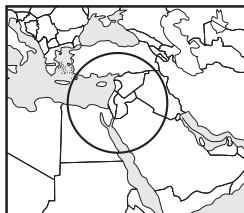


Relying on others: provision of water and health care

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Palestinian dependence on Israel for water and on the international community for healthcare services underscores the crippled state of Palestinian welfare and its subjugation to Israeli military decisions. This is not the result of shortcomings of the traditional development approaches (in particular the differing incentive and sanction structures behind state and market approaches to basic service provision¹) but of Israeli military and government policy towards the West Bank and Gaza.

The current failures in service provision should not be seen within the context of the past two years alone. Israeli policies since 1967, especially in the West Bank, have sought to promote Jewish over non-Jewish development. The consequence of these policies is Israeli cooption of the potential of both the Palestinian National Authority (PNA) and private organisations to provide basic services to Palestinians.

This assessment will look at two basic services: water and health care. The Israeli government has sought to control water resources in PNA areas. The impact of this control confounds normal state-vs.-market development theory, leading to questions about its applicability in Palestine. In the case of health care, the unique context of the Palestinian territories and the current crisis of Israeli invasion favour service provision by foreign NGOs, as opposed to traditional state or market approaches.

The water supply: dependent on a private Israeli monopoly

Water supply is dependent upon Mekorot, an Israeli private contracting company that supplies Israeli settlements in the West Bank and Gaza. Mekorot controls over 90% of all water resources in the Palestinian territories. (Private Palestinian dug or rainfall wells provide the additional 10%.) Mekorot is an outgrowth of Israeli military orders concerning the licensing of Palestinian wells and water supply that were put into place after the occupation of the Palestinian territory during the 1967 war. These orders placed the control of water sources in the hands of regional commanding officers, and eventually under control of the Israeli 1959 Water Law, in which all water is declared Israeli state property. Since 1967, Israel has worked to incorporate the occupied territories into the Israeli water system. After 1967, water was distributed from the Israeli system in the occupied territories by the Israeli Army's civil administration at the district level. Distribution was handed to the PNA upon its establishment, although the occupied territories are still linked to the Israeli settlement water network. Currently, the Palestinian Water Authority is responsible for purchasing water from Mekorot and providing it to the Palestinian districts that are responsible for final distribution.

Israelis use 85% to 90% of the water resources of the West Bank, either inside Israel through laterally drilled wells, or in Jewish settlements in the West Bank and Gaza Strip.² The drilling of Palestinian wells is forbidden without

permission from the Israeli military authorities even in Palestinian ruled areas, as water issues are a part of final status talks to be negotiated in the future. Agricultural water use by the Palestinians has stayed at 1967 levels, and domestic use has only increased by 20% since 1967, despite a 300% increase in population during the same period.³ Palestinians must cope with serious shortages and the Israeli monopoly's high prices. Water consumption prior to the Israeli invasions was rationed by Mekorot to provide 110 million cubic metres (MCM) of water to more than one million Palestinians and 50 MCM to 125,000 Israeli settlers, a ratio of 4:1 in favour of settlers. In Gaza this ratio was 12:1 in favour of settlers prior to the second Intifada. Prices for water for Palestinians were seven times those charged to settlers, a fact that the Israelis blame on the cost of distribution. Other sources claim «the issue is not the absolute price that Palestinians pay for water, which may indeed reflect real costs. The issue is one of blatant and formalised discrimination on the part of the Israelis.»⁴ Mekorot essentially subsidises water provision for Jewish settlement of the West Bank, and taxes Palestinians to pay for the costs incurred.

The Israeli invasions of PNA areas since September 2000 damaged Palestinian water distribution systems and affected the safety of the supply. Direct attacks by the Israeli army to the Palestinian water infrastructure have amounted to USD 774,405 in damages since March 2002. Prices for drinking water have increased, especially in the private-sector trucking of water to non-networked villages, where prices are as much as 40% higher than pre-Intifada PNA rates. In response to Israeli water needs, Mekorot reduced water pressure in the West Bank in May 2002; the entire city of Hebron received less than 2000 cubic metres of water daily.⁵ In April 2002, Israeli military forces tore up water pipelines entering the cities of Nablus and Jenin, leading to extreme shortages in some areas. The overall consumption per person in Jenin has been reduced to 20 litres per month, a rate 80% below World Health Organization estimates for reasonable health.⁶ Israeli closures and curfews have reduced Palestinian access to safe water resources. The Union of Palestinian Health Work Committees (UPMRC) reported 95 cases of hepatitis A in Nablus during August 2002, and according to a USAID study, 30% of Palestinian homes currently have at least one case of diarrhoea as a result of contaminated water sources.

From the perspective of the policy debate over public or private provision of water, the Palestinian case does not fit simply into the established discourse. Currently the PNA, a state-like entity, purchases most Palestinian water from

1 The usual debates over the different incentives and the effectiveness of public or private service provision do not apply well to a situation of foreign military occupation. For a strong analysis of Palestine and development theory under occupation see «Theories of Development and Underdevelopment: the Particularity of Palestinian Dependence» in S. Roy, *The Gaza Strip: the Political Economy of De-Development*, Washington DC: Institute of Palestine Studies, 1995.

2 The West Bank has three main water basins that are consumed by the Israelis as follows: of the Western Basin, 91.4% Israel proper and 2.69% settlers; Northern Basin, 68.67% Israel proper, 3.33% settlers; and Eastern Basin, 29.41% Israel proper and 30.88% settlers.

3 The Palestinian population increased from 1,013,000 in 1967 to over 3.3 million in 2002. Cf. population statistics in <http://www.pnic.gov.ps>

4 D. Brookes and S. Lonergan, *The Economic, Ecological and Geopolitical Dimensions of Water in Israel*. Centre for Sustainable Regional Development, Victoria, Canada, 1993.

5 K. Kamphoefner, «Water Inequalities,» CPTnet, 9 September 2002, p. 1. See www.palestinemonitor.org.

6 Interview with Taher Nasser El-Dein, District Deputy of the Ramallah Water District, 28 October 2002.

an Israeli contracting company. Whether this is public or private provision is debatable. Also, given the current crisis, answering questions about the benefits of public or private water provision for Palestinians depends heavily on short-term considerations, leaving long-term discussions for a time when Palestinians again control their lives through the PNA. Israel's invasion has crippled the PNA's efforts to provide most basic services.

The healthcare sector: outside dependence for funding and supply

After the 1967 war Israel moved to incorporate the health care of Palestinians into the Israeli healthcare system by linking military control of hospitals in the West Bank and Gaza to its national healthcare system. Military orders from the late 1960s and 1970s banned Palestinians from opening new health clinics or hospitals, and the Israeli army took over the operation of most Palestinian hospitals. The situation in the occupied territories remained stable until the outbreak of the first Intifada in 1987, after which charitable societies and NGOs defied Israeli orders and opened healthcare clinics to care for the thousands of injured Palestinians. NGOs formed the basis of health care during the 1980s and early 1990s. In 1994, the Israeli military's civil administration of the West Bank and Gaza transferred authority for health care to the Palestinian Authority's Ministry of Health (MOH), which in turn has undertaken a process of integrating PNA, NGO and private healthcare provision. A major trend since the establishment of the PNA is the transfer of international funding from the non-governmental sector to PNA institutions, reducing the number of NGO clinics by 65% since 1993.

Before the start of the second Intifada in September 2000, an integrated strategy was being employed, recognising the importance of developing a national plan that included public, private and NGO sources. In 1999, there were 52 hospitals in the West Bank and Gaza, 14 run by the MOH, 24 run by NGOs and 14 run as private companies. Of primary healthcare centres, 60% were run by the MOH, 31% by NGOs and nine percent by the United Nations Relief and Works Agency for Palestinian Refugees (UNRWA). Ninety-four percent of hospital beds in the West Bank and Gaza are publicly provided either through the MOH, NGOs or UNRWA; only six percent are provided privately. In 1998, recognising the importance of the NGOs, the MOH began a system of outsourcing health care by funding services provided by NGOs. This parallel service provision approach includes either partial or full funding from MOH for NGO health services.

The Palestinian health sector depends on international support for funding and supply of healthcare services. Funding is given to the MOH through the PNA –funded through international sources– health insurance payments, and co-payments and fees. UNRWA is funded through donor countries. Palestinian NGOs depend on international donors either directly from governments or through international NGOs, and private clinics depend on outsourcing from the MOH, fees and charity. In 1999, the last period for which sector-wide statistics are available, the foreign funding distributed was nearly USD 175 million. To give a sense of the scale of this contribution to the Palestinian healthcare system, this figure may be compared with the overall budget for the MOH in 2000, which was USD 50 million not including salaries and approximately USD 95 million including salaries. In 1997, Japan provided the greatest proportion of international funding to the Palestinian healthcare system (39%).

Israeli actions since September 2000 have seriously damaged the Palestinian health sector –and indeed health itself–, mostly as a result of reduced expenditures on the part of public providers, and lack of access to services by the Palestinian population. The health of Palestinians has also suffered as a result of increased poverty, and a consequent decrease in ability to pay for health insurance. PNA losses in income due to Israeli seizure of tax income have averaged USD 20 million per month since April 2001. The Authority faced a 76% decline in revenues between the end of 2000 and the beginning of

2001.⁷ The MOH reports that because of decreased income its hospitals and other facilities are now functioning at only 30% of capacity.⁸ In 2001, 62.5% of households in Gaza reported difficulty in accessing health care because «they have faced problems...due to Israeli [road] closure.»⁹

In the face of the Israeli siege, the MOH implemented a strategy of «decentralisation» whereby local NGO and private health clinics were given additional authority. Strategies employed by the MOH to confront the health crisis included the purchasing of drugs on credit from local suppliers, coordination of medical efforts with national and international NGOs, the promotion of home care, and the development of mobile health teams. In many cases, increasing international aid efforts given to NGOs has propped up the healthcare sector. The Union of Palestinian Medical Relief Committees (UPMRC) reports that the total number of treated people in its clinics increased from 32,000 in 2000 to 308,000 in 2001, as a result of external funding increases, the fact that services are provided without charge, and the establishment of clinics throughout the West Bank and Gaza.¹⁰ Anecdotal evidence shows that private healthcare companies are suffering. The inability of individuals to pay insurance, and the reduction in MOH funding, means that private suppliers have had to cut costs or go out of business. In some cases, private hospitals and clinics are being purchased by NGOs that are benefiting from increased international aid.

Conclusion

Developmental models of public versus private service provision do not apply to water and healthcare provision in Palestine. As a result of the current structure of water provision, Palestinians depend entirely upon Israeli price and supply controls for the provision of water. Palestinians cannot sanction these Israeli controls through either market or state mechanisms. Palestinians do not have the choice to purchase water through secondary sources –the market option– or voice opposition to Israeli water provision policy –the state provision option.

The overall dependence of the Palestinian healthcare system on international funding –especially important with the Israeli withholding of Palestinian tax revenues– leads to a structure that favours NGO provision of services over government or private healthcare provision. NGOs are more flexible given the changing circumstances and do not depend upon taxation for their funding. Neither do they depend on private wealth and insurance to cover the costs of their operations, as do private service providers.

Under the current circumstances, dependence on Israel for water will continue to dominate public and semi-public distribution networks in PNA areas regardless of Palestinian choices about public and private provision. In the health sector, circumstances dictate a return to the pre-PNA days of NGO service provision. ■

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7 World Bank Draft Report, «One Year of Intifada - The Palestinian Economy in Crisis,» World Bank, November 2001, p. 25.

8 Cited in The Palestinian Initiative for the Promotion of Global Dialogue & Democracy: Miftah, «Palestinian Humanitarian Disaster,» 10 July 2002. See www.miftah.org

9 Palestinian Central Bureau of Statistics, «Impact of the Israeli Measures on the Economic Conditions of Palestinian Households (3rd Round: July-August, 2001)» PCBS, 2001, p. 5. Available at <http://www.pcbs.org>.

10 Interview with Dr. Jihad Mashal, general director of UPMRC, 20 October 2002.