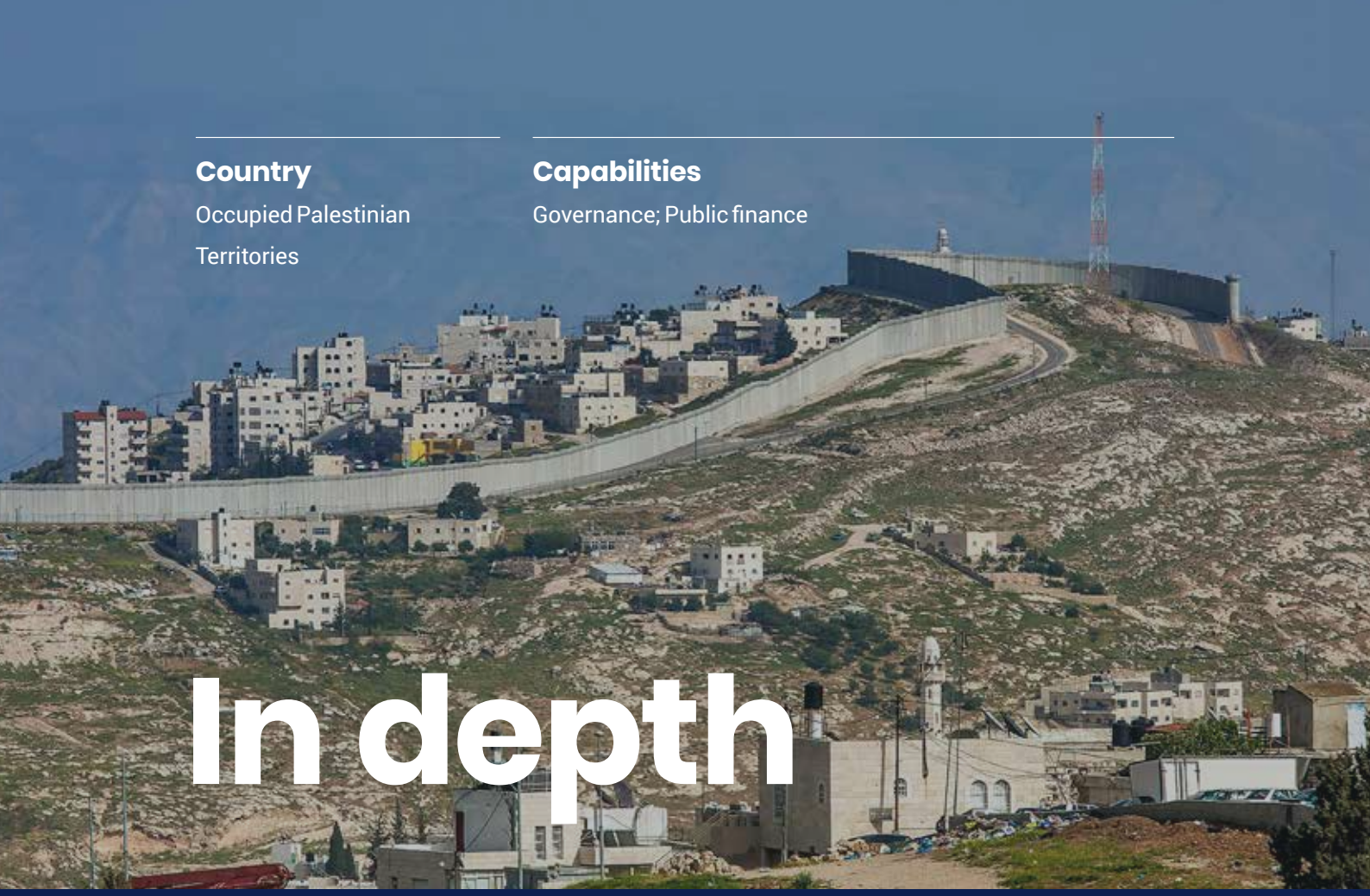

Country
Occupied Palestinian Territories

Capabilities
Governance; Public finance

In depth

Flexible, adaptive, politically-led reform in the Occupied Palestinian Territories

A growing body of literature and evidence demonstrates that conventional aid interventions focused on technical issues and capacity building alone are not sufficient to deliver developmental impact. In view of the growing interest in 'doing development differently' and 'thinking and working politically' to deliver more effective development assistance, there is a need for operational models that illustrate what this can mean in practice. This note describes a problem-driven iterative adaptation (PDIA)[1] approach to donor-supported health efficiency reform in the challenging context of the Occupied Palestinian Territories (OPTs). Focusing on the management of external medical referrals,[2] which emerged as a political problem, the note highlights how a flexible logframe allowed a series of small, gradual interventions to be introduced, in sharp contrast to the traditional pre-planned 'projectised' approach that has been the standard in the development industry to date.

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About Oxford Policy Management's *In depth* series

Our *In depth* publications aim to share detailed learning and analysis from our practical experiences working with governments, funders, practitioners, and partners to achieve lasting, positive change through policy reform.

Background

The OPTs present a challenging reform environment, with a fragile nascent state beset by both internal and external issues. Public finances in the OPTs have been under chronic fiscal pressure. The health sector has been a key source of fiscal problems, with external referrals for tertiary health services seen as a major financial burden on the Ministry of Finance. The issue moved up the political agenda swiftly in early 2014. The problem was characterised by both technical (medical) aspects – i.e. decisions on which patients to refer for costly care outside of the public health system – and also political ones: internal pressures favoured the continuation of what had become fiscally unsustainable, while bureaucratic capacity limits and foreign (Israeli) control over some public revenues, exacerbated the situation.

Any public policy issue will have both technical/economic and political elements, but these are likely to be especially interrelated in the case of a fragile state such as the OPTs. This means that the attempted solutions must be equally multi-faceted.

Identifying the problem

The Palestinian Governance Facility programme, implemented with support from the UK Department for International Development, is a long-term assignment related to public financial management. As part of the programme, the project team considered how to improve the operational efficiency of the OPTs' Ministry of Health (MoH). Despite not being part of the original project design, this area of reform soon emerged as a priority. Working together with the MoH and the Deputy Minister, the project team identified a number of areas to focus on – the most pressing being external referrals. At the end of 2013, the Deputy Minister (with one year remaining in office) perceived the exploding external referral costs as a major political problem for government and was keen to 'do something about it'.

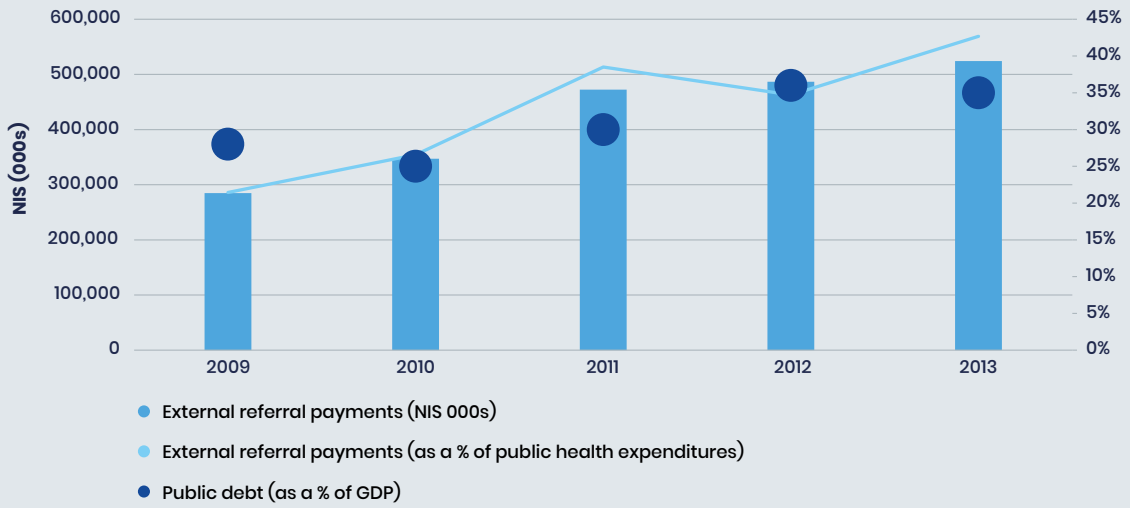
The MoH was unable to identify the full costs of referring patients as its data covered only payments in a given year, meaning they were often significantly in arrears and did not include that current year's referrals. Apart from weak record-keeping, the MoH was also limited in its cost control ability due to external politics: Israeli hospitals were able to extract any payment they wished for the patients they received, requesting these sums be deducted directly from the OPTs' customs revenues, over which Israel had control. 2013 payments were around NIS 524 million (US$ 145million), equivalent to around 43% of public sector health spending (Figure 1), in a context of mounting public debt. This covers Gazan as well as West Bank patients – the OPTs' MoH is responsible for both, despite only having a physical base in the West Bank.

[1] For more details, see Andrews, M. (2013). 'The Limits of Institutional Reform in Development: Changing Rules for Realistic Solutions', Harvard Kennedy School of Government, Cambridge University Press.

[2] i.e. patients treated outside of the Ministry of Health using public funds, most often in private sector East Jerusalem hospitals within the OPTs, although also in Israeli facilities and occasionally Egyptian and Jordanian ones.

To ensure the most efficient, targeted use of resources, the project team searched for a single therapeutic area to pilot as a reform. Cardiac catheterisation (the insertion of artificial tubes to improve blood circulation in the heart) was selected because it was a substantial source of referrals that had grown rapidly and was likely to continue to do so due to increasing levels of cardiovascular disease among Palestinians. Also, unlike the largest cost area – oncology (see Figure 2) – it was an area where the team believed the MoH's capacity to treat patients itself could be built relatively cost-effectively. This is because, after the initial equipment investment, marginal treatment costs are relatively low and predictable.

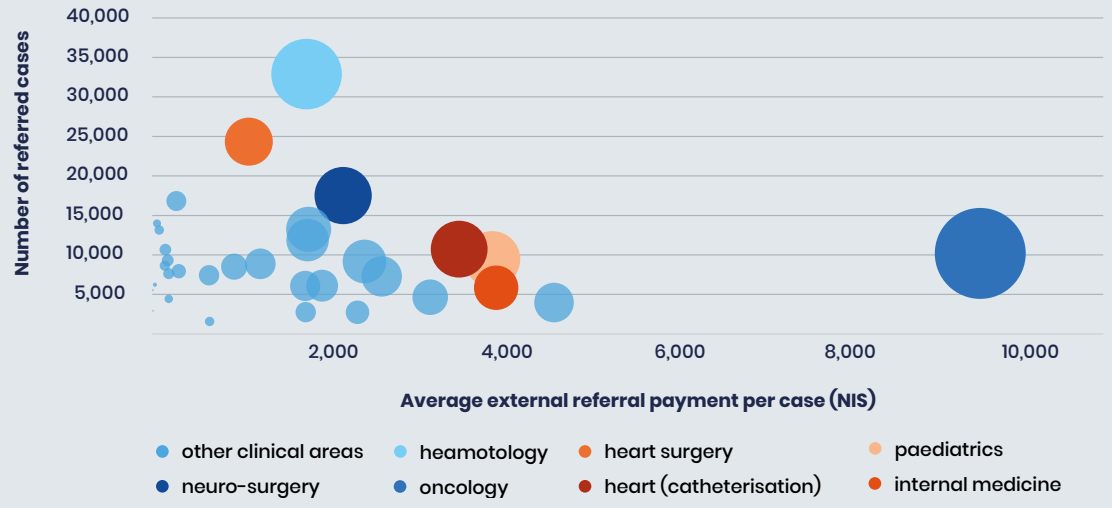
Figure 1 | Growth of the external referrals problem



Sources: West Bank and Gaza, MoH, Ministry of Finance, Palestinian Authority.

NB: The true cost of external referral payments will have been higher than this due to subsequent revisions not included in the MoH's annual data.

Figure 2 | The shape of the problem



Source: 2013 data, West Bank and Gaza, MoH, Palestinian Authority.

NB: The true cost of average external referral payments will have been higher than this due to subsequent revisions not included in the MoH's annual data.

Problem-driven, flexible, and adaptive responses

A flexible logframe allowed the team to broaden the scope of the project with a new workstream beyond core public financial management reform. Preliminary small interventions were introduced and tested. Through stakeholder mapping, the team initially identified key agents, including donors, around which coalitions and working partnerships could be built. We then conducted focused political economy analyses, breaking down the referrals problem in cardiac catheterisation using an Ishikawa/fishbone diagram (see Figure 3). This helped identify root problem causes (e.g. a disadvantageous position relative to external hospitals) and sub-causes (e.g. lack of linguistic capacity), which pointed us to the 'entry areas' for reform. The strategy employed by the team remained flexible and reactive so as to help ensure that opportunities could be used whenever they emerged and to ensure challenges were addressed rapidly. Key considerations and issues were:

- Collaborating with other stakeholders was important to ensure that work was complementary and without duplication;
- The original contact point, the Ministry's Planning Directorate, was not amenable to reform and so building a relationship with other influential stakeholders – e.g. the Deputy Health Minister – became a key priority;
- Staff turnover (including the resignation of the Deputy Health Minister) and the decentralised nature of the MoH meant the cultivation of relationships with several 'institutional entrepreneurs' was vital;
- Face-to-face interviews with the MoH's chief cardiologist evidenced that, while the MoH had adequate equipment to carry out many more catheterisation procedures, what was lacking was further training for junior cardiologists, as well as better public appreciation of its capabilities;
- Furthermore, there was a lack of clear guidelines regarding when a patient could be referred externally, compounded by a counterintuitive incentives structure for referring doctors, receiving hospitals, and patients themselves, which served to encourage referrals;
- Finally, the relationship between the MoH and the external hospitals was unsatisfactory: procedures were not well defined, prices were not effectively negotiated, and there was virtually no clinical or financial audit after patients had been treated. Bills were eventually settled but sometimes years in arrears (leading to higher prices).

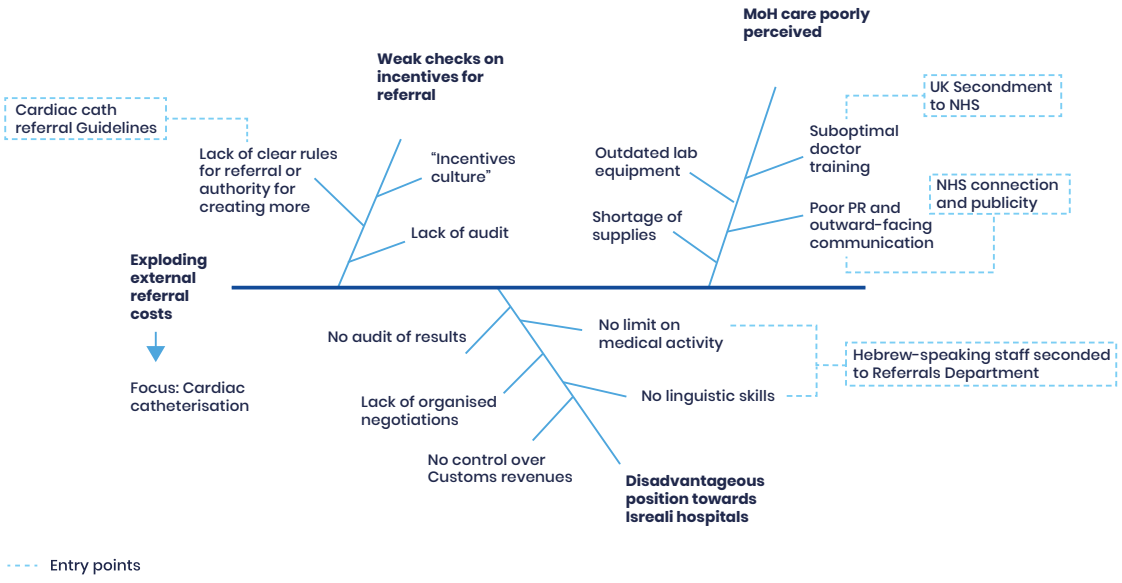
The situation was even more pronounced with Israeli hospitals: these had the right to take revenues directly from the OPTs' customs revenue account, while a lack of linguistic ability at the MoH restricted communication between the two entities. At the Deputy Minister's suggestion, the project team organised a cardiac catheterisation workshop, bringing in an internationally renowned UK cardiologist. This provided external authority and helped all of the OPTs' cardiologists agree to a new set of external referrals guidelines.

These included rules for when a patient might be referred, and how they should be treated in either MoH or external facilities.

The team scaled up support in response to initial positive results. The MoH's chief cardiologist, Dr Mohammed Batrawi, became an ally of the reform efforts and nominated junior staff for a planned UK secondment that would raise their training level. A junior staff member who spoke Hebrew was hired and seconded to the Referrals Department. To help enhance collaboration with other stakeholders, this staff member worked closely with USAID-funded counterparts, who developed a complementary programme incorporating further disease-specific workshops with the same format as the cardiac one, negotiations with external hospitals, selecting a shortlist that would receive larger volumes in exchange for better prices, and improving the Department's IT systems, so that all relevant information was captured – a World Bank audit project found that clinical information was lacking from 70% of files. A new Referrals Departmental head became a third ally of the reform – important in an organisation in which distinct power bases sometimes pushed in opposite directions.

While the departure of the Deputy Minister was a blow (no replacement had been appointed more than a year later), a number of other external events had a positive impact. International pressure led to the OPTs receiving the right to better information about customs deductions by Israeli hospitals (several of which had also entered financial distress themselves, stimulating their willingness to negotiate). At the same time, the MoH continues a policy to maintain some flow of patients to private (generally non-profit) Palestinian hospitals in East Jerusalem, as part of a political aim of protecting Palestinian institutions located there from Israeli pressure to close.

Figure 3 | 'Fishbone' of problem causes, sub-causes and 'entry points'



Source: Authors.

A continuing process...

While addressing the external referrals problem is a long-term endeavour, there are clear initial signs of improvement. Some quantifiable results are starting to be discernible on the back of improved functionality. In turn, this has provided greater political legitimacy, which is allowing the project to keep 'trying new things'. MoH cardiac catheterisation procedures rose from an average of 10 per day in 2013 to 13 per day in 2014 and in the first quarter of 2015. At the same time, the average cost of a cardiac catheterisation referral fell from NIS 10,748 in 2013 to NIS 9,864 the following year. The official report showed that external referral expenditure fell from an estimated 43% of public sector health spending in 2013 to 31% in 2014. Provisional 2015 data also show overall referral numbers to be significantly reduced. Nonetheless, rising rates of chronic non-communicable diseases and increasingly expensive new treatments for these mean that demand pressure for the clinical interventions liable for external referrals is likely to continue.

Key points and lessons learned

This project has highlighted a number of key lessons that may be broadly applicable in a range of development programming contexts:

1. A flexible development assistance delivery model can allow reform areas not anticipated at project design to be tackled as they emerge in the political agenda.

2. Traditional 'gap-filling' aid may be counter-productive – in the current project, if donors had merely continued to cover the external referrals cost this would have provided more revenues for interests that abused the system, increasing their stake in its continuance and their ability to block reform.

3. A complex problem requires a multi-faceted solution. The process of constructing problems using various techniques, such as fishbone diagrams, can help analyse the local context and determine a practical and politically feasible entry point that draws agents together.

4. Where resources are constrained a pilot may be an effective initial step. Small improvements in functionality around the problem can provide greater legitimacy for all involved in addressing it - in turn allowing the reforms to gain momentum.

5. The ideal coalition involves flexible, aligned donors and relevant 'institutional entrepreneurs' from within local organisations. This coalition should be involved in analysis and reform implementation.

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Oxford Policy Management is committed to helping low- and middle- income countries achieve growth and reduce poverty and disadvantage through public policy reform. We seek to bring about lasting positive change using analytical and practical policy expertise. Through our global network of offices, we work in partnership with national decision makers to research, design, implement, and evaluate impactful public policy. We work in all areas of social and economic policy and governance, including health, finance, education, climate change, and public sector management. We draw on our local and international sector experts to provide the very best evidence-based support.

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