1% in comparison with 2000, and from 2003 to 2004 with an increase of 55.6%.

For the year 2003, total cost of treatment abroad was 15,000,000 NIS (33,5million USD). The total MOH budget in 2003 was 98,5million USD. Where treatment abroad represented 33.8% of the actual health expenditure in 2003 (MOH, 2003).

For the year 2004, the total cost of treatment abroad was 262 million NIS (60 million USD), the total MOH budget in 2004 was 126,474,889 USD. Treatment abroad represented 46.00% of the actual health expenditure in 2004(Health Indicators in Palestine,MOH- 2004).



*Source: health status in Palestine. MOH annual report, 2004.

Graph (1.1) annual number of referred cases abroad, (2000-2004).

If we compared the number of referred cases in 2000 and 2004, we see that the number of these referred cases increased with significant percent 55.7%. If we compare the cost of treatment abroad in 2003 and 2004, the cost increased by 74.7% in only one year. While the average annual increase of population is about 3%.

In 2001 treatment abroad took up 10.6% of the total Ministry of health budget of approximately 80,000,000 USD. For 2003 total cost of

treatment abroad has been 15 million NIS or 33,5 million USD. The total MOH recurrent budget for 2003 is USD 98,5 million and in 2004 the number of cases 31,5 within an increase of 55.6% the treatment abroad represents 33.8% of the actual expenditure for 2003 and in 2004 the total cost of treatment abroad was 262 million NIS (60 million USD) of the actual health expenditure this is an indication that treatment abroad continues to be an important expenditure category in the MOH budget. It is therefore relevant to look into how savings can be realized under this expenditure category. (Health indicators in Palestine. MOH-2004).

1.3 Statement of the problem

The MOH has been facing greater pressure to refer more and more patients for specialized medical services to neighboring countries and to non-governmental health facilities in West Bank and Gaza Strip. The trend rate of cost has been tremendously increasing year after year demanding more and more tens of US millions of dollars, given the fact of the very limited resources in Palestine.

1.4 Significance of the problem

The importance of this study arises from percentage of number of patients treated abroad & the high cost that it needs this percentage increased year after year. It is for there relevant to look into how to rationalize the high cost and how to make options to the MOH against falling into the trap of rapid increase in health expenditure and avoid unnecessary costs, given the facts of rising needs and demand for health care services, limited resources with increased fiscal pressure on government.

The health sector receives considerable international support from a multiplicity over donors to finance activities that are implemented by not only the MOH services but also a number of other significant providers including UNRWA, NGO'S and the private sector. There is a need for more effectively planed and coordinated cooperation between internal and external health sectors, to maximize revenue and to improve efficiency in the face of continued uncertainty and insecurity. The potential of secondary and tertiary care for the treatment of priority health problems still insufficiently developed. To make options for replacing treatment abroad by treatment in WB & GS, health care facilities should be explored and implemented.

The advancement and the development in health service delivery in the recent history has loaded governments world wide with greater responsibilities towards providing their communities with reasonable health services. Health has become an interchangeable vital issue with three dimensions that include, health is an essential acquired human right, health services is a good that users may purchase and health is an investment. Therefore, health has an inextricable association with the economics and social development of the country health service costs zoomed up to an unprecedented level, health services became greatly governed by the wheel of highly sophisticated technology, expectations of health services users are increasingly soaring, and so on. These irrevocable changes confounded by the additional prevalence of political and economic instability and the limited resources constituted great challenges to the Palestinian National Authority (PNA).(MOH,2003).

Many patients who are referred to receive specialized health care service abroad “from out side the MOH facilities” suffer from a variety of problems. Main problems may include the nature and complications of the illness, the experience of the patients before referral, difficulties of referral procedures, psychosocial and economic difficulties and the harsh humiliating treatment on passing at Israeli checkpoints and borders. Despite those difficulties, some can not even get the service because of the military siege.

1.5 Purpose of the study

General Purpose:

This study aims to increase capacity building of MOH (human resources, technical resoureces, equipment and capital investment), of treatment abroad institutions by treatment in West Bank and Gaza Strip health care facilities.

Specific objectives:

1. To provide options for replacing treatment abroad by treatment in West Bank and Gaza Strip health care facilities.
2. Clarify the importance of having centers of excellence, based on the results of assessment.
3. To demonstrate the importance of promoting medical and paramedical health personnel to cover sub specialist in Palestine.

4. To stress on the importance of integration between different health sectors in Palestine, to provide optimal medical care at Palestine without the need of abroad.

1.6 Hypothesis of the study

- 1- There exists no significant relationship, in the significant level 0.05, between the area and type of disease
- 2- There exists no significant relationship, in the significant level 0.05, between the area and referral cause
- 3- There exists no significant relationship, in the significant level 0.05, between the area and referral source
- 4- There exists no significant relationship, in the significant level 0.05, between the area and their any price controlling or financial contracting before intervention.
- 5- There exists no significant relationship, in the significant level 0.05, between the disadvantages of referral abroad and suggestions to avoid referral treatment abroad ministry of health should provide medical system.
- 6- There exists no significant relationship, in the significant level 0.05, between the type of disease and medical services
- 7- There exists no significant relationship, in the significant level 0.05, between the type of disease and nursing services
- 8- There exists no significant relationship, in the significant level 0.05, between the type of disease and general services..

- 9- There exists no significant relationship, in the significant level 0.05, between the period that patient stay in hospital (hospitalization period) and their any price controlling or financial contracting before intervention.

1.7 Limitations and constrains of the study

The following were the major limitations of the current study:

- 1- Lack of resources and literature in the field of treatment abroad in regarding of data and publish materials.
- 2- Lack of co-operation and concern by decision maker from MOH.
- 3- Prevailing political situation in the area which greatly limited movement.

Chapter Two

(General overview of treatment abroad patients)

2.1 Inpatient & out patients

In 2004, the total number of admission to the Palestinian MOH hospitals was 288,450 and the total number of outpatient clinic visits was 751,988. The figures for treatment abroad were 31,496 represents 3.06% of MOH hospital patients.(MOH,2004).

The number of hospitalized cases abroad was 23,470 equals to 8.14% of the MOH admission and outpatient procedures abroad were 8,101 equal to 1.08% of MOH hospital outpatients.(MOH,2004).

Table (2.1) distribution of referred cases abroad inpatient and outpatient and associated cost, 2004.

Indicator	Number	%	Cost	%
Inpatient	23,388	74.26	225,592,174	86.17
Outpatient	8,108	25.74	36,205,185	13.83
Total	31,496	100	261,797,259	100

*Source: health status in Palestine. MOH annual report, 2004.

2.2 Patient gender and sex

Table (2.2) the distribution of referred cases abroad by type of services and gender,2004.

Gender	Inpatient	Outpatient	Total	%
Male	13,642	3,890	17,532	55.7
Female	9,750	4,214	13,964	44.3
Total	23,392	8,104	31,496	100

*Source: health status in Palestine. MOH annual report, 2004.

55.7% of all patients referred for treatment broad are males, while the males 50.7% of the total population.(MOH,2004). In Palestine 47.4% of all patients referred for treatment at age (15-49) year, while this age group represents 45.7% of the total population this is related to intifada injuries.

2.3 Patients age group

Table (2.3) distribution of referred cases by age group.

Age group	Number	%
Less than 1 year	582	1.8
1 - 14 year	5,610	17.8
15 - 49 year	14,679	46.6
50 – 59 year	4,171	13.2
More than 60 years	6,245	19.8
Unknown	209	0.7
Total	31,496	100

*Source: health status in Palestine. MOH annual report, 2004.

2.4 Rules and Regulation

The treatment abroad operation procedure is based on a pragmatic approach where the standard way is as follows:

1. Patient goes to general practitioner (GP).
2. GP refers patient to specialist in MOH hospital.
3. Specialist finds out that patient needs treatment which is not available at Palestinian MOH hospital.
4. Specialist prepares referral form no.1 with the patient biomedical data, and a referral report is prepared comprising patient medical history, recommendation for treatment outside MOH, photocopy of patient identifier (ID) card and insurance card.
5. Referral report is submitted by treatment abroad office to Superior Medical Committee (SMC) members appointed by MOH and representing all medical specialties either in Gaza Strip or the West Bank.

6. SMC studies referral report and decide to refer the patient or not.
7. After approval, the treatment abroad office contacts the patient.
8. Treatment abroad office (TAO) issues file number for referral selects and contacts hospital for treatment.
9. Patient gets financial commitment from treatment abroad office and goes for treatment (waiting list is dependent on patient status).
10. Contracted hospital submits invoice to treatment abroad office when patient is discharged. Treatment abroad office checks invoice and transfers to financial department in the Palestinian MOH for payment.

In special cases the patient can also receive an approval based on an alternative approach directly through the Palestinian President's office or through the Palestinian Minister of Health.

2.5 Distribution of referral abroad by region & governorate

Out of referred cases, 31.5% of them from Gaza Strip with 24, 5% of the total cost and 68.5% from the West Bank, with 75.5% of the total cost. Taking in consideration that Gaza population constitutes 36.8% of total Palestinians. Distribution of referred cases by governorate shows that 16.6% of total cases where from Gaza city and 13.5% from Ramallah city. Although residence of the two cities contributed respectively 12.9% and 7.4% of the total Palestinians in Gaza Strip and the West Bank. (MOH, 2004).

Table (2.4) number of procedures and the cost by region (NIS), 2004.

Area	#	%	Estimated Cost	%	% of Population
Gaza Strip	9,908	31.46	64,092,795	24.48	36.8
West Bank	21,588	68.54	197,704,564	75.52	63.3
Palestine	31,496	100	261,704,564	100	100

*Source: health status in Palestine. MOH annual report, 2004.

2.6 Monthly distribution of referral abroad

The average number of monthly referred cases was 1.686 (749 in Gaza Strip and 917 in West Bank). In 2003 the highest percent of referred cases was 13.9% in December and the lowest was 5.1% in February but in the year 2004 the average number of monthly referred cases was 2625, (829 in Gaza and 1796 in West Bank).

The highest percent of referred cases was 10.97% in August and the lowest was 6.1% in February.

2.7 Source of Referral

Means the Palestinian Authority that approves the treatment inside or outside of Palestine.

Table (2.5) distribution of referred cases according to the referral source, 2004.

Referral source	#	%	Estimated cost	%
MOH hospitals	15,710	49.49	91,040,861	34.83
MOH (Exceptions)	2,369	7.46	16,260,996	6.22
Not covered financial by MOH	13,665	43.05	154,054,744	58.94
Total	31,744	100	261,356,601	100

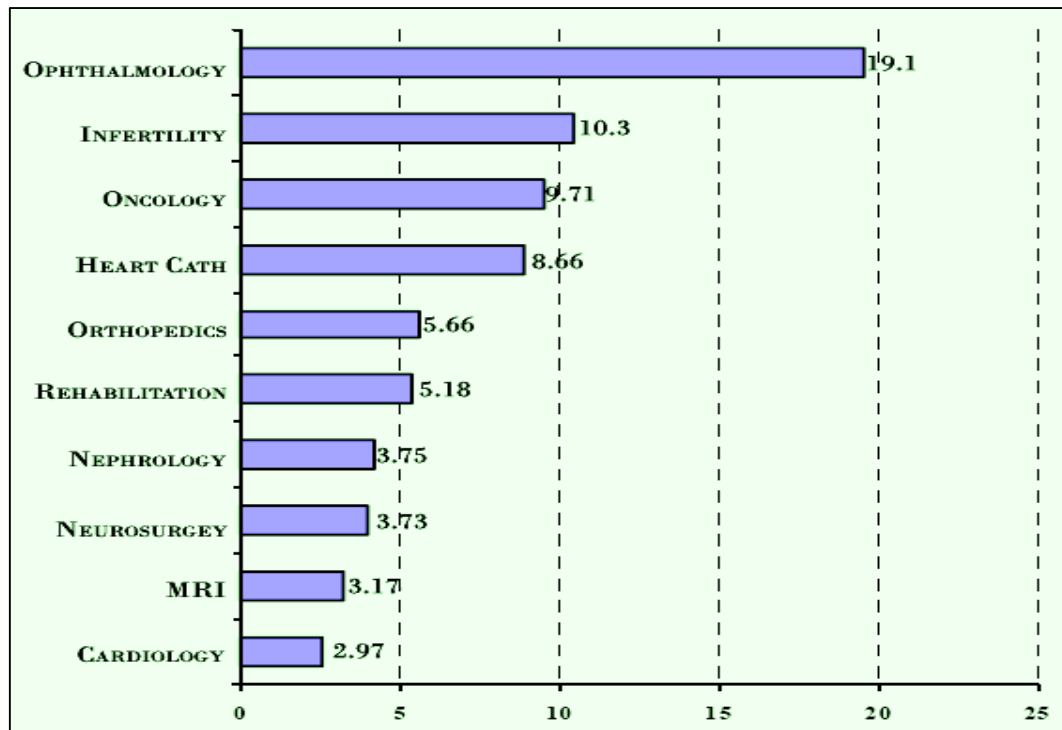
2.8 The average waiting time

Waiting time means time elapsed from approval until the patient is admitted at place of referral. The average waiting time from the beginning of treatment abroad shows that 8,665 cases (27.51%) had their referral approval in the same day, 8112 (25.76%) after the first day and before a week, 7,825 cases (19.75%) after one month and less than year. (MOH, 2004).

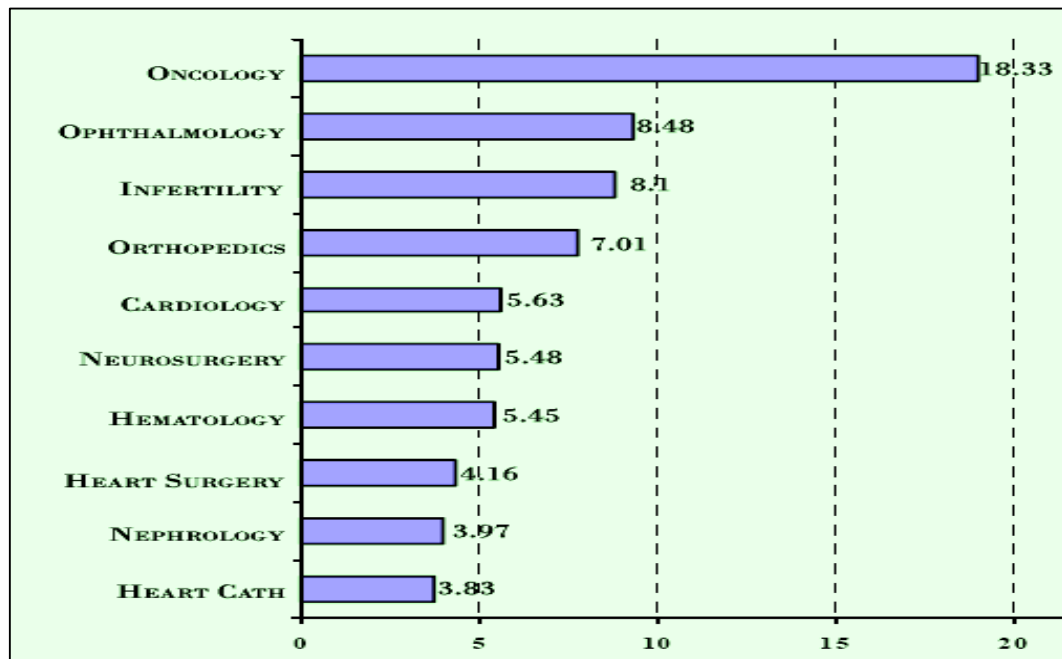
2.9 Analysis of referred cases according to ICD10 and medical procedures

A study of the ICD10 diagnosis and the medical procedures registered for the treatment abroad office leaves the impression that although adequate and relevant treatment are given to the major part of the patients within Palestine hospital services, a substantial number of patients must be referred to hospital outside Palestine. Of course, some specialized services and the professional competence needed for such services can not be available on an acceptable level for populations of limited size. The catchments population must be large enough to run sustainable activities, which calls for centralization of very specialized services either regionally or on national level or even by using services abroad.

The total number of medical procedures carried out was 20,235 with an estimated cost of 150 million NIS in 2003. About 54% of all cases were treated inside Palestine, and the associated costs are only 33.8%. The number of cases treated outside Palestine is the remaining; equal to 46% and the corresponding cost were 66.2% in 2003.(MOH,2004).



Graph (2.2) the top ten procedures (number) (%)



Graph (2.3) the top ten procedures (cost) (%), 2004

2.9.1 The top ten of the main medical procedures and the associated cost

73.6% of all cases are represented in the top ten lists of main procedures; however, the top ten numbers represent only 62% in cost. The remaining number of cases is distributed over 23 different main procedures.

The main number of procedures was for ophthalmology and represented about 16%. Heart Catheterization cases were 11.6% of the total cases. Infertility cases were about 9% of the total cases. Oncology cases were 9% with the highest cost which was about 23.8 million NIS (15.9% of total cost). Infertility was the second in the cost with 13.2 million NIS (8.8% of total cost).

Table (2.6) the top ten of the medical procedures according to the number and the associated cost, 2004.

Procedure	Number	%	Cost	%
Ophthalmology	6,018	19.11	22,212,429	8.48
Infertility	3,235	10.27	21,210,475	8.1
Oncology	3,059	9.71	47,982,596	18.33
Heart Catheterization	2,726	8.66	10,037,544	3.83
Orthopedics	1,782	5.66	18,360,119	7.01
Rehabilitation	1,630	5.18	8,063,688	3.08
Urology	1,180	3.75	6,731,124	2.57
Neurosurgery	1,176	3.73	14,341,528	5.48
M.R.I	997	3.17	1,406,507	0.54
Cardiology	936	2.97	14,738,034	5.63
Total	22,739	72.2	165,084,044	63.06

*Source: (PCBS, 2004)

2.10 Referral places

Means the place inside or outside Palestine where the patients receives the treatment. In general Gaza strip refers patients to Egypt which

tack care of about 55% of all Gaza strip referrals and nearly 15% referred to Israel and only 15% of all patients tack care within Gaza strip. The West Bank tacks care of nearly 49% of all patients within the West Bank and nearly all the remaining patients are treated in either East Jerusalem (27.5%) or Jordan (21%). Treatment in Israel from West Bank constitutes 2.5%.

2.10.1 Referral inside Palestine

2.10.1.1 Gaza Strip

At Al-Helo Center and Al-Basma Center, all cases are In Vitro Fertilization (IVF)

1. About 505 cases; with a cost of 3,9million NIS.
2. Gaza Diagnostic Center cases were mainly concerned with Computer Tomography (CT) scan and related diagnostic procedures and the number of cases are 351; with a cost of 840,444 NIS.
3. In Al-Quds Hospital, 161 referrals, the key cases are ICU management, gastroscopy and colonoscopy; with a cost of 599,087 NIS.
4. AL-Wafaa Hospital for rehabilitation and Physiotherapy, and the number of cases was 96; with a cost of 206,242 NIS

2.10.1.2 West Bank

1. The highest number of cases at Ramallah Hospital was 1,570 cardiac catheterization; with a cost of 2,730 NIS (This is a governmental hospital).

2. Mosalam Center is specialized in ophthalmology and cataract extraction, number of cases was 737; with a cost of 3,589,315 NIS.
3. Arab Care Center has managed 781 cases, the key procedure is Magnetic Resonance Imaging (MRI) scan; with a cost of 1,113,960 NIS.
4. Arab Association managed 473 and Abu Raia Center managed 377 cases in Rehabilitation and Physiotherapy; with a cost of 4,754,625 NIS.
5. Mohtaseb Hospital managed 81 cases in Pediatric Intensive Care Unit (PICU); with a cost of 745,512 NIS.
6. Annahda Women's Associations is providing hearing aids to 109 patients; with a cost of 310,315 NIS.
7. Medicare is managing 97 cases for CT scan; with a cost of 61,895 NIS.
8. Razan Center is interesting in IVF, 793 cases; with a cost of 5,324,300 NIS.

2.10.1.3 Jerusalem

1. Makassad Hospital received 1,705 cases concerned with cardiac catheterizations and a lot of different surgical procedures and diagnostic procedures; with a cost of 13,608,324 NIS.
2. Augusta Victoria's concerned with Endoscopic Retrograde, cholangiopancreatography (ERCP) and haemodialysis. The number of cases was 451; with a cost of 3,190,288 NIS.

3. Saint Jhon ophthalmic hospital, the number of referred cases was 1,357; the key procedures were cataract extraction and laser therapy for the eyes; with a cost of 3,592,061 NIS.

In total 10,917 different treatment procedures only take place inside Palestine at a total cost of NIS 50,625,729 with an average cost per treatment procedure of NIS 4,638.(MOH annual report, 2004).

Table (2.7) distribution of referred cases inside and Outside Palestine and the associated cost (NIS), 2004.

Referral places	No	%	Cost	%	AVG cost
Inside GS	2,094	6.65	11,568,553	4.42	5,525
Inside WB	9,235	29.32	36,195,875	13.83	3,919
Inside Jerusalem	8,179	25.97	58,932,347	22.51	7,205
Inside Palestine	19,508	61.94	106,696,775	40.76	5,469
Egypt	4,831	15.34	24,964,324	9.54	5,168
Jordan	4,634	14.71	90,882,437	34.71	19,612
Israel	2,523	8.01	39,253,823	14.99	15,558
Outside Palestine	11,988	38.06	155,100,584	59.24	12,938
Total	31,496	100	261,797,359	100	8.312

*Source: health status in Palestine, MOH annual report .2004.

Table (2.8) the top ten treated hospitals (inside Palestine only), 2004.

Treated hospital	No	%	Cost	%	AVG cost
Makassed Hosp	4,245	13.48	42,792,383	16.35	10,081
Sant. Jhoun Hosp	2,634	8.36	7,053,336	2.69	2,678
Ramallah Hosp	1,890	6	35,443	0.01	19
Mosallam Center	1,421	4.51	5,549,495	2.12	3,905
Razan Center	1,378	4.38	8,266,580	3.16	5,999
Arab Accosiation for Rehabilitation	1,135	3.6	5,838,418	2.23	5,144
Augesta Vectoria	1,016	3.23	7,277,119	2.78	7,163
Arab Care Center	912	2.9	1,659,538	0.63	1,820
Al-Basma Center	746	2.37	4,993,480	1.91	6,694
Abu Raia Center	654	2.08	2,895,225	1.11	4,427
Total	16,031	50.9	86,361,017	32.99	5,387

*Source: health status in Palestine, MOH annual report .2004.

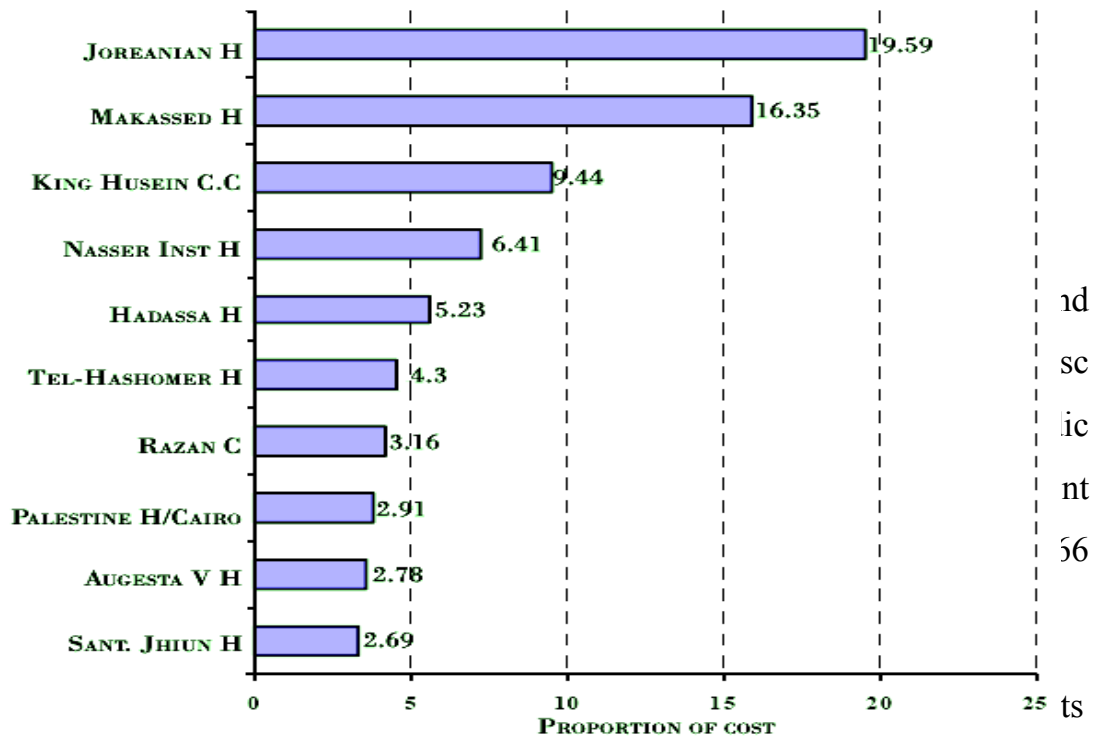
Table (2.9) the top ten treated hospitals (inside and outside), 2004.

Hospital	No	%	Cost	%	AVG cost
Makassed Hosp	4,245	13.48	42,792,383	16.35	10,081
Jordan Hosp	2,851	9.05	51,285,665	19.59	17,989
Sant. Jhoun Hosp	2,634	8.36	7,053,336	2.69	2,678
Nasser Instiute	2,451	7.78	16,793,464	6.41	6,852
Palestine Hops/Cairo	2,226	7.07	7,615,818	2.91	3,421
Ramallah Hosp	1,890	6	35,443	0.01	19
Mosallam	1,421	4.51	5,549,495	2.12	3,905
Razan Center	1,378	4.38	8,266,580	3.16	5,999
Arab Accosia.	1,135	3.6	5,838,418	2.23	5,144
King Hussein center	1,057	3.36	24,722,000	9.44	23,389
Total	21,288	67.59	169,952,602	64.92	7,983

*Source: health status in Palestine, MOH annual report.2004.

Table (2.10) the top ten hospitals according to average cost per case, 2004.

Hospital	Cost / Case
Al-Injeeli Hospital – Al Nasrah	132,000
Lanyado Hospital	50,000
Shneider Paediatric Hosp	33,824
Lasainte famille hosp	30,875
BIKOR-HOLIM HOSP	30,000
Al-Italee Hospital – Hayfa	28,000
Maeir Hosp	26,600
Rambam	26,437
King Husein cancer center	23,389
Hadassa – Ein Karim Hosp	22,929



Graph (2.4) the top ten treated hospital according to cost.

2.10.2 Outside Palestine

2.10.2.1 Jordan

1. Jordan Hospital has mainly received patients from West Bank and key procedures are Cardiac management, urology management, neurological management, neurosurgical management, ophthalmic management, cardiac catheterization, oncology management, chemotherapy, orthopedic management, cardiac surgery, pediatric cardiac surgery, Coronary Artery Bypass Grafting (CABG) and surgical management. The number of procedures that managed was 1,873; with a cost of 37,543,429 NIS.
2. Hussein Medical Center the key procedures are Oncology management, chemotherapy, plastic surgery management, cardiac

surgery, pediatric cardiac surgery. The number of referred cases was 317; with a cost of 5,758,997 NIS.

3. Amman Hospital has carried out cochlear implantation.
4. Al Bashir Hospital is mainly concerned with 269 cases of radiotherapy; with a cost of 2,661,700 NIS.
5. Al-Amal Center concerned with Oncology management and treated 141 cases; with a cost of 3,645,200 NIS.

2.10.2.2 Israel

1. Tel-Hashomer Hospital is concerned with Pediatric consultation, hematological investigations, oncology follow-up, ICU management, pediatric cardiac surgery, vascular management. The number of referred cases was 666, with a cost of 7,838,813 NIS.
2. Echolof Hospital the key procedures are Neurosurgical management, chemotherapy and ICU management. The total number of cases that referred to was 425; with a cost of 3,214,439 NIS.
3. Hadassa-Ein Karim Hospital has received 204 patients and carried out Neurosurgical management, oncology management, chemotherapy, burn management, pediatric cardiac surgery; with a cost of 4,709,767 NIS.
4. Soroka Hospital is concerned with ICU management, burn management and surgical management; it received 61 cases from Gaza Strip with a cost of 766,764 NIS.

In total 10,917 different treatment procedures only take place inside Palestine at a total cost of NIS 50,625,729 with an average cost per treatment procedure of NIS 4,638.(Health indicator in Palestine . 2004).

Chapter Three

(Literature Review)

3.1 Introduction

Many nationals are willing to travel abroad for various reasons in search of health care services. Wealthy and "privileged" patients might wish to take advantage of the advanced, specialized medical and other diagnostic services that may be unavailable in home countries or sometimes available but yet not satisfying or perceived as better quality, or avoid long waiting lists. On the other hand, people from developed countries, to benefit from a lower-price treatment of equal quality or to get benefit from exotic or exclusive therapies, or to have affordable sources of services not covered by health insurance he searches abroad (World Bank, 2005).

The United States of America enjoyed a trade surplus in health care services by providing medical treatment during 1996. It was reported that four Mayo clinics in USA expected 10,000 patients from abroad in 1997. Most developing countries act as sources of patients wanting to have medical treatment abroad even though a few if these may well provide health care to outsiders. (World Bank, 2003).

Most countries have established high level government committees to screen those patients who would be allowed to go for treatment abroad, in order to limit the use of scarce foreign exchange. Some countries also offer a wide range of health care services to foreigners, including a wide range of medical check-ups to specialized tertiary care facilities. At prices estimated to be one-fifth or one-tenth of those charged in developed countries for similar interventions. Other countries could also develop tailor-made services through their local expertise. In a few countries, the

interest in promoting "health tourism" using indigenous medical practices, under this mode of services is growing. (Health policy research, WHO.1995).

The most important challenge in this respect will be the portability of health insurance. Health insurance, which is covered under the financial sector, is often not portable the border and acts as a determinant to the movement of patients wishing to be treated abroad. The entry of private insurance companies into developing country markets, while still quite small, could potentially leave a large impact on the health system, by creating more demand for expensive health services provided in the private sector. Some argue that this may have no significant negative impact if such trends serve to free resources in the public sector for the poor. However, it is important to estimate the net effects of such policies. Such benefits may be offset by the loss of health personnel from public sector facilities who could be lured away by the higher salaries and better work conditions in private facilitation. For the health service trade, it is also very important to share information across countries about multinational hospitals or health insurance companies, and therefore efforts should be made to pool information and make its available to all countries.

Health services provided for foreign patients should not have adverse effects on the national health sector. However, if these services involved the use of public funds to subsidize them, it may reduce the access in the domestic population to general health services. The supply of service in the domestic market can also be affected if public sector providers attend to foreign patients, especially when the capacity of such a health care system is limited. For example in Intifada 60%of Palestinian are insured, this has

affected negatively health care service in Palestine decreasing the quality of services, work overload and limited resources. Countries have to improve the quality of health care if they wish to attract foreign patients. (World Bank, 2005).

3.2 Back ground on the Palestinian health system

The health sector is an important propeller for sustainable development and must be afforded with utmost attention by the state and the donor community. The guiding principals for its development must be equitable access by the population to quality health services enhanced through coordination by health providers and intersectional linkages and cooperation especially under the existence of multiple providers, a unique political environment and financial and human resource constraints. Here it is important to demonstrate what mean by health sector reform.

3.2.1 Health sector Reform

The term "Health Sector Reform" has been frequently used in health development literature, including health policy research, and also in the main context of dialogues with donor agencies. Recent experience in both developed and developing countries has shown that health sector reform is a highly political and fiercely contested process. Especially, in least developed countries, the reforms are more complex due to a wide range of contracting partners, including donor agencies.

In recent years, economic pressures on the government & specifically on the health sector have forced the governments of developing countries of initiate health sector reforms. This thrust is made to ensure that an appropriate share of public funds is spending on health care, especially

at local levels. The users should also be satisfied with the form and content of health services offered (improved health status and client satisfaction), and the benefits of publicly funded health care are equitably distributed (improved equity of access to care). These health sectors reforms varied in social, economic and political environments, as well in development stages of health care systems.

Health sector reform implies a sustained process with fundamental change and purposive, rather than merely incremental or evolutionary change, in which the government has a key role. It is designed to improve the organization and management of health systems and ultimately to achieve overall health policy objectives. Without institutional or structural change. It is likely that existing health organizational structures and management systems will continue to fail to deal adequately with the problems listed above. Health sector reform will therefore, have to be concerned with defining priorities, reforming policies and reforming institutions through which the policies are implemented.

Health sector reforms, in most countries, have been triggered by political and economic changes, rather than by the need for a change due the overburden of diseases or the dysfunctional of health systems. Shifting in thinking of the governments for reforms is more influential than epidemiological or demographic factors alone. Reforms are usually provoked by the drastic political and economic change (macro contextual factors), such as in Myanmar, or the arrival of completely new administration such as in Nepal. (Romer, 1991).

Learning, the experience on the change in health system, requires and increasing understanding of health systems themselves. In the simplest way, the health system means the "Combination of resources, organization, financing, and management that culminates in the delivery of health services to the population" (Romer, 1991).

A National Palestinian Health Plan (NHP) was developed in the early nineties (1993) and was complemented by a strategic health plan 1999-2003. Both plans were meant as a blueprint for planning and implementation in the health sector. Progress has been achieved in several areas 1994-2000 in an attempt to create organizational capacities and bridge gaps in the inherited health care system from the Israeli occupation. However, many health initiatives deteriorated post 2000 and the eruption of the Palestinian Intifada with the health sector becoming more vulnerable with mounting financial and service delivery constraints concentrating on meeting rising emergency needs with much less attention to development needs seen as secondary under prevailing circumstances. This is also reflected in the MOP emergency plan 2003-2004 (section on health) which included two areas where emergency resources would be poured into health: Job creation and infrastructure development. The health elements of the plan included: Vaccination program, supply of medical apparatuses program including mobile clinics, rehabilitation of hospitals and clinics, building new clinics in remote and neglected areas, a training program and a special program for offering medical services to families of military personnel and others. (Aghabekian, 2004).

3.3 Treatment abroad in other countries

3.3.1 Treatment abroad or cross-border health care in Europe

3.3.1.1 History of patient mobility in Europe

People have been crossing borders within Europe for as long as borders have existed. In the middle ages, pilgrims in need of care could rely in a network of monasteries providing free, if basic, care as they made their way slowly to centers such as Santiago de Compostela in what is now Spain.

The situation now is, of course, very different. First, many more people are crossing borders, conveyed not on foot or horseback but by trains, cars, and increasingly, but low-cost-air-lines. Second, the scope of what health care can offer has changed beyond recognition, with increasingly sophisticated pharmaceuticals and technology.

Until the establishment of European Union mechanisms for cross – border health care, anyone requiring health care abroad would have considered this to be a private matter. Even now, thousands of European citizens who require health care at side their own country pay of it and reclaim their payment from their holiday insurance policy. However, in the mid- 1970s, the then European Economic Community recognized that freedoms enshrined in the European Treaties, was meaning less if only those who were in full health could take advantage of this freedom.

In 1971, Council Regulation, on the application of social security schemes of employed persons, to self – employed persons and to members of their families moving within the community was adopted. It established

a series of mechanisms by which individuals could obtain health care in another member state.

The situation changed dramatically in 1998 with two linked rulings by the European Court of Justice in some cases, that patient could use internal market provisions to gain access to health care in other member states. As a consequence, the European Commission convened a high level process of reflection to address the issue of patient mobility explicitly. This reflection process led to a series of recommendations that sought to maximize the potential benefits of patient mobility & minimizing the problems.

3.3.1.2 Who might seek health care abroad in Europe

The vast majority of health care is obtained from providers located in the same country, with individuals often unwilling to travel significant distances even in their own country. However, there are also many people who will require treatment in another country, for a variety of reasons, including:

- Temporary visitor's abroad.
- Long-term residents abroad.
- People who use facilities serving border regions.
- People who go abroad to seek treatment.
- People sent abroad by their own health provider, because the treatment is unavailable at home or because there would be under delay in obtaining it.

3.3.1.3 Sending patients abroad

Some countries have adopted explicit policies to send patients abroad for treatment. In some, this is a short-term move designed to challenge domestic monopolies and thus bring about change in the home health care system. Some small countries have long traditions of sending people abroad for highly-specialized treatment; treatments involved include cardiac surgery and transplants of bone marrow, liver, heart, & lungs.

3.3.1.4 Patients traveling independently for treatment abroad

Despite their prominence in cases brought before the European Council of Justice, patients traveling abroad to seek treatment are relatively few and often seeking treatments that are on the margins of what funded by their health care system. Some of the new-member states have identified opportunities to take advantage of their low costs and attract patients from Western Europe. While some movement has taken place, there is, however growing competition from lower-priced providers in other parts of the world, such as South Africa or India. (WHO, 2005).

Although the absolute volumes of patient and professional mobility within the European Union remain relatively limited, movement is taking place and raises complex questions about its impact for these patients and professionals who move and those who do not. Moreover, the increasing impetus to this debate given by recent court judgments has come at a time when health systems throughout the European Union are facing increasing pressures from the aging of populations, introduction of new health technologies and techniques, and increasing difficulties in meeting public expectations within available resources.

Chapter Four

(Methodology)

4.1 Introduction

The study was conducted during the period of January – May, 2006. It was implemented in private sector, NGOS, (UNRWA), public sector in Palestine, and Jordan hospital. This study is considered as an investigation of basics, principles, opinions & recommendations of TAD to be in the future. It will explain how to invest the improvement of health care system & finally to abandon Treatment Abroad especially out side Palestine, it Portrays patients currently utilizing services, & other key informant in MOH like Deputy Minister of Health, chair man of TAD, clinical director or chief of administration & specialists physicians at all levels.

The patient questionnaire was conducted by face to face interviews. Therefore, questions should be exceptionally clear and easy to respond for this type of questionnaire to guarantee successfulness. The researcher herself conducted the interview, in addition to other trained staff on such interview. Also questionnaires for other key informants conducted in the same way.

4.2 Ethical Consideration

A formal letter: from Coordinator for Scientific Centers at An-Najah University was sent to each center requesting the director, or chief executive manager of the hospital as applicable, to allow the researcher to conduct the study.

Explanatory form: every eligible manager, chair persons, physicians, and specialists was given a full explanation about research, including the purpose, nature of the study, importance of participation in addition to

assurance of confidentiality of information and voluntary participation & was given total freedom to accept or reject participation in this research.

4.3 Instrument

To explore the causes of treatment abroad, the type of treatment that not found in MOH, suggestions of employees in different health care sectors providers to abandon treatment abroad and to know the elements affecting the result. Questionnaire was structured by the researcher after reading the related literature.

The questionnaire consisted of 5 key informants:-

1. Questionnaire 1 for patient treating abroad.
2. Questionnaire 2 for decision maker of MOH.
3. Questionnaire 3 for chair man of TAD.
4. Questionnaire 4 for employees in private and NGOS sectors.
5. Questionnaire 5 for employees in public "governmental sector".

4.4 Pilot Testing

In order to increase the reliability and validity of the instrument, the researcher did a pilot testing to ensure the comprehensives of the questionnaire. 20 questionnaires submitted to patients in Nablus Specialty Hospital. The data were analyzed to clarify any unclear question. These 20 patients were excluded from the study.

4.5 Data collection

Patients and employees in our study or sample were chosen randomly from the following hospitals:

1. Ministry of Health Hospitals. Ramallah, Nablus and Beit Jalah hospitals.
2. Palestinian private sectors, Nablus Specialty Hospital, Arab care hospital and Al-Arabi Hospital.
3. Jordan hospitals.
4. Al-Maqaded
5. And others International hospitals.

The data collected from five sources using modified questionnaires designed to facilitate and supply of required information according to the aim of the study.

The number of patients of sample of the study was 191, 92 patients chosen from Jordan hospitals (Jordan hospital and Al-Amal center) 99 patients chosen from West Bank hospitals, in random stratified sample.

Other group of the study sample was made from (20) physicians and administrative from public sector and same like for private, NGOS, and UNRWA, in addition to deputy of ministry and chair man of treatment abroad department.

4.5.1 Patient questionnaire, which involve

- Patient satisfaction about health care services in "MOH", and treatment abroad "external MOH".
- Type of disease.
- Waiting list.
- The place where they referred.
- If case treatment available at Palestinian MOH or not.
- The reason why they are referred.
- Patient satisfaction about treatment abroad in Palestine in private sector "external MOH" & external Palestine.
- The disadvantages of treatment abroad.
- Recommendations from patients for private sector in Palestine to improve his satisfaction.

4.5.2 Decision Maker of MOH questionnaire which involve

- The reasons that leading to establish the activities of TAD.
- Year that in which department established and the need at that year.
- The strategy of MOH from implements the activities of TAD.
- The main points in job description in TAD and if the department is fulfilling completely its objectives.
- The future of TAD as seen by MOH.

- If there is any control or monitoring system for TAD strategy and the changeable situation.
- Revision of located budget for TAD and if the variability budget of MOH affect the activities of this department.
- How the limitation in resources affect TAD.

4.5.3 Chair man of treatment abroad department questionnaire, which involve the following

- If they really have strategic planning, mission statement, vision, goals, or if the treatment abroad department want to achieve strategic planning?
- Opportunities in treatment abroad department, strengths, weaknesses & threats that (TAD) face .Also if there is co-operation with donors or not.
- Criteria that (TAD) follow to evaluate the level of satisfaction of their customers.
- If there is a controlling system or monitoring system for achievements the strategy that (MOH) state it.
- Is there is optimum usage of human, physical financial resources in this department.
- Criteria that should meet to refer any patient for treatment abroad.
- If the organizational structure in this department is appropriate and fits with MOH structure.

- The total budget of MOH spent in treatment abroad department.
- Administration of treatment abroad department, can be governmental (MOH), semi governmental (decentralized), or independent.
- The reasons of increase number and cost of treatment abroad.
- About percentage of referred patients for treatment abroad.
- If treatment abroad outside Palestine can be replaced by treatment abroad inside Palestine.

4.5.4 Public sector employees questionnaire, submitted to the specialist about the related issues:

- Satisfaction with the activities and performance of treatment abroad department.
- If human, physical, technical ... etc. resources available in the MOH sufficient to treat Palestinian patients in Palestine, or need some improvement.
- Rules and regulation that followed by (MOH) in referring patients.
- Pressure from patients & their families faced by doctors to transfer patients to treatment abroad.
- Integration between public & private sector. The role of private sector in playing efficient role to satisfy the needs of the patients.
- If we decrease the number and cost of treatment abroad, can this lead to invest in implementing comprehensive or total medical services in Palestine?

- Important of quality health care services and patients satisfaction will affect percentage of (TA) or not.
- If (TAD), can be governmental, semi governmental (decentralized), or independent institution.
- The MOH role in the health system can be health regulator, health care provider for primary, or both.
- Public health insurance coverage increase up to 60% of people, how this affected negatively the health care delivery in public sector.
- How to strengthen, human, financial, physical and technical resources in MOH.

4.5.5. Questionnaires submitted a to the specialist in different positions, chief executive managers, in private, NGOs and UNRWA, asked about the following:

- If there is an integration between the two sectors, and if this integration built on complementary, competitive, independent base.
- Obstacles that prevent the integration between health care sectors.
- If the private sector is aware about the causes of referral of patients to treatment abroad. (out side Palestine)
- The differences between public services and private services.
- If patients attended in the private sector are public health insured or not.
- Quality of services & patients satisfaction in private & other sector.

- Differentiation between patient satisfaction inside Palestine & outside Palestine.
- Rationality of the services cost in private sector.
- Political and economical situation available taken into consideration.
- Recommendation in order to achieve more integration between

4.6 Data analysis

The relevant quantitative data about different variables is analyzed and entered to the statistical model using SPSS include mean stander deviation, and percentage, to find the results for the established hypothesis. While other qualitative information analyzed manually to obtain result.

4.7 Design of the study

Related to patient group the study includes these variables:

4.7.1 Independent variable

- type of disease
- referral cause
- referral source
- price control or financial contract before intervention
- suggestions to avoid referral treatment abroad Ministry of Health .
- medical services
- nursing services
- general services

4.7.2 Dependant variable

- the area
- the disadvantages of referral abroad
- the type of disease
- the period that patient stay in hospital (hospitalization period)

Chapter Five

(Results)

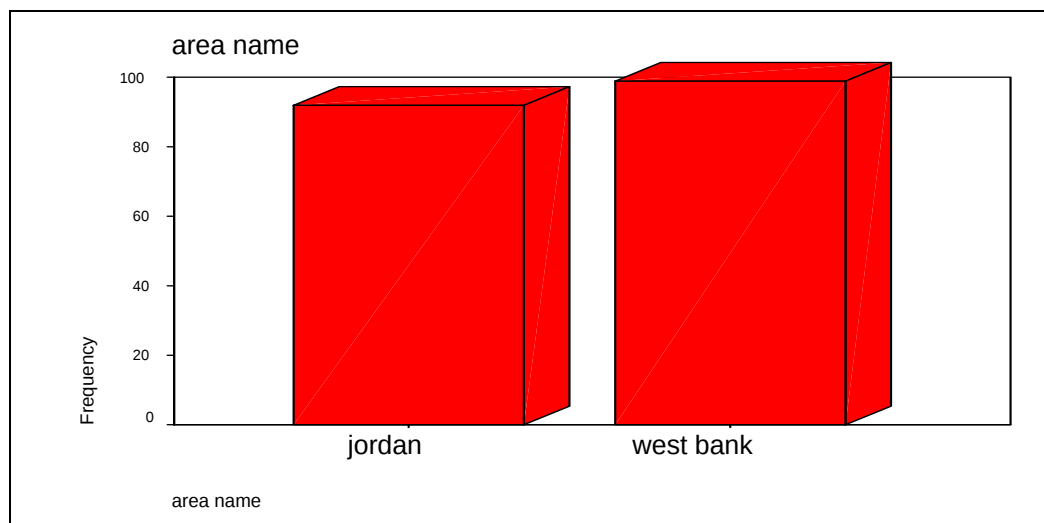
5.1 Distribution of patients study sample.

The table (5.1) and the bars chart (5.1) shows the frequencies and the percentages of the study sample

Table (5.1) distribution of patients and related area.

Area name		
Valid	Frequency	Percent
Jordan	92	48.2
West Bank	99	51.8
Total	191	100.0

We notice from the table (5.1) that 51.8% of the samples of the study were from West Bank and 48.2 % were from Jordan.



Graph (5.1) patients frequency and related area.

Table (5.2) type of disease frequency and %

Type of disease		
Valid	Frequency	Percent
Cardiac	34	17.8
In Vitro Fertilization	3	1.6
Organs transplantation	11	5.8
Tumor	63	33.0
Others	78	40.8
Total of valid	189	99.0
Missing System	2	1.0
Total	191	100.0

We notice from table (5.2) that the highest percent of cases had other disease with percent 40.8%, then tumor disease with percent 33%, then cardiac with percent 17.8%, organs transplantation with 5.8%. The rest is 1.6% In Vitro Fertilization and 1.0 % not answering this variable.

Table (5.3) frequency and percent of hospitalization period.

Period that patient stay in hospital or hospitalization period:		
Valid	Frequency	Percent
1-3 days	63	33.0
4-7 days	41	21.5
More than one week	83	43.5
Total of valid	187	97.9
Missing System	4	2.1
Total	191	100.0

From table (5.3) we notice that the highest percent of period that patient stay in hospital was more than one week with percent 43.5% then 33.0% stay from 1-3 days, 21.5% of sample stay from 4-7 days and 2.1 % not answering this variable.

Table (5.4) Reason of referral and related frequency and %

Referral cause		
Valid	Frequency	Percent
Treatment not found in Palestine	91	47.6
Services not in good quality	51	26.7
There is a long time waiting for intervention	27	14.1
More economical.	8	4.2
Lack of trust for medical team in Palestine.	9	4.7
Total of valid	186	97.4
Missing System	5	2.6
Total	191	100.0

According to patients we notice from table (5.4) that the highest percent of referral reason that treatment not found in Palestine with percent 47.6%, second because the service not in good quality 26.7%, third because there was a long time waiting for intervention 14.1%, 4.7% Lack of trust for medical team in Palestine's, finally 4.2% see that referral was more economy and 2.6 % not answering this variable.

Table (5.5) frequency, percent and related referral source.

Referral source		
Valid	Frequency	Percent
From ministry of health	127	66.5
From private insurance company.	37	19.4
Patient willingness or self referral	26	13.6
Total of valid	190	99.5
Missing System	1	.5
Total	191	100.0

The table (5.5) shows that the 66.5% of the sample their referral sources were from ministry of health and the rest 19.4% and 13.6% their referral sources were from private insurance company and/or Patient

willingness (self referral) respectively with 0.5 % not answering this variable.

Table (5. 6) medical services at referral institution, related frequency and percent.

Medical services			
Status		Frequency	Percent
Valid	Good	3	1.6
	Very good	43	22.5
	Excellent	24	12.6
	Total	70	36.6
Missing System		121	63.4
Total		191	100.0

We notice from table (5.6) that the highest percent of patient opinion see that the medical services out MOH were very good with 22.5%. and 12.6 % see that the medical services is excellent, only 1.6% of sample see the medical services was good and 63.4% not answering this variable.

Table (5. 7) Satisfaction with nursing services at referral institution and related frequency.

Nursing services			
Status		Frequency	Percent
Valid	Good	6	3.1
	very good	39	20.4
	Excellent	24	12.6
	Total	69	36.1
Missing System		122	63.9
Total		191	100.0

We notice from table (5.7) that the highest percent of cases see that the nursing services was very good with 20.4% . and 12.6 % see that the

nursing services was excellent, only 3.1% of sample see the nursing services was good and 63.9% not answering this variable.

Table (5. 8) Patient satisfaction with general services at referral institution and related frequency and percent.

general services			
Status		Frequency	Percent
Valid	Good	1	0.5
	Very good	37	19.4
	Excellent	15	7.9
	Total	53	27.7
Missing System		138	72.3
Total		191	100.0

From table (5.8) we notice that the highest percent of cases see that general services were very good with 19.4%, 7.9% see it was excellent, 0.5 % see it was good and 72.3 % not answering this variable.

Table (5. 9) Estimation of cost pre-intervention treatment services, related frequency and percent.

Cost estimation pre-intervention treatment services.			
Status		Frequency	Percent
Valid	No	43	22.5
	Yes	109	57.1
	Total	152	79.6
Missing System		39	20.4
Total		191	100.0

From the table (5.9) we notice that 57.1% of the sample answer yes to the question (cost estimation pre- intervention treatment services?) 22.5% answer no and 20.4% not answering this variable.

Table (5. 10) suggestions of patients to MOH to avoid treatment abroad.

Your suggestions to avoid referral treatment abroad, Ministry Of Health should provide medical system.		
Valid	Frequency	Percent
Personnel resources	10	5.2
Financial resources	49	25.7
Technological resources	18	9.4
MOH should work on quality and patient satisfaction	4	2.1
Improve patient's trust for present medical services	1	0.5
Others	17	8.9
Total of valid	99	51.8
Missing System	92	48.2
Total	191	100.0

We notice from table (5.10) that the highest percent of suggestions to avoid referral treatment abroad, Ministry Of Health should provide medical system in MOH by Financial resources with 25.7% agreement second Technological resources with percent 9.4%,third other medical system 8.9%,fourth personnel resource 5.2%,fifth MOH should work on quality and patient satisfaction.2.1% the last Improve patient's trust for present medical services.0.5% agreement .and 48.2% of the sample study not answering this variable.

Table (5. 11) disadvantages of referral abroad and its frequency and percent.

Disadvantages of referral abroad		
Valid	Frequency	Percent
Far from relatives.	19	9.9
Need more money	13	6.8
Difficulty of barriers and transportation	6	3.1
Others	25	13.1
Total of valid	63	33.0
Missing System	128	67.0
Total	191	100.0

We notice from table (5.11) that the highest percent of patient see that the Disadvantages of referral abroad was other thing that mention in questionnaire with 13.1% and 9.9% see that the far from relative and 6.8% see the disadvantage was a need for more money and finally 3.1% of the sample see the Difficulty of barriers and transportation percent and 48.2% of the cases not answering this variable.

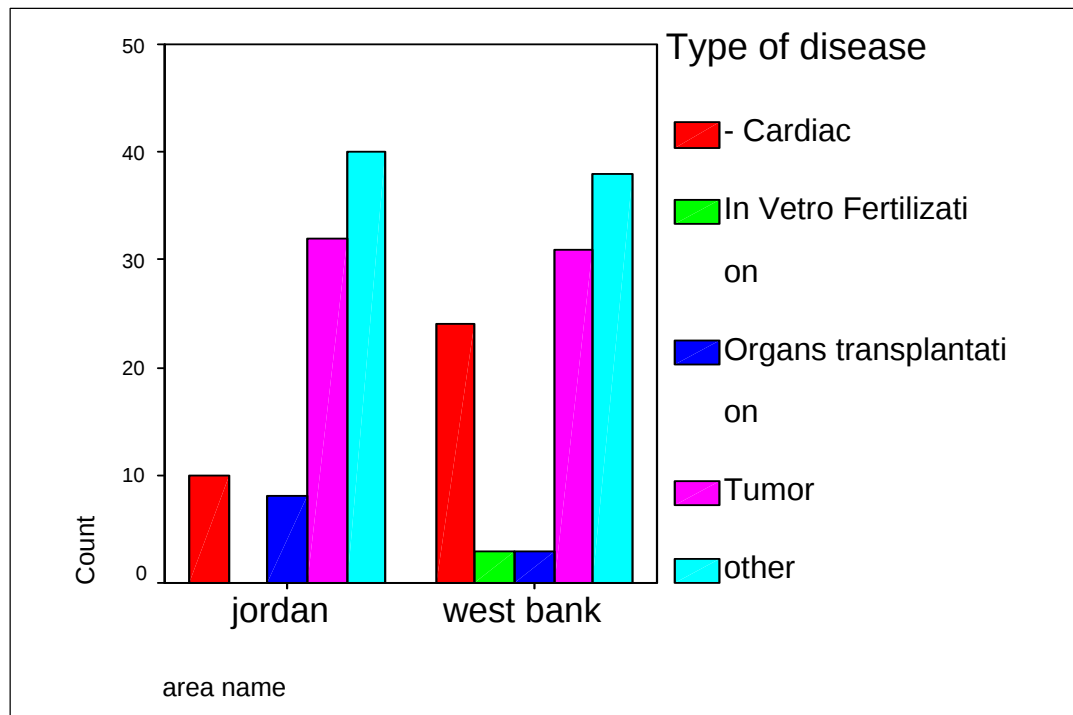
Table (5. 12) Type of services/illness by place of referral.

Area name		Type of disease					Total
		Cardiac	In Vitro Fertilization	Organs transplantation	Tumor	other	
Jordan	#	10	0	8	32	40	90
	%	11.1	0	8.9	35.6	44.4	100.0
West Bank	#	24	3	3	31	38	99
	%	24.2	3.0	3.0	31.3	38.4	100.0
Total	#	34	3	11	63	78	189
	%	18.0	1.6	5.8	33.3	41.3	100.0

From the table (5.12) we notice that the most type of disease in Jordan in these cases were other diseases than mention in this questioner with percent 44.4% and second Tumor with 35.6%, then Cardiac 11.1% and finally Organs transplantation with 8.9% and their was no case in Jordan have In Vitro Fertilization disease from the sample we take

Compare with Jordan the most type of diseases in West Bank was also came first other diseases than mention in this questioner with percent 41.3% and second Tumor with 33.3%, then Cardiac 18.0% and Organs transplantation came four with 5.8% differ from Jordan their was 3 cases in West bank have In Vitro Fertilization disease with percent 1.6%.

And the bar chart (5.2) shows frequency of the two variables the area and type of disease result.



Graph (5. 2) Type of services/illness by place of referral

And the table (5.13) shows the result of the Pearson chi square test.

Table (5. 13) Pearson Chi Square test between the area and type of disease.

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.700 (a)	4	0.030
Likelihood Ratio	12.095	4	0.017
Linear-by-Linear Association	4.641	1	0.031
N of Valid Cases	189		

According to the results it is clear that there is a significant statistical relationship between the place/area of referral and illness ($p=0.003$).

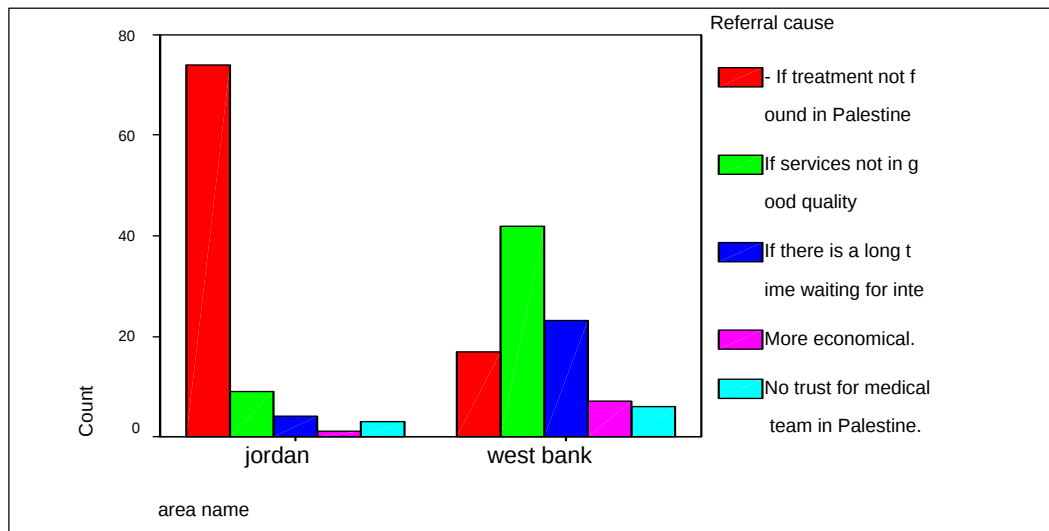
Table (5. 14) Place of referral by reason of referral.

Area name		Reason of referral					Total
		Treatment not found in Palestine	Services not in good quality	Long time waiting for intervention	More economical	Lack of trust for medical team in Palestine	
Jordan	#	74	9	4	1	3	91
	%	81.3	9.9	4.4	1.1	3.3	100.0
West bank	#	17	42	23	7	6	95
	%	17.9	44.2	24.2	7.4	6.3	100.0
Total	#	91	51	27	8	9	186
	%	48.9	27.4	14.5	4.3	4.8	100.0

From the table (5.14) we notice that the most reason for referral in Jordan in these cases were treatment not found in MOH with percent 81.3%, second services not in good quality with 9.9%, third there was a long time waiting for intervention 4.4% and for lack of trust for medical team in Palestine 3.3% and finally 1.1% see the referral was More economical.

Compare with Jordan the most reason for referral in West Bank was also came first in these cases were treatment not found in MOH with percent 48.9%, second services not in good quality with 27.4%, third there was a long time waiting for intervention 14.5% and differ from cases in Jordan referral was More economical came four with 4.8% and lack of trust for medical team in Palestine came five with 4.3%

And the graph (5.3) shows frequency of the two variables, place of referral and reason of referral.



Graph (5. 3) Place of referral by reason of referral

And the table (5.15) shows the result of the Pearson chi square test.

Table (5. 15) Pearson Chi Square test between the place of referral and referral reason.

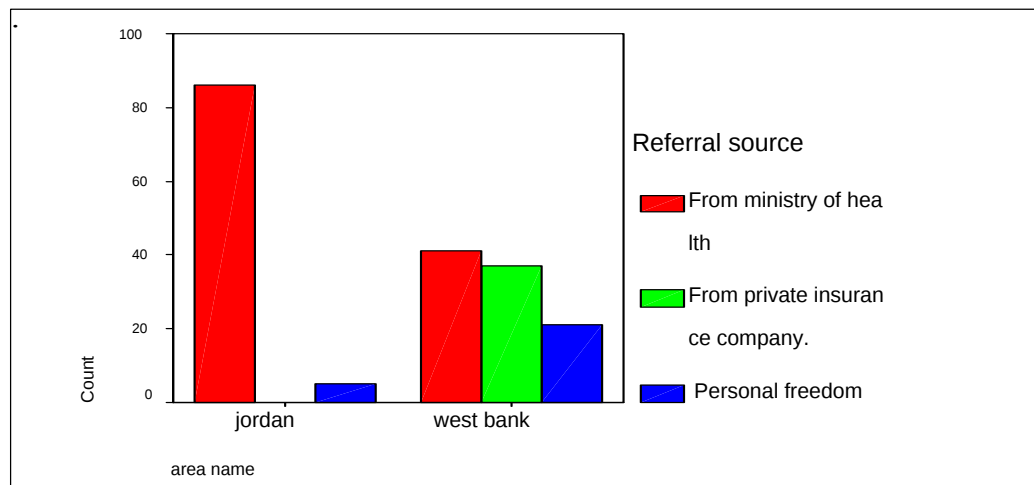
Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	75.876 (a)	4	.000
Likelihood Ratio	82.450	4	.000
Linear-by-Linear Association	41.334	1	.000
N of Valid Cases	186		

Since the level of significance (0.000) was smaller than 0.05, we reject the hypothesis and conclude that "There exists a significant relationship, in the significant level 0.05, between the place of referral and reason of referral."

Table (5. 16) the frequency and percentages of the place and referral source.

Area name		Referral source			Total
		From ministry of health	From private insurance company	Self referral	
Jordan	#	86	0	5	91
	%	94.5	0	5.5	100
West Bank	#	41	37	21	99
	%	41.4	37.4	21.2	100
Total	#	127	37	26	190
	%	66.8	19.5	13.7	100

From the table (5.16) we notice that the most referral source in Jordan in these cases were from MOH with percent 94.5%, then with 5.59%, there was no case in Jordan have their referral source from private insurance company from the sample we take compare with Jordan the most referral source in West Bank is also came first from MOH with 66.8%, and differ from cases in Jordan there was referral source from private insurance company with 19.5% and finally 13.7% in cases in West Bank their referral resource came from self referral.



Graph (5. 4) the frequency of the two variables the place and the type of referral source

And the table (5.17) shows the result of the Pearson chi square test.

Table (5. 17) Pearson Chi Square test between the place of referral and referral sources.

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	62.565 (a)	2	.000
Likelihood Ratio	77.839	2	.000
Linear-by-Linear Association	42.725	1	.000
N of Valid Cases	190		

Since the level of significance (0.000) was smaller than 0.05, we reject the hypothesis and conclude that "There exists a significant relationship, in the significant level 0.05, between the place of referral and referral source".

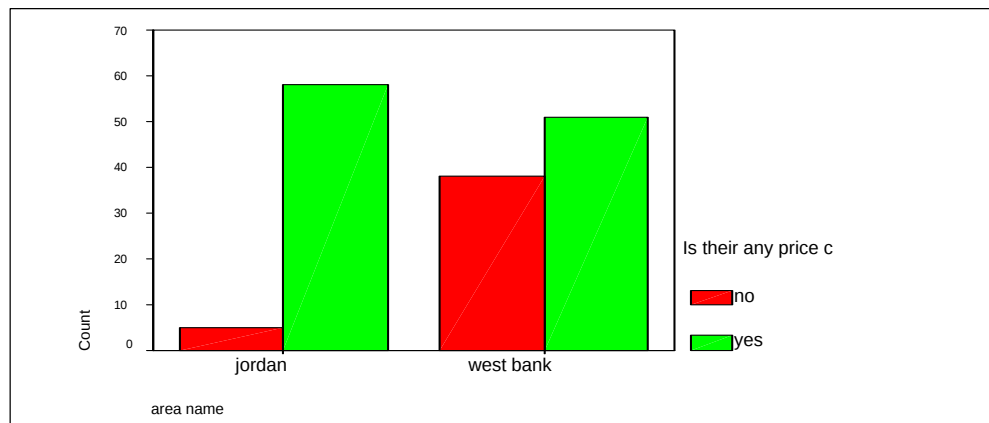
Table (5. 18) the frequency and percentages of the place of referral and estimation of cost pre- intervention.

Area name		Estimation of cost pre-intervention.		Total
		No	Yes	
Jordan	#	5	58	63
	%	7.9	92.1	100
West bank	#	38	51	89
	%	42.7	57.3	100
Total	#	43	109	152
	%	28.3	71.7	100

From the table (5.18) we notice that the 92.1% of patients in Jordan answered yes to the question (estimation of cost pre-intervention.) And only 7.9% of them said that there was no cost estimation before intervention.

In comparison in the West Bank patients indicated that there was a cost estimation before intervention with 71.7% and 28.3% answered their was no cost estimation before intervention.

The graph (5.5) shows frequency of the two variables the area and type and if their any price control or financial contract before intervention.



Graph (5. 5) the frequency of the two variables the place of referral, and estimation of cost before intervention.

The table (5.19) shows the result of the. Pearson chi square test

Table (5. 19) Pearson Chi Square test between the place of referral and cost estimation before intervention.

Chi-Square Tests			
Statistic	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.971(b)	1	.000
Continuity Correction(a)	20.291	1	.000
Likelihood Ratio	24.679	1	.000
Linear-by-Linear Association	21.826	1	.000
N of Valid Cases	152		

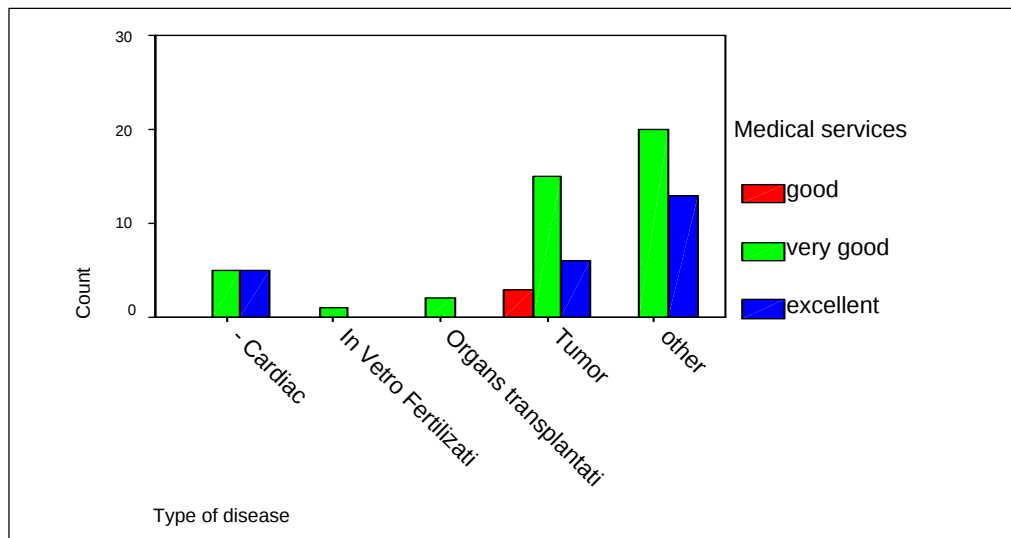
Since the level of significance (0.000) was smaller than 0.05, we reject the hypothesis and conclude that "There exists a significant relationship, in the significant level 0.05, between the place of referral and cost estimation before intervention".

Table (5. 20) Satisfaction of medical services by type of disease.

Type of diseases		Medical services			Total
		good	very good	excellent	
- Cardiac	#		5	5	10
	%		50	50	100
In Vitro Fertilization	#		1		1
	%		100		100
Organs transplantation	#		2		2
	%		100		100
Tumor	#	3	15	6	24
	%	12.5	62.5	25	100
Other	#		20	13	33
	%		60.6	39.4	100
Total	#	3	43	24	70
	%	4.3	61.4	34.3	100

From the table (5.20) we notice that the half of the cases which have cardiac diseases say that there was an excellent medical service and the other have say their was a very good services .how have In Vitro Fertilization and Organs transplantation disease say the service was very good with 100% and 62.5% of tumor say the medical services was very good and 25% of them say it is excellent and the rest 12.5% say it was good. And how have other diseases said with 60.6% the services were very good and the rest say the medical services are excellent.

The graph (5.6) shows frequency of the two variables the type of disease and medical services.



Graph (5. 6) Satisfaction of medical services by type of disease.

And the table (5.21) shows the result of the. Pearson chi square test.

Table (5. 21) Pearson Chi Square test between satisfaction of medical services by type of disease.

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.301(a)	8	.318
Likelihood Ratio	10.861	8	.210
Linear-by-Linear Association	.075	1	.785
N of Valid Cases	70		

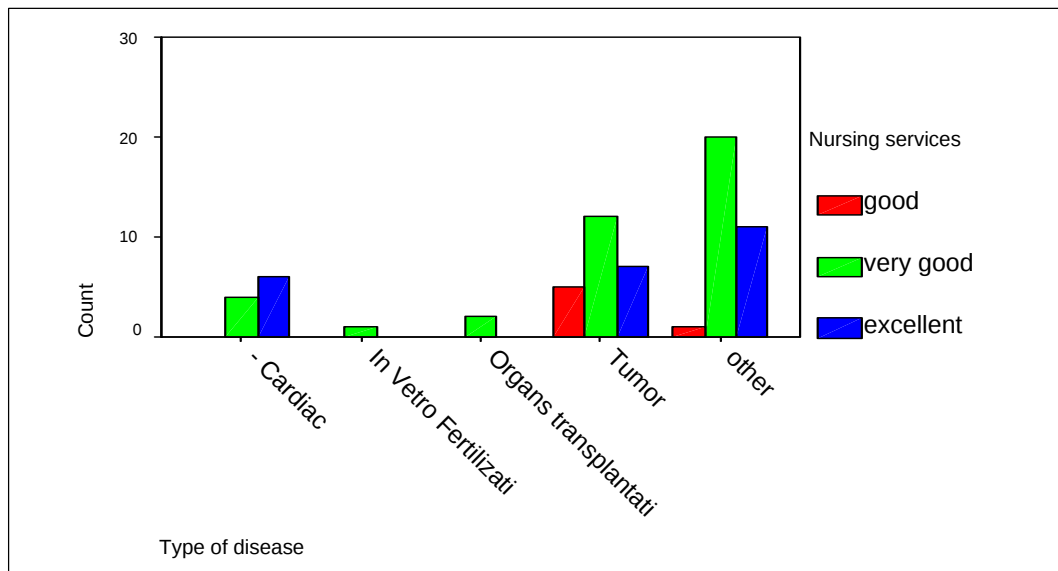
Since the level of significance (0.318) was bigger than 0.05, we accept the hypothesis and conclude that "There exists no significant relationship, in the significant level 0.05, between the type of disease and medical services".

Table (5. 22) Satisfaction of nursing services by type of disease.

Type of disease		Nursing services			Total
		good	very good	excellent	
Cardiac	#		4	6	10
	%		40.0%	60.0%	100.0%
In Vitro Fertilization	#		1	0	1
	%		100.0%	0	100.0%
Organs transplantation	#		2	0	2
	%		100.0%	0	100.0%
Tumor	#	5	12	7	24
	%	20.8%	50.0%	29.2%	100.0%
Other	#	1	20	11	32
	%	3.1%	62.5%	34.4%	100.0%
Total	#	6	39	24	69
	%	8.7%	56.5%	34.8%	100.0%

From the table (5.22) we notice that how have cardiac diseases say that there was an excellent nursing service with 60% and the other say their was a very good services with 40%, how have In Vitro Fertilization and Organs transplantation disease say the nursing service was very good with 100% and 50% of tumor say the nursing services was very good and 34.4% of them say it was excellent and the rest 20.8% say it was good. And how have other diseases said with 62.5% the services was very good 34.4% say the nursing services was excellent. And the rest 3.1% say it was good.

And the Graph (5.7) Satisfaction of nursing services by type of disease.



Graph (5. 7) Satisfaction of nursing services by type of disease.

And the table (5.23) shows the result of the Pearson chi square test.

Table (5. 23) Pearson Chi Square test between the type of disease and nursing services.

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	11.299(a)	8	.185
Likelihood Ratio	12.245	8	.141
Linear-by-Linear Association	1.175	1	.278
N of Valid Cases	69		

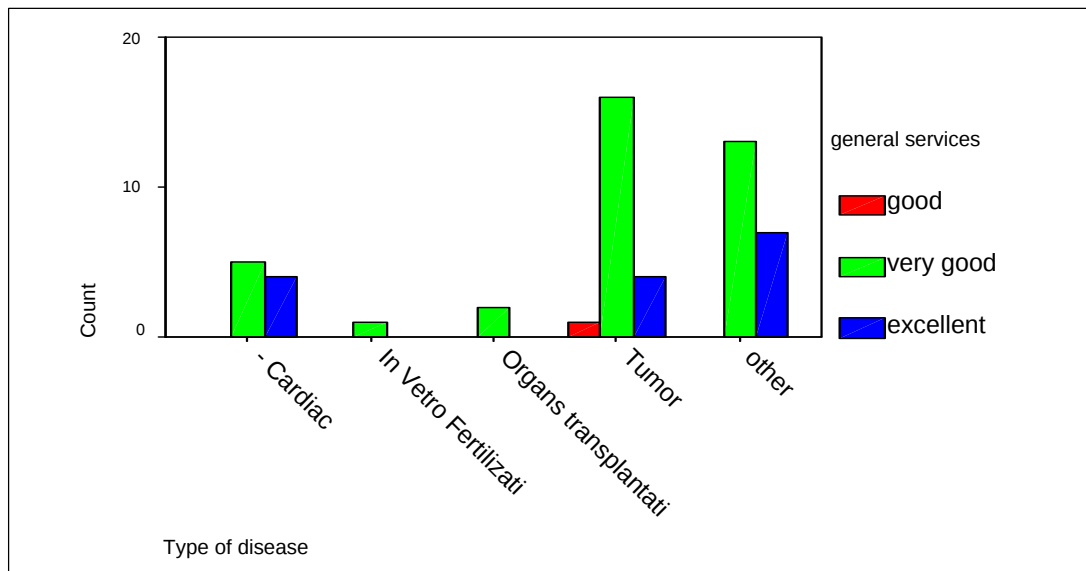
Since the level of significance (0.185) was bigger than 0.05, we accept the hypothesis and conclude that "There exists no significant relationship, in the significant level 0.05, between the type of disease and nursing services".

Table (5. 24) Satisfaction of marketing services by type of disease.

Type of diseases		Marketing services			Total
		Good	very good	excellent	
Cardiac	#		5	4	9
	%		55.6%	44.4%	100.0%
In Vitro Fertilization	#		1		1
	%		100.0%		100.0%
Organs transplantation	#		2		2
	%		100.0%		100.0%
Tumor	#	1	16	4	21
	%	4.8%	76.2%	19.0%	100.0%
Other	#		13	7	20
	%		65.0%	35.0%	100.0%
Total	#	1	37	15	53
	%	1.9	69.8%	28.3%	100.0%

From the table (5.24) we notice that how have cardiac diseases say that there was an excellent general service with 44.4% and the other say their was a very good services with 55.6%, how have In Vitro Fertilization and Organs transplantation disease say the marketing service was very good with 100% and 76.2% of tumor say the general services was very good and 19% of them say it was excellent and the rest 4.8% say it was good. And how have other diseases said with 65% the services was very good 35% say the general services was excellent.

And the graph (5.8) shows satisfaction of marketing services or general services by type of disease.



Graph (5. 8) Satisfaction of marketing services by type of disease.

And the table (5.25) shows the result of the Pearson chi square test.

Table (5. 25) Pearson Chi Square test between the type of disease and marketing services.

Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.996 (a)	8	.758
Likelihood Ratio	6.082	8	.638
Linear-by-Linear Association	.177	1	.674
N of Valid Cases	53		

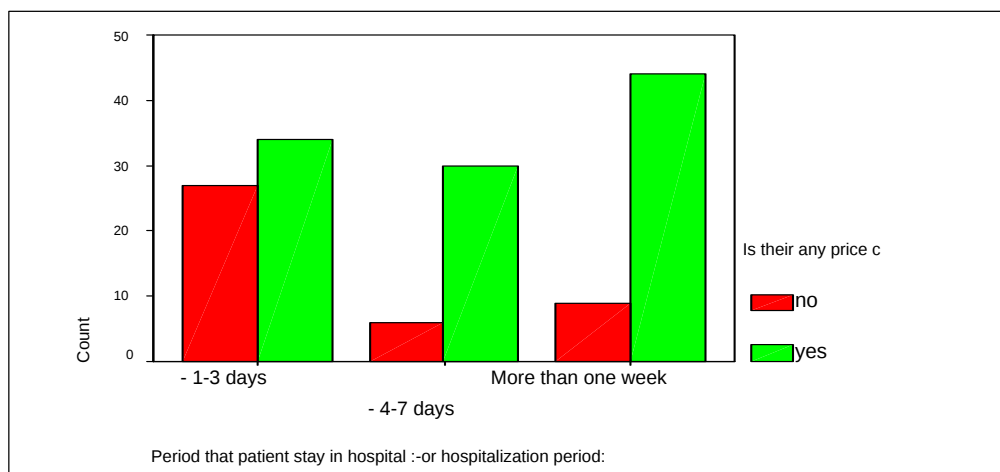
Since the level of significance (0.758) was bigger than 0.05, we accept the hypothesis and conclude that "There exists no significant relationship, in the significant level 0.05, between the type of disease and marketing services".

Table (5. 26) Hospitalization period by cost estimation or financial contract pre-intervention.

Period that patient stay in hospital: or hospitalization period:		Cost estimation pre- intervention?		Total
		No	Yes	
1-3 days	#	27	34	61
	%	44.3%	55.7%	100.0%
4-7 days	#	6	30	36
	%	16.7%	83.3%	100.0%
More than one week	#	9	44	53
	%	17.0%	83.0%	100.0%
Total	#	42	108	150
	%	28.0%	72.0%	100.0%

From the table (5.26) we notice that 55.7% the hospitalization period from 1-3days how say yes hospitalization period and the rest 44.3% say no and how stay from 4-7days in hospital say yes with 83.3% and 16.7% say no, and finally how was hospitalization period was more than one week say yes with 83% and no with 17 answer to the question (Is there a cost estimation or financial contract before intervention?).

And the graph (5.9) shows hospitalization period by cost estimation pre- intervention.



Graph (5.9) Hospitalization period by cost estimation pre- intervention.

And the table (5.27) shows the result of the. Pearson chi square test.

Table (5. 27) Pearson Chi Square test between hospitalization period and cost estimation or financial contract before intervention

Chi-Square Tests			
Statistic	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.488 (a)	2	.001
Likelihood Ratio	13.394	2	.001
Linear-by-Linear Association	10.776	1	.001
N of Valid Cases	150		

Since the level of significance (0.001) was smaller than 0.05, we reject the hypothesis and conclude that "There exists a significant relationship, in the significant level 0.05, the period that patient stay in hospital (hospitalization period) and cost estimation or financial contracting before intervention".

5.2 Results related to physicians and policy makers in public sector (governmental sector). About the following:

1. Their satisfaction about TAD performance. 50% of participants of the sample study replay that they were satisfied about TAD performance. While the other 50% replay that they are not satisfied and it should be striated for very specialized cases.
2. Their opinion about human, physical and technical resources in the MOH. 100% of participant show that there is deficiency in all resources in MOH,
3. If physician follow MOH criteria about TAD. 85% of participant show that physicians follow the rules implemented by MOH, and

the other 15% enhance for referring abroad and not committed to the rules.

4. The pressure of patient's family on physicians to treat their patients abroad. All employees show that very frequently and daily face this problem.
5. The role of private sectors to improve patient satisfaction. 65% of the participant show that private sector can't play efficient role to satisfy the needs of patients while the remain 35% replay that it become possible for private sector to play this role if providing customers with services not found in MOH and by giving their best treatment.
6. The replacement of TA from outside Palestine to inside Palestine. 50% of participant said that it is possible, and the other 50% said that is possible by:
 - Creating new services.
 - Training specialized stuff.
 - Cooperation with the other health system in neighbor countries and making benefits from their experiences.
7. Decreasing the size of TA. 100% of participant show that if the size of treatment abroad decreased, this may help to meet the goal by transferring large amount of money used in treatment abroad and direct this toward implementing new medical services not existing before.

8. The role of quality and patient satisfaction in the improvement of TAD. 100% of participant opinion demonstrates that the percentage of treatment abroad will be decreased by gaining also confidence to patients in the present medical system.
9. The best administration of TAD. 50% of the participants exhibit that treatment abroad department can be independent from MOH, while 35% of the participants of the sample study represent that this department is the best and appropriate to be semi governmental "decentralized" and the other 15% of the participants of the sample study show that it should be governmental administrative institution .
10. The best administration of health care system. 75% of the participants of the sample study display that mixed is the best while 15% of the participants of the sample study replay that public health care system could be health regulator .and the remain 10% of the participants of the sample study see that public health care system could be health provide for primary health care and secondary but regulator for tertiary and rehabilitation services.
11. The effectiveness of public health insurance coverage on health care delivery. Most of participants show that the second intifada affect health care delivery negatively in public sector. here was increase in numbers of insured persons without following increase in the budget, putting a great burden on the actual

existing medical services in addition to decrease the level and the period of treatment for the patient.

12. Employee recommendations and suggestions to strengthen:

A- Human resources:

- Studies in different areas or researches.
- Excess of employee is one important area, should have no appointment. And increase appointment in lacking areas.
- Improve quality of personnel.
- Sending new persons for specialization in different branches.

B- Financial resources:

- Decreasing the health insurance that is covering more than 60% and give the patient all the care needed in governmental hospitals by decreasing the load there.
- Stop intifada health insurance.
- Regular seminar on how to be cost effective on drugs, laboratory tests and other investigations.

C-Technical resources:

- Choose the right persons who have faculty or capability and sending them for advanced technical resources to try to implement here.

5.3 Results related to physicians and administrative persons in Private sector, NGOS and UNRWA.

1. 70% of participants of the sample study show that the relationship is independent; the other 30% shed light upon the regulation should be complementary.
2. 70% of participants of the sample study demonstrate that there is no integration between health sectors in Palestine, one of respondent show that private sector was not involved in MOH health plan .While the other 30% review that there is integration but at certain limits.
3. Obstacles that prevent the integration between private and public sector:

The obstacles that were mentioned:-

- Administrative obstacles in MOH.
- Having commitment with Jordan hospital.
- Part of Palestinian authority are major share holder in Jordanian hospitals.
- There are no clear rules and regulation, and no direct link between two sectors.
- Every system has different management and different aims.
- Health policy in Palestine not working on this direction

4. 100% of participants show that they are aware about reasons of treatment abroad. And the causes that were mentioned are:-

- Some of services are not available in Palestine or lack of specialized centers like oncology.
- The vision by the people that abroad medicine is better.
- Loss of confidence in public sector or some time in private sector.

5. When you plan to establish a medical service, do you concern about services that not found in MOH? 100% of participants answered this question positively.

6. Private services differ from public services:

- Private services need more money.
- Better services, doctors more aware about the patient, better follow up and optimum care in private sector.
- More medical specifications in private.
- Long waiting list in public sector and over crowded. In private number of patients is much less.
- General services in private better than public.

7. Private customers or NGOS customer's public health insured patients or non insured. According to replay on this point, the result or consequences was:

- 70-85% of patients were private.

- 5-10% was insured by national health insurance.
- 10-15% was insured by private insurance (companies).

8. 20% from respondent show that patients not always more satisfied in private sector than public, , while the other 80% review that private patients more satisfied because time saving and better services

9. All participants replay that always and indeed, they tell all customers about the possibility to receive in public sector, especially if they can not offer staying in private hospitals and the same procedure can be done there.

10. Why public health insured patients attend private sector?

Physicians and administrative suggestions about this issue:

- Better care, services, and better hygienic services.
- Due to difficulty in appointment and lack of some specialty.
- Long waiting list in public sector.
- Ask about accuracy of diagnosis.

11. 40% of respondents show that the satisfaction of patients inside Palestine is the same outside Palestine, but after intifada and the current situation may affect negatively. While 60% of respondents illustrate that patient satisfaction in Jordan more than in Palestine.

12. Participants replay that the available situation taking into consideration all the time. All administrative confirm that medical services in Palestine have already low cost in comparable to our neighbored.

13. In order to achieve more integration between different health sectors, physician's suggestion that MOH should do:

- Up grading administrative plans and strategies.
- Spending more on MOH hospitals and primary health care.
- Improve human power resources.
- Long term plan to cover the missed specialty.
- Stop of giving permissions for treatment abroad.
- Make private sector as a part of health plan.
- Encourage the private sector to add deficient sub-specialties to fill the gap.

Chapter Six

(Discussion)

6.1 Discussion the result related to patient group

From analysis of the data in the chapter five, the study indicates that there is a relationship between the referral abroad and type of disease, where treatment not found in MOH like tumor, IVF, organs transplantation, heart disorder that include catheterization and open heart surgery. Here, MOH should work at this point, on how to implement these services, and should think about how to establish medical centers in MOH to supply patients with comprehensive medical care rather than to send them out side. On the other hand MOH should shed light upon cost of treatment abroad and if client treated or supply them with services inside MOH save money than treated them out side.

The data on hospitalization period illustrated that 43.5% of cases was hospitalized more than one week, usually long hospitalization period need more money, and increase the complication. So it possible in some cases to take services out side then follow up in MOH institutions to try to decrease the cost and the load on MOH.

Related to referral reasons abroad, there were several reasons, the most one that show 47.6% was treatment not found in MOH, this need more concern from MOH to be in the future and to exist these services instead to send patients to other institutions abroad. Second reason because services not in good quality, how to improve quality and other question if the MOH improve quality and patients satisfaction with services inside this may decrease the number and cost of treatment abroad. The same for waiting list, if MOH increase centers inside its institutions, waiting list and percent 14.1 will decrease. The last one trust on medical team in Palestine

with 7.4%, MOH should work on this point by increase knowledge and attitudes of Palestinian people toward medical team.

Concerning to the referral source, the percent was 66.5% from MOH, It was a high percent in relation to other source. This condition refer to some exceptions and Al-aqsa insurance, here referral abroad should concise on some special cases in addition to improve the health insurance within MOH which this system started in the first year 2006.

In relation to medical, nursing, and marketing services, the data shows that the evaluation of Palestinian patients to these services was centered around very good pattern and the percent was as the following, medical services was 22.5%, in nursing services a very good pattern was the highest with 20.4%, and in the marketing services we notice that the highest was very good pattern with 19.4%. This picture can be shifted from very good pattern to excellent pattern, if it is actually occurred it will affect the treatment abroad.

Although there were advantages to treatment abroad, the disadvantages more than the advantages, so patients had suggestion to avoid referral abroad. So MOH should provide institutions with comprehensive and inclusive medical system which is considered the most important one, in addition to other disadvantages that mentioned in chapter five MOH should care about.

6.2 Discussion related to employee:

The Palestinian health care system is made up of several health providers, the MOH (governmental/public), the NGOS health providers, UNRWA and the growing private sector. Additionally, the military health

services and the Palestinian Red Crescent society are also part of the providers in the system. This arrangement has various advantages as well as disadvantages. It could increase the advantages if coordination and complementarity among providers is espoused it could create tremendous conflict over resources, duplication of services and wastage.

From this point the researcher discussed the results of the employee questionnaire in relation to his suggestions about how to decrease the number and cost of treatment abroad, how to treat with patients that need special treatment, his roles to improve the quality and patients satisfaction, otherwise how to change the impression of Palestinian patients, behaviors, attitudes towards medical teams and MOH institutions in Palestine.

In relation to the employee suggestion was to increase integration between all sectors health providers inside Palestine rather than out side Palestine. In addition to improve all resources in the MOH, human, physical, and technical resources that will increase the activities of MOH institutions to decrease the size of treatment abroad and finally to abandon it.

Conclusion:

This study discusses the assessment of treatment abroad department in Palestine, and the assessment included the following criteria's, if the physicians and administrative persons are strict to the rules and regulation that MOH stated, how to improve human, financial, technical, and physical resources, inside MOH institutions to decrease or abandon treatment abroad, and how to invest treatment abroad cost in comprehensive medical system in Palestine.

The results of this study indicate that there was a direct relation between the area that MOH refer to and referral reasons or types of disease. And there was direct relation between the disadvantages of referral abroad and suggestions to avoid referral treatment abroad. Also there was strong relation ship between the types of disease and the health services not available in the governmental sector.

In summary, this study survey presents opinions of policy makers and administrative persons on how to invest the cost of treatment abroad, rationalize this cost and how to decrease it. Also illustrate how to encourage the integration between health care providers in Palestine and improve the contractionh process with private sector in Palestine, NGOS, and UNRWA rather than out side Palestine.

Recommendations:

1. Policies, rules, and regulation for treatment abroad should be evaluated and improved according to the needs .And strict referral abroad for very specialized cases.
2. Creation a department in MOH for Strategic planning courses, trained personnel, and more coordination for local coverage to substitute treatment abroad.
3. Invest treatment abroad cost in establishing comprehensive medical services in Palestine.
4. Increase and strengthening the decentralization of treatment abroad department with more effective controls, monitoring and evaluation of key process.
5. Review of the health insurance system within MOH, and establish strategy in order to arrive for a unified health insurance system.
6. Real justifications for budget allocations.
7. Establish strategy to attract qualified staff, for every specialized case to abandon treatment abroad.
8. Appointment for the right person in the right job.
9. Activate a strong human resources department with qualified staff and leadership.
10. More coordination and networking amongst the MOH and other health services providers.

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Appendices

Appendix A

Definitions

1- Health sector reform:

Is a sustained process of fundamental change in policy, and institutional arrangements, guided by government and designed to improve the functioning and performance of the health sector and ultimately the health status of the population.

2- General government expenditure on health:

General government (excluding social security) (expenditure on health refers to expenditures incurred by central, state/ regional and local government authorities, excluding social security schemes. Included are non – market, non – profit institutions that are controlled and mainly financed by government units.

3- Health infrastructure:

- General hospital: A hospital which provides a range of different services for patients of various age groups and with varying disease conditions.
- Specialized hospital: A hospital admitting primarily patients suffering from a specific disease or affection of one system, or reserved for the diagnosis and treatment of conditions affecting a specific age group or of a long – term nature.
- First level referral hospital: A hospital at the first referral level that is responsible for a district or a defined geographical area

containing a defined population and governed by politico – administrative organization such as a district health management team. The role of district hospitals in primary health care has been expanded beyond being dominantly curative and rehabilitative to include promotional, preventive and educational roles as part of a primary health care approach. The district hospital has the following functions:

- 1- It is an important support for other health services and for health care in general in the district.
 - 2- It provides wide – ranging technical and administrative support and education and training for primary health care.
 - 3- It provides an effective, affordable health care service for a defined population, in cooperation with agencies in the district that have similar concerns.
- Primary health care center: A center that provides services which are usually the first point of contact with a health professional. They include services provided by general practitioners, dentists, community nurses, pharmacist's midwives, among others.

4- Injuries:

The number of recorded or estimated number of diseases/ injuries and/ or deaths related to work accidents, motor and other vehicle accidents, suicide, homicide and violence which have occurred in the general population during the latest year for which valid statistics are available. A

work accident is defined as an occurrence arising out of or in the course of work which results in an occupational injury.

5- In patient:

A person who is formally admitted to a health care facility and who is discharged after one or more days.

6- Outpatient:

A person who goes to a health care facility for a consultation, and who leaves facility within three hours of the start of consultation. An outpatient is not formally admitted to the facility.

7- Per Capita gross domestic product (GDP):

Gross domestic product divided by the midyear population (or population size in case midyear population is not available).

8- Per Capita gross national income (GNI):

Gross national income divided by midyear population (or population size in case midyear population is not available). GNI, is the sum of value added by all resident producers plus any product taxes (less subsidies) not included in the valuation of output plus net receipts of primary income (compensation of employees and property income) from abroad.

9- Per Capita gross national product (GNP):

The per capita GNP is obtained by dividing the total gross national product by the total population. The GNP comprises:

- 1- The gross domestic product (GDP), which measures the total output of goods and services for final use produced by residents and nonresidents regardless of the allocation to domestic and foreign claims, plus.
- 2- Net factor income from abroad, which is the income residents receive from abroad for factor services (labor and capital) less similar payments made to non – residents who contributed to the domestic economy.

10- Per Capita health expenditure (US \$):

The average health expenditure (in us dollars) per person in a year.

11- Per Capita income:

Income per person in a population. Per capita income is often used to measure a country's standard of living.

12- Skilled health personal or skilled attendant:

Doctors (specialist or non specialist), and/ or persons with midwifery skills who can diagnose and manage obstetrical complications as well as normal deliveries.

Appendix B

"استبيان المريض"

الحمد لله على سلامتكم.

نشكر إدارة مستشفى " لتعاونهم في انجاز هذه الرسالة لدرجة الماجستير في الصحة العامة، والمقدمة لجامعة النجاح الوطنية بنابلس.

نرجو الإجابة على الأسئلة التالية والتي تتمتع بسرية تامة، كما ونأمل كامل الصراحة، ووضعها في المغلف المرفق.

1. ما هو نوع المرض:

أ- قلب

ب- زراعة أنابيب

ت- زراعة أعضاء (كلى، قرنيه....)

ث- أورام

ج- غير ذلك

2. مدة الإقامة المتوقعة في المستشفى:

أ- 1-3 أيام

ب- 4-7 أيام

ت- أكثر من أسبوع

3. سبب التحويل:

أ- هل هو لعدم توفر العلاج الطبي بالوطن

ب- هل هو لعدم تميز الخدمة الطبية

ت- هل هو لطول الانتظار والحاجة السريعة للإجراء الطبي

ث- هل هو أوفر ماديا

ج- هل هو بسبب الثقة بالطاقم الطبي خارج الوطن

4. مصدر التحويل:

أ- من خلال وزارة الصحة الفلسطينية

ب- من خلال القطاع الخاص في فلسطين

ت- الحرية الشخصية في التحويل

ج- غير ذلك.

5. هل أنت راض عن الإنجاز الطبي في الخارج من ناحية:

أ- خدمات طبية:- راض كثير - راض - غير راض.

ب- خدمات تمريضية:- راض كثير - راض - غير راض.

ج- خدمات فندقية:- راض كثير - راض - غير راض.

6. هل هناك تحديد مسبق بالمبلغ أو الجهة المالية المتعاقد عليها:-

أ- نعم

ب- لا

7. هل هناك أي ملاحظات أخرى؟

8. ماذا تقترح من إضافات لتحسين القطاع الخاص لتجنب التحويل الخارجي؟

9. التحويل الخارجي له مميزاته، ما سيئات التحويل الخارجي؟

Appendix C

For governmental employee

As part of my thesis for Masters Degree of public Health, at An – Najah National University – Nablus, this survey was designed.

This study aims to assess the performance of Treatment Abroad Department in West Bank (MOH) & How to decrease cost treatment abroad or rationalize spending cost.

The survey examines how to improve health care services, how to improve human, financial, physical & technical resources in Palestine to abandon treatment abroad external MOH. All available information and personal opinions will be treated with confidentiality. Results of this survey will be used for scientific research uses only and optimum secure

Marwa Kharouf

2006

1. Are you satisfied with the activities and performance of treatment abroad department in the ministry of health (MOH):

A- Yes

b- No, why?

2. What about your opinion for:

A- Human resources in the ministry of health (MOH)?

B- Physical resources in (MOH)?

C-Technical resources in (MOH)

3. Do you follow the rules implemented by ministry of health (MOH), in referring patients abroad?

4. How frequent do you face pressure from patients and their families to transfer any patient to treatment abroad:-

A- Never.

B- Frequently.

C- Very frequently.

5. Do you believe that private sector can play efficient role, to satisfy the needs of the patients:-

A -Yes, how?

B - No.

6. Do you believe that treatment abroad can be replaced by treatment inside Palestine? How?
7. Do you believe that decreasing the size of treatment abroad, can this lead to invest in implementing comprehensive or total medical services in Palestine?
8. Do you believe that, if we improve quality and patient satisfaction, we decrease the percentage of treatment abroad?
9. From your point of view, treatment abroad department can be:-
 - A- Governmental administrative institution.
 - B- Semi governmental institution (decentralized).
 - C- Independent.
10. From your opinion, what is the appropriate for treatment abroad department?
11. Public health care system (MOH) could be:-
 - A- Health regulator.
 - B- Health care provider.
 - C- Mixed.
12. As a result of second intifada, public health insurance, covering up to 60%. From your point of view, how this affected the health care delivery in public sector?
13. Do you have any recommendation or suggestion to strengthen:-

A- Human resources in MOH.

B- Financial resources in MOH.

C- Technical resources in MOH

Appendix D

For private, NGOS, UNRWA employees

As part of my thesis for Masters Degree of public Health, at An – Najah National University – Nablus, this survey was designed.

This study aims to assess the performance of Treatment Abroad Department in West Bank (MOH) & How to decrease cost treatment abroad or rationalize spending cost.

The survey examines how to improve health care services, how to improve human, financial, physical & technical resources in Palestine to abandon treatment abroad external MOH. All available information and personal opinions will be treated with confidentiality. Results of this survey will be used for scientific research uses only and optimum secure.

Marwa Kharouf

2006

How do you see the regulation between public and private sector :

- a- Complementary relationship.
- b- Competitive.
- c- Independent.

2. Do you have any partnership between public and private sector?
3. What are the obstacles that prevent the integration between private and public sector?
4. Are you aware about the causes of referral patients to treatment abroad?
5. When you plan to establish medical services, do you concern about services that not found in ministry of health?
6. From point of view, what are the differences between public services and private services?
7. Are your customers publicly health insured patients or non insured? If yes what is the percent?
8. Do you believe that the patients more satisfied about services in private sector than public?
 - a- yes, why?
 - b- No, why?
9. Do you use to tell your public health insured customers, about the possibility to receive services in public sector ?

10. From your point view, why public health insured patients attend private sector?
11. Do you believe that private customers satisfaction (inside Palestine), have the same level in Jordan?
12. Taken the available situation in Palestine into consideration, are you involved to decrease or increase the cost of medical services in the private sector?
13. In order to achieve more integration between different health sectors in Palestine, what should the ministry of health (MOH) do?

Appendix E

For chair person of treatment abroad department

As part of my thesis for Masters Degree of public Health, at An – Najah National University – Nablus, this survey was designed.

This study aims to assess the performance of Treatment Abroad Department in West Bank (MOH) & How to decrease cost treatment abroad or rationalize spending cost.

The survey examines how to improve health care services, how to improve human, financial, physical & technical resources in Palestine to abandon treatment abroad external MOH. All available information and personal opinions will be treated with confidentiality. Results of this survey will be used for scientific research uses only and optimum secure.

Marwa Kharouf

2006

1. a- What is the mission statement of treatment abroad department in the ministry of health (MOH)?

b- What is the vision and goal?
2. Can you discuss the following:-

a- Has no co-operation with donors?

b- The challenges faced by treatment abroad department?

c- The strengths and weaknesses of treatment abroad department?
3. Do you have any criteria or survey to evaluate the level of satisfaction customers of treatment abroad department?
4. Do you have any control system or monitoring system for achievements and implementations of strategy in treatment abroad department?
5. Do you have any plan to start any control system in treatment abroad department?
6. Is there any established criteria, strictly followed for treatment abroad department?
7. Do you believe that the organizational structure in treatment abroad department is appropriate and fits with MOH structure?
8. How much the total budget of MOH spent in treatment abroad department?
9. From your point view, treatment abroad department can be administered:-

a- Governmental (MOH).

b- Semi-governmental (decentralized).

c- Independent.

10. What are the reasons of increase numbers and cost of treatment abroad?

11. A- What is the percentage of referred patients for treatment abroad

B- From your point view its:-

-Its high

-very high

-normal

12. Do you believe that treatment outside Palestine can be replaced by treatment inside Palestine? And how?

Appendix F

For deputy of ministry

As part of my thesis for Masters Degree of public Health, at An – Najah National University – Nablus, this survey was designed.

This study aims to assess the performance of Treatment Abroad Department in West Bank (MOH) & How to decrease cost treatment abroad or rationalize spending cost.

The survey examines how to improve health care services, how to improve human, financial, physical & technical resources in Palestine to abandon treatment abroad external MOH. All available information and personal opinions will be treated with confidentiality. Results of this survey will be used for scientific research uses only and optimum secure.

Marwa Kharouf

2006

1. What are the reasons for establish the activities of treatment abroad department?
2. A- In which year this department established?

B- What was the need at that time?
3. What is the strategy of ministry of health (MOH), to implement the activities of treatment abroad department ?
4. What are the main points in the job description of treatment abroad department?
5. Do you think that treatment abroad department is fulfilling completely the above objectives?
6. How (MOH) see the future of treatment abroad department?
7. Dose the (MOH) implements any control or monitoring system for treatment abroad department strategy and the changeable situation?
8. Dose the (MOH) reviews the located budget for treatment abroad department?
9. is the variability budget of (MOH), affect the treatment abroad department functions? And how?
10. How the limitation in the resources of (MOH), affect treatment abroad department?

جامعة النجاح الوطنية
كلية الدراسات العليا

دراسة المرضى المحتاجين للتحويل الخارجي عبر دائرة
العلاج للخارج في وزارة الصحة الفلسطينية

إعداد

مروة عبد الرازق صالح خاروف

إشراف

د. سليمان الخليل

د. قاسم المعاني

قدمت هذه الأطروحة استكمالاً لمتطلبات درجة الماجستير في الصحة العامة بكلية الدراسات
العليا في جامعة النجاح الوطنية في نابلس، فلسطين.

2006

ب

دراسة المرضى المحتاجين للتحويل الخارجي عبر دائرة
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إعداد

مروة عبد الرازق صالح خاروف

إشراف

الدكتور سليمان الخليل

الدكتور قاسم المعاني

الملخص

استناداً إلى سياسة "الصحة للجميع في القرن الواحد والعشرين" المتبناة من قبل المجتمع الدولي في أيار 1998، ولتطبيق رؤية مجلس الصحة العالمي في مؤتمر المآت لعام 1978، طورت منظمة الصحة العالمية (WHO) المسح الصحي العالمي (WHS) كوسيلة لتقديم معلومات غير مكلفة 'صالحة' يعتمد عليها ومقارنة. (WHS) تخدم كقاعدة دلائلية لمراقبة فعالية نظم صحية مختلفة في استجابتها للأهداف المبتغاة. بالإضافة إلى تزويد صناعات القرارات بالدلائل التي يمكن أن يحتاجوا إليها لتطوير سياساتهم، استراتيجياتهم وبرامجهم كما ينبغي.

هذه الدراسة تهدف إلى تقييم أداء دائرة العلاج الخارجي في وزارة الصحة الفلسطينية، لتبرير تكلفة العلاج الخارجي، ولإيجاد بدائل للعلاج الخارجي من خلال وزارة الصحة الفلسطينية وتطوير نموذج صحي متكامل في فلسطين.

أجريت هذه الدراسة في الفترة الزمنية من كانون ثاني إلى أيار للعام 2006. ولتحقيق هدف هذه الرسالة، جمعت المعلومات من خلال مقابلات مهيكليه باستخدام استمارات خاصة لكل مجموعة من مجموعات الدراسة لكل من المرضى والعاملين، التي ضمت وكيل وزارة الصحة الفلسطينية رئيس دائرة العلاج الخارجي، أطباء وصناع القرار في القطاع الحكومي "القطاع العام" أطباء وإداريين من القطاع الخاص في فلسطين، بالإضافة إلى المرضى الذين تلقوا العلاج خارج وزارة الصحة الفلسطينية.

شملت عينة الدراسة كل من المرضى والعاملين في القطاع الصحي حيث كان عدد العينة (191) مريض، ممن تلقوا العلاج الخارجي منهم (99) من القطاع الخاص في فلسطين والمؤسسات الغير حكومية الأخرى "NGOS" و"UNRWA". و(92) من مستشفيات الأردن

"مستشفى الأردن" و"مركز الأمل". أما بالنسبة للعاملين فكان حجم العينة (40) من الأطباء والإداريين في كلا القطاعين العام والخاص. وقد تم تحليل هذه البيانات الكمية إحصائياً باستخدام النظام الإحصائي SPSS.

أما بالنسبة للبيانات النوعية فقد حلت عينياً. و تم صياغة عدة فرضيات وفحصها، وقد بينت النتائج أن أعلى نسبة مئوية للمرضى المحولين للخارج لدى مرضى السرطان حيث شكلت 33%، تليها مرضى القلب وكانت نسبتهم 17%، زراعة الأعضاء 5'8% وزراعة أطفال الأنابيب شكلت 1'6%. وبالنسبة إلى دواعي التحويل الخارجي، عدم وجود الخدمة الصحية في فلسطين احتلت النسبة الأكبر 43,6% ثانياً التقصير في جودة الخدمات الصحية 26,7%، ثالثاً طول الفترة لتلقي الخدمة الصحية حيث شكلت 14,1%. وأخيراً كانت نسبة 4,7% من المرضى أشاروا إلى عدم وجود الثقة في الطاقم الطبي في فلسطين. ومن خلال تحليل البيانات، بينت النتائج إلى وجود علاقة وطيدة بين سيئات التحويل الخارجي واقتراحات المرضى المحتاجين للتحويل الخارجي إلى ضرورة تزويدهم من خلال وزارة الصحة الفلسطينية بمراكز صحية متكاملة تضاهي جاراتها الدول الأخرى.

ومن خلال تحليل بيانات العاملين في القطاع الصحي سواء الحكومي أو الخاص أشارت إلى أهمية الدمج بين القطاعين الحكومي والخاص والقطاعات الأخرى مثل NGOS و UNRWA و قد دعت أيضاً إلى ضرورة تشجيع القطاع الخاص في فلسطين للنهوض بمؤسساتنا الوطنية فضلاً عن التحويل الخارجي للدول المجاورة.