AN AILING SYSTEM:
LITARY GOVERNMENT HEALTH INSURANCE
OCCUPIED PALESTINIAN TERRITORIES

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MILITARY GOVERNMENT HEALTH INSURANCE
THE OCCUPIED PALESTINIAN TERRITORIES

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PREFACE

Al-Haq was founded in 1979, as Law in the Service of Man, with the twin purposes of defending human rights and promoting the rule of law in the Palestinian Territories occupied by Israel in the aftermath of the 1967 war. Today, the members of al-Haq staff implement a varied program which includes monitoring, documentation, research, a computerized database of human rights violations, a public law and human rights library, and the provision of legal services to the community. Al-Haq's interests within the universe of human rights include women's rights, labor and children's rights, and economic rights.

A central theme guiding al-Haq's work continues to be the quest to discover and understand the long-term effects of the Israeli occupation on the Palestinian community. Al-Haq has, in a number of studies, discussed how the Israeli authorities have amended the legal system in the Occupied Territories, and what effect such amendment has had on the lives and rights of Palestinians living within those Territories.

One of the areas of keen interest to the organization has been the investigation of Israel's administration of the Occupied Palestinian Territories, and the degree of its compliance with the duties and obligations incumbent upon it as an Occupying Power. Pursuant to that quest, al-Haq organized an international conference in January 1988, and invited international and local experts to compare notes on the consistency of Israel's military administration with international standards and law. The papers were compiled and edited by Emma Playfair into *International Law and the Administration of Occupied Territories.*

In 1989, al-Haq commissioned *Town Planning Under Military Occupation: An Examination of the Law and Practice of Town Planning in the Occupied West Bank* by Professor Anthony Coon which explored Israeli land-use planning and practice in an effort to understand the long-term effect of such practices in terms of Palestinian population growth, physical needs, and future development potential. The study was published in 1992.

The initiation of the planning study was followed in 1990 by

the publication of a study on Israeli taxation policies in the West Bank. One of the main issues raised by *Taxation in the Occupied West Bank 1967-1989*, written by Marc Stephens, was Israeli fiscal responsibility *vis-a-vis* public money collected in the form of taxes and tariffs levied on the Palestinian population in the West Bank. The study confirmed, *inter alia*, the lack of public accountability regarding how Palestinian public money is actually spent.

The present study is the most recent to explore the duties and responsibilities of an Occupying Power as administrator. This research work focuses on the health insurance scheme provided by the military authorities for the population of the West Bank and Gaza Strip, and looks again at the question of Israeli fiscal and legal responsibility through an investigation of the level and quality of medical care provided to subscribers to the Israeli government health insurance program and at the alternatives available to Palestinians who choose not to, or who cannot afford to, participate in the program.

It is al-Haq's hope that this study, in addition to contributing to a clearer understanding of the health situation of Palestinians living under Israeli occupation, will help to clarify further the nature and priorities of this 26-year occupation.

Fateh Azzam
Program Coordinator

[T]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

Preamble to the World Health Organization Constitution

INTRODUCTION

The Israeli military government is a major provider of health care in the Occupied Palestinian Territories,[1] and the government of Israel is the entity which has ultimate control over all health care provision. Israel's provision of health care to Palestinians living in the Gaza Strip and the West Bank excluding East Jerusalem is inadequate and falls below the standard set in international law. Although the Palestinian population has grown in the 25 years since Israel's occupation in 1967, facilities have not satisfactorily met increased needs, many medical services have deteriorated, and medical conditions are poor relative to what they could and should be. This report, based on information obtained by al-Haq from primary and secondary sources, examines one particular aspect of the inadequate provision of health care to Palestinians in the Occupied Territories: Israeli military government health insurance (hereinafter GHI), as it existed prior to and during 1992.

Israeli government health insurance provides, at high cost relative to per capita income, patchy access to an inadequate health care system. Poor medical facilities and poor quality care are some

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[1] In 1989, Israeli military government health services provided 90 percent of the primary health services and 60 percent of all health services in the West Bank (excluding East Jerusalem) and 90 percent of all health services in the Gaza Strip. Ministry of Health for the State of Israel, *Health in Judea, Samaria, and Gaza (1988-1989)* (Jerusalem: 1989) p. 21; Medical Aid for Palestinians, *Health in Gaza: A Casualty of Occupation* (1991) p. 31. While that percentage has fallen since 1989, military government health services still provide the majority of hospital services in the Gaza Strip and a sizeable percentage of those in the West Bank. Hereinafter, "military government" and "government" will be used interchangeably when referring to the Israeli military administration of the Occupied Territories.

of the factors responsible for decreased Palestinian enrollment in GHI, but the slight chance of referral to better Israeli facilities when medically necessary, along with high monthly insurance premiums, are other factors, directly attributable to the GHI system itself, which make it an unsatisfactory system. GHI is also fraught with other problems which discourage participation, such as ineligibility for some family members, delayed hospitalization coverage, and extra costs for medication and services. In the opinion of most Palestinians, GHI is not worth the expense. Although without GHI many government health services are completely out of reach financially for most Palestinian families, more than 70 percent of them do not hold GHI. Even taking into account health care services provided by other agencies, particularly services for refugees, at least one-third of all Palestinians in the Occupied Territories, excluding East Jerusalem, have been left with no access to affordable, comprehensive health care. The problematic Israeli government system of health insurance, by alienating many Palestinians from available health care, has substantially contributed to a situation where only a few Palestinians have access to even the minimal health services available in the Occupied Territories.

No effective domestic legal remedy exists to redress the problems with GHI. Individuals who attempt to remedy a breach of their GHI contract or obtain compensation for a breach must apply to the Israeli military Legal Advisor. The act of appealing a negative decision by the Legal Advisor has been discouraged by the conditions of military occupation under which Palestinians live; in the fourteen years that GHI has existed (1978-1992), there have been no remembered cases of a subscriber appealing to either the civil court or the Claims Committee for justice, despite the fact that many difficulties with GHI have been experienced.

Examination of international provisions that Israel is legally bound to apply as the occupying power in the Palestinian territories reveals that Israel's provision and control of health care, including GHI, violate its international obligations. Under specific provisions of humanitarian law, it is the duty of other States to ensure Israel's compliance with its international responsibilities if Israel fails to comply.

In the absence of Israeli or international action and without themselves obtaining comprehensive control of all factors affecting health, Palestinians lack the power to improve the GHI system or other aspects of their severely ailing health care system. Without the ability to promulgate, legislate, and enforce laws and regulations pertaining to health in its broadest conception, and without control over economic resources and infrastructure, including water, land, taxation, and education, Palestinians can do little to ensure that a rational health care system is established, funded, and maintained. Only such a system will assure to even the poorest person in the Occupied Territories adequate health care, through a sound health insurance system or by other means, as well as providing suitable environmental conditions for the populace, financing and accommodating new health equipment and facilities, and ensuring that medical specialists are available and adequately trained.

This report seeks to illuminate existing areas of concern within the GHI system in the hope that future changes to the health system, or future systems, will take these issues into account.

I. The Context: Deteriorating Health Services and Poor Health Conditions

Before discussing Israeli military government health insurance specifically, a brief discussion of the general health services and conditions prevailing in the Occupied Territories will provide the context for understanding GHI. The health care system in the Occupied Territories suffers from sustained policies of underfunding, restrictions, bureaucratic obstructions, and harassment. These policies have been implemented and carried out by the Israeli occupation authorities since 1967. The result is an underdeveloped system characterized by a shortage of trained personnel, medical services, and facilities, in addition to poor sanitation and community infrastructure. Thus after 25 years of occupation, Palestinians are experiencing inadequate health conditions and deteriorating health services.

A. Health Care Providers

The Israeli government health care system discussed in this report provides much of the health care for between 1.68 and 1.8 million Palestinians who live in the Occupied Territories, outside of East Jerusalem.[2] Due to that city's illegal annexation by Israel, Palestinians living there have a different health care system and do not use GHI. United Nations Relief and Works Agency for Palestine Refugees (UNRWA) and private or charitable institutions provide the rest of the health care in the Occupied Territories.

According to official Israeli estimates, government health

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[2]The official Israeli estimate of the population in 1991 (there has been no census since 1967) was 1,005,600 Palestinians in the West Bank, excluding East Jerusalem, and 676,100 Palestinians in the Gaza Strip, totalling 1,681,700. Central Bureau of Statistics, *Statistical Abstract of Israel No. 43* (Jerusalem:1992) p. 732. Unofficial Palestinian estimates in 1992, also without benefit of a recent census, place the population of the West Bank, including East Jerusalem, at 1,202,000 and of the Gaza Strip at 714,800, totalling 1,916,800. National Health Plan Commission, *National Health Plan Interim Report* (1992) p. 18.

services comprise 60 percent of all services in the West Bank (excluding East Jerusalem) and 90 percent in the Gaza Strip.[3] The 1991 figures in Table A for hospital beds, numbers of patients, and numbers of surgical operations give some indication of the major role that government services play in health care:

TABLE A[4]

	West Bank	Gaza Strip
1(a) Total Hospital Beds	1,412	945
(b) Beds in Government Hospitals	1,002	870
2(a) Total Patients Hospitalized (for at least one day)	80,976	75,795
(b) Patients in Government Hospitals	52,820	68,896
3(a) Total Surgical Operations	21,353	28,486
(b) Surgical Operations in Government Hospitals	10,937	25,818

Palestinian public health experts note that while the Israeli government system still plays a major role in health care provision, the share of health services provided by the government health sector has dropped from 92 percent prior to the beginning of the Palestinian uprising, or Intifada, in December 1987, to 44 percent by 1992.[5] The current Israeli government health care system was inherited from the previous Jordanian (in the West Bank) and

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[3]Ministry of Health 1988-1989, *supra* note 1, p. 21.

[4]*Statistical Abstract* 1992, *supra* note 2, p. 783.

[5]Barghouti, M., "Palestinian Health: Toward a Healthy Development Strategy in the West Bank and Gaza Strip" in Brown A., Heacock R., La Torre I., eds., *Palestine Development for Peace: Proceedings of the ECCP NENGOOT Conference, Brussels, September 28-October 1 1992* (Jerusalem: 1992) p. 12.

Egyptian (Gaza Strip) administrations, and altered by Israeli military orders and regulations implemented by Israeli military personnel. The quality of care and services offered in government clinics and hospitals will be discussed in detail below after a brief summary of other available health care providers in the Occupied Territories.

UNRWA provides free medical services to just over one million Palestinian refugees living in the Occupied Territories. Its 168 clinics and health centers provide free medical services such as immunization, prenatal care, and well-baby clinics. Besides physicians and nurses, it employs environmental workers who deal with sewage, water, and garbage disposal in the refugee camps.[6] UNRWA's health care provision is discussed further in following sections.

Charitable or private health institutions, funded by governments, intergovernmental agencies, and non-governmental organizations, operate nine private hospitals (only one, al-Ahli, is in the Gaza Strip) and dozens of clinics in the Occupied Territories.[7] While these institutions were encouraged to complement Jordanian government and UNRWA health care institutions during Jordanian rule of the West Bank, Israeli occupation authorities have been uncooperative, restrictive, and sometimes hostile towards development of these institutions during the 25 years of Israeli occupation. Examples of restrictions and harassment of the private or charitable sectors include: a selective policy of granting permits for the establishment of new clinics and hospitals; substantial delays and deferrals in health-related activities and projects; restrictions on funding, personnel, equipment, and travel abroad for academic development; harassment of health professionals; and imposition of

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[6]UNRWA, "UNRWA in the Gaza Strip" (1992) p. 2; UNRWA, "UNRWA in the West Bank" (1992) p. 2.; Smith, C., *Health Development in the Gaza Strip: A Case for the Support of Local Groups* (1987) p. 4.

[7]*Al-Bayader al-Siyassi*, 13 May 1989, p. 36 (Arabic); Central Bureau of Statistics, *Statistical Abstract of Israel No. 42* (Jerusalem:1991) p. 760.

heavy taxation on health institutions.[8] Nonetheless, according to the Association of Israeli and Palestinian Physicians for Human Rights (AIPPHR), the only private hospital in the Gaza Strip is also the cleanest and offers better treatment and medical equipment than any of the government hospitals.[9]

B. Health Indicators

To ascertain the state of health conditions in the Occupied Territories, various methods of measurement can be used, including: examining population access to health services; the ratios of hospital beds to population and patients; infant mortality rate; hospital access to medical equipment; degree of control of diseases; sanitation; and access to basic necessities such as food, water, and shelter. Evaluating the results of these measurements shows that health conditions in the Occupied Territories are worse in many cases than in Israel or Jordan.

1. Access to Health Services

Access to health services in the Occupied Territories is restricted by location and cost, as well as by a lack of facilities, personnel, and services. A majority of the health services are located in towns, while approximately 70 percent of the population

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[8]Barghouti, M., Giacaman, R., "The Emergence of an Infrastructure of Resistance -- The Case of Health" in Nassar, J., Heacock, R., eds., *Intifada -- Palestine at the Crossroads*, (Birzeit: 1991); Association of Israeli and Palestinian Physicians for Human Rights, *Report on the Conditions of Health Services in the Gaza Strip* (1989). In 1987, the following partial list was compiled of restrictions on Gaza Strip health institutions: five Palestinian health associations were refused permission by the Israeli occupation authorities to establish four clinics and a hospital; an existing clinic run by a Palestinian trade union was closed by the occupation authorities; a health education lecture and a first aid course were banned by the authorities; and the chair of the Red Crescent Society in Gaza was prevented for a number of years from travelling abroad. Smith, *Health Development in the Gaza Strip, supra* note 6, p. 9.

[9]AIPPHR, *Health Services in the Gaza Strip, supra* note 8, p. 15.

lives in villages or refugee camps.[10] The cost of government health care is prohibitive without insurance and insurance premiums are expensive, as discussed in subsequent sections of this report. UNRWA health services are only available to refugees and the private and charitable sectors are small in relation to the population's health needs.

While the total number of hospitals in the Occupied Territories excluding East Jerusalem has increased from 20 to 23 since 1967,[11] the total number of government hospitals has actually declined. There were 20 government hospitals in 1967 (14 in the West Bank and six in the Gaza Strip); however, today there are only 14 (nine in the West Bank and five in the Gaza Strip).[12] There are also seven nongovernmental hospitals in East Jerusalem to which Palestinians have access whenever they are allowed access to East Jerusalem.[13] Of the six government hospitals which have been shut down, three of the buildings were converted, respectively, into a police station, the military headquarters of the West Bank (Beit El), and a prison.[14] In addition to closing hospitals, the Israeli authorities have closed a number of medical facilities, including the Central Laboratory, the Tuberculosis Center, the Central Government Blood Bank (all located in East Jerusalem), and two dental units in the West Bank.

The government health system is understaffed and its health

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[10]The Union of Palestinian Medical Relief Committees, West Bank and Gaza Strip, *An Overview of Health Conditions and Services in the Israeli Occupied Territories* (Jerusalem: 1987) p. 19.

[11]*Statistical Abstract* 1992, *supra* note 2, p. 783; Katbeh, S., *Health Services in the West Bank* (Jerusalem: 1988) p. 4 (Arabic). The number actually declined from 1990, when there were 24 hospitals, after a government hospital was closed.

[12]*Statistical Abstract* 1992, *supra* note 2, p. 783; al-Haq Report 355/90.

[13]Nammari, R, "Hospitals and Their Problems in the West Bank and Gaza Strip," in *Palestine: Development for Peace, supra* note 5, p. 39.

[14]*Al-Fajr* English Weekly, 19 February 1982; *al-Fajr* Arabic Daily, 21 July 1985; al-Haq Report 355/90.

workers are overworked[15] and underpaid. There is only one physician to 1,300 patients in the Gaza Strip, as compared to a physician-population ratio of 1 to 400 in Israel.[16] According to Israel's Ministry of Health, medical services which are unavailable include radiotherapy, hematologic oncology, pediatric nephrology, pediatric urology, complicated nerurosurgery, and pediatric, infant, and respiratory intensive burn treatment.[17] Problems with available government health care services include lack of a central technical and administrative management system; an inefficient filing and index system; lack of dieticians and properly controlled meals; and inadequate ambulance services.[18] Despite the traumatic experiences sustained by Palestinians as a result of the occupation, services for the physical rehabilitation and mental well-being of the population are inadequate or lacking. No rehabilitation programs, government or otherwise, exist in the Gaza Strip and only a small private, charitable program (with 122 beds) exists in the West Bank. By comparison, there are 1,500 publicly funded beds available for rehabilitation to the Israeli population of 4.5 million.[19] Only one hospital and one other hospital unit provide any psychological or psychiatric health services, with only 354 beds available in the entire Occupied Territories for patients with

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[15]*Al-Alam*, 15 February 1992, p. 58 (Arabic) (interview with Dr. Ahmad al-Yazeji). In government clinics in the Gaza Strip, doctors reported seeing 100 to 200 patients each day. Clinics are open about six-and-a-half hours a day, meaning that the doctors were seeing, on average, a patient every three minutes. Al-Haq Reports 104/92, 102/92.

[16]Ahmed, H., "Medicine As A Political Weapon: Interview with Dr. Martin Rubenberg," *American-Arab Affairs*, 6 December 1989, p. 78.

[17]State of Israel Ministry of Health, *Health in Judea, Samaria, and Gaza (1989-1990)* (Jerusalem: 1990) p. 24.

[18]MAP, *Health in Gaza*, *supra* note 1, p. 34.

[19]Grodinsky, Y., Marton, R., *Report on Rehabilitation Services in the Occupied Territories* (1991) pp. 10, 17.

psychological difficulties.[20]

Physical access to health services is blocked by curfews, closed military areas, permit requirements, and military roadblocks or checkpoints, which are imposed frequently by Israeli military authorities. Palestinians with medical emergencies may be denied permission to travel to a hospital, or may have their travel delayed.[21]

2. Hospital Bed to Population and Patients Ratios

The hospital-bed-to-population and hospital-bed-to-patients ratios in government hospitals in the Occupied Territories, excluding East Jerusalem, have actually decreased over the years of occupation, indicating that the number of beds has not even increased to cope with natural population growth. Table B below shows that throughout the years of occupation there have been fewer beds per thousand persons than the recommended international standard[22] of two per thousand persons:

TABLE B[23]

	1974	1990
1. Beds per thousand persons	1.8 (1,925 beds)	1.2 (1,872 beds)
2. Beds per thousand patients	2.4	1.2

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[20]Civil Administration: Judaea and Samaria, *Health Services in Judaea and Samaria, Statistical Report* (1988) p. 3; State of Israel Ministry of Health, *Health in Judaea, Samaria and Gaza (1990-1991)*, (Jerusalem: 1991) p. 41.

[21]Al-Haq, *A Nation Under Siege* (Ramallah: 1990) Chapter Two; al-Haq, *Focus: Restriction of Access To and Through East Jerusalem*, 4 April 1991.

[22]Bellisari, A., "Special Report: Health and Medical Care in the Occupied Territories," *The Center for Policy Analysis on Palestine* No. 2 (Fall 1991) p. 4.

[23]Central Bureau of Statistics, *Statistical Abstract of Israel No. 29* (Jerusalem: 1978) p. 808; *Statistical Abstract* 1991, *supra* note 7, pp. 760, 710.

By comparison, in 1990 there were 3.5 beds per thousand patients in Jordan and five beds per thousand patients in Israel.[24]

3. Equipment and Specialists

Since the beginning of the Israeli occupation, the Palestinian community has complained about the lack of medicine, equipment, and trained technicians in government hospitals and clinics.[25] Existing medical equipment is in chronic disrepair. Lack of medication and shortages of medicine continue to be problems. Patients with heart problems, diabetes, chest problems, and dermatological difficulties find it difficult or impossible to obtain enough medicine. Antibiotics to treat children's illnesses are often in short supply. Prior to the Gulf War in 1991, facilities in the Occupied Territories lacked equipment and specialists to treat, among others, cancer, diabetes, and kidney problems. More recently, some equipment, such as CT scans, has been acquired. However, according to doctors, these are inadequate. MRIs and certain blood tests also cannot be performed and there are too few functioning X-ray machines to provide services to all those who need them.[26] The cost of sending patients to Israel for advanced X-ray scans for a period of six months alone would pay for such a machine in the Gaza Strip.[27] Despite this, the Israeli occupation authorities cut

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[24] *Al-Nahar*, 30 April 1992 (Arabic).

[25] In four major Palestinian publications (*al-Quds*, *al-Sha'b*, *al-Fajr*, and *al-Mithaq*) surveyed from 1980 to 1985, 43 separate articles appeared in the press concerning the lack of medication at government hospitals and clinics in the Occupied Territories, with the most complaints occurring in 1984 and 1985. These complaints show that medication shortages began well before the Intifada. The shortages included shortages of medication for serious conditions, including diabetes, heart problems, infections, chest diseases, children's illnesses, skin diseases, and shortages of pain killers and anesthetic.

[26] Bellisari, *Health and Medical Care*, *supra* note 22, p. 5; al-Haq Report 102/92(c); and other al-Haq sources.

[27] MAP, *Health in Gaza*, *supra* note 1, p. 35.

their health services budget in half in 1990;[28] and medical personnel were forced to work for low salaries at levels frozen during a period of high inflation.

Other problems encountered by Palestinians in government hospitals include misdiagnosis and other negligent medical care, lack of specialists, and lack of accountability. Two serious incidents concerning the same hospital and reported in the press illustrate these problems. On 12 July 1985, 19-day-old Adan Hussain Qabha was brought to Jenin Government Hospital with pneumonia. After waiting ten hours for treatment, during which time Adan began bleeding from the nose, a physician visually diagnosed her as dead and she was transferred to the hospital corpse storage area. When her parents came to collect her body for burial six hours later, they found that she was actually still breathing. Although she was then placed in an incubator and attempts were made to save her, she died. No public investigation of the case ever took place and no one was held accountable for this negligence.[29]

Seven years later, in 1992, the quality of care had not changed. A pregnant woman was hospitalized in the maternity ward in Jenin Government Hospital. After the natural birth of her child, her doctor, who was also the Administrator of the Hospital, discovered that another baby was still inside her womb and that she needed a cesarean operation. But this was impossible because the anesthesiologist was on leave. The woman was transferred to the Rafidya Government Hospital in Nablus in an ambulance belonging to al-Amal (private) clinic because the hospital's ambulance did not have enough fuel to get to Nablus. At Rafidya Government Hospital, the child was born naturally. The Rafidya physician decided that she should leave the hospital the next day, despite the family's opposition. The woman remained in serious condition and by that evening the family had returned her to the Jenin Government

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[28]Abed-Rabbo, S., Savie, D., eds., *The Palestinian Uprising* (Association of Arab-American University Graduates, Inc., 1990), in Bellisari, *Health and Medical Care, supra* note 22, p. 6.

[29]*Al-Quds*, 29 November 1985 (Arabic); *al-Fajr*, 30 December 1985 (Arabic).

Hospital. The family then transferred her to al-Amal clinic because her Jenin doctor was not present. The clinic transferred her to Rafidya Government Hospital, which then transferred her to al-Watani Government Hospital, Nablus, where she remained in the Intensive Care Unit for over a week until she died on 4 November 1992. To al-Haq's knowledge, there has been no public investigation of this tragedy, nor has anyone been held accountable.[30]

While it is not al-Haq's contention that problems such as these are restricted to the Israeli government system, this does not negate the grave nature of the problems nor the responsibilities assumed by that system and the serious need for immediate redress.

4. Infant Mortality Rate

The infant mortality rate in the Occupied Territories is higher than in either Israel or Jordan, indicating that poor nutrition, inappropriate pre- and post-natal medical care, and uncontrolled infant diseases are more common in the Occupied Territories.[31] In 1990, the Israeli government stated that the infant mortality rate in the Gaza Strip was 25/1000 and in the West Bank was 22/1000,[32] but admitted that these figures were inaccurate because most births occur at home and early neonatal deaths sometimes go unreported. According to Palestinian sources, the actual infant mortality rate in the Occupied Territories is 50/1000, and may surpass 80/1000 in some areas (such as the Jordan Valley).[33] By comparison, the infant mortality rate in Israel has

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[30] *Al-Quds*, 8 November 1992 (Arabic).

[31] This was the opinion of both Dr. Mustafa Barghouti, head of the Union of Palestinian Medical Relief Committees and Dr. Farouq Abdul-Rahim, director of al-Maqased Charitable Hospital, interviewed in *al-Fajr* English Weekly, 21 October 1991, p. 6.

[32] Ministry of Health 1990-1991, *supra* note 20, p. 25.

[33] *Al-Fajr* English Weekly, 21 October 1991, p. 6; AIPPHR, *Health Services in the Gaza Strip*, *supra* note 8, p. 6.

been reported as only 12/1000, and in Jordan as 16/1000.[34] The infant mortality rate for refugees in the Occupied Territories was 40/1000 in 1991; this lower rate, in comparison to the rate reported by Palestinian health experts for the population as a whole, may be due to the superior pre- and post-natal care and children's care offered by UNRWA to refugees.[35] In the Occupied Territories as a whole, approximately 20 percent of Palestinian babies are born prematurely. Given the sparse pre- and post-natal medical care and the existence of only 59 incubators in the Occupied Territories (of which 26 are in private hospitals),[36] many of the premature babies born in the Occupied Territories face a virtual death sentence.

5. Economic and Environmental Conditions

The poverty and poor environmental conditions prevailing in the Occupied Territories and created, perpetuated, or exacerbated by the 25 years of Israeli occupation, contribute to high levels of respiratory and intestinal diseases and general debility within the Palestinian community, especially in the Gaza Strip.[37] Ninety

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[34] *Al-Nahar*, 30 April 1992 (Arabic). It is possible, as some sources assert, that the Jordanian infant mortality rate is not quite as low as reported.

[35] UNRWA -- Gaza Strip, *supra* note 6, p. 1; UNRWA -- West Bank, *supra* note 6, p. 1; *al-Fajr* English Weekly, 21 October 1991, p. 6.

[36] Letter from Yosef Shechter, Administrator of Health Services, Civil Administration, Judea and Samaria District Health Services, Office of the Staff Medical Officer to Charlie Greenbaum, Chair of Children's Committee, Association for Civil Rights in Israel, 10 May 1992, p. 12. Many cardiac defects in neonates can be corrected by surgery in Israeli hospitals if the procedure takes place within 24 hours; however, referral permission from the Israeli military Civil Administration is not often granted. Gruschka, R., Veerman, P., "Medical Care on the West Bank: How Occupation is Unhealthy for Children," *Israel Children's Rights Monitor*, Vol. III (November 1992) p. 50. The "Civil Administration" is the branch of the Israeli military government which administers civilian affairs in the Occupied Territories; thus, it is a military "civil administration."

[37] Rubenberg, M., "Medical Care Under Occupation in the Gaza Strip" *American-Israeli Civil Liberties Coalition* (Summer 1990) p. 16.

percent of Gaza's populated areas have no sewage systems and raw sewage runs through the streets and alleyways of the refugee camps.[38] Even those areas with sewage systems have difficulty with bacteria and insects because the sewage is gathered into large open pools and left untreated chemically. Irregular and inadequate garbage disposal (due to a lack of municipal organizations and sanitary services) is also a significant problem. Not surprisingly, poor sanitary conditions, caused by lack of proper infrastuctural development and by overpopulation, have caused the quality of the limited Gaza Strip drinking water to deteriorate.[39] In the West Bank, less than 10 percent of the population has access to a piped sewage system and only 21 percent of the communities have garbage disposal systems.[40]

Poor sanitation, limited water availability, and poverty contribute to the poor health of Palestinian children. According to a prominent Gaza physician, 70 percent of preschool children and 60 percent of pregnant women are anemic, while 50 percent of children under age five suffer from various levels of malnutrition.[41] The spread of various types of diarrheas, pneumonia, whooping cough, asthma, and skin diseases, especially in the Gaza Strip, is also attributable to the poor environmental conditions prevailing in the Occupied Territories.

C. Harassment of Health Care Workers

In addition to neglecting, or restricting improvement of, health conditions in the Occupied Territories, the occupation authorities have actively impeded the provision of health care. Many of the Palestinian organizations providing primary health care

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[38] *Al-Nahar*, 23 January 1992 (Arabic).

[39] *Al-Nahar*, 23 January 1992 (Arabic).

[40] Barghouti, "Palestinian Health," *supra* note 5, p. 13.

[41] *Al-Nahar*, 23 January 1992 (Arabic).

have been outlawed by Israel.[42] Israeli military forces often harass health care workers, impose curfews on locations and refuse to allow medical personnel or patients (even ones with valid curfew passes) to reach their destinations, and violate the neutrality of hospitals and clinics (especially government-run facilities) by shooting tear gas into the premises, arresting patients, or beating personnel.[43] The only private hospital in the Gaza Strip is also the only one without a military lookout post in or near the hospital; these posts, as well as the requirement that all patients' names be recorded, severely restrict access to medical care in Israeli government facilities.[44]

In 1990, it was reported that all physicians employed by the government health care system in the Gaza Strip "must sign an 'agreement' not to permit 'foreigners' or 'journalists' to visit, tour, or work at their particular government hospital, nor may they discuss medical conditions with 'foreigners' or 'journalists' without the express consent of the civil administration." A number of physicians were fired as a result of violating this agreement[45] which appears designed to make the government health system accountable only to itself, and not to the public which it is supposed to serve.

D. Health Conditions in Prisons and Detention Centers

The worst medical and health conditions in the Occupied

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[42]Barghouti, "Palestinian Health," *supra* note 5, p. 14.

[43]*See, e.g.,* al-Haq Affidavits 3642 (1992) (ambulance prevented by soldiers from reaching hospital and patient died); 3442 (1991) (beating ambulance driver); 3157 (1991) (woman gave birth at checkpoint when not allowed to reach hospital); 3100 (1991) (soldiers raided medical clinic and prevented milk deliveries); 2715-18 (1990) (tear gas in Gaza pediatric clinic); 2829 (1990) (raid on al-Ahli Hospital, Gaza).

[44]Vlessing, E., "Intimidating Palestine's Health Workers," *Middle East International* No. 321 (19 March 1988) p. 17.

[45]Rubenberg, "Medical Care," *supra* note 37, p. 16.

Territories exist in Israeli prison and detention facilities situated within the Occupied Territories and inside Israel. Al-Haq and other human rights or medical organizations have repeatedly decried the shocking conditions in these facilities. Torture and ill-treatment, together with inadequate -- and sometimes unethical -- health care services, are commonly experienced by the thousands of Palestinian prisoners and detainees. Poor nutrition; exposure to extreme temperatures with inadequate clothing; lack of ventilation, light, or proper toilet facilities; overcrowding; and lack of space to exercise, all contribute to the poor health which plagues many prisoners and detainees, sometimes continuing long after they have been released.[46] Israeli government health insurance, however, is not applicable within the prison system; this report's focus does not permit analysis of this extremely serious subject.

E. The Health Budget

Despite the deteriorating situation of Israeli government health services, equipment, and facilities, government health care budgets have actually decreased in recent years, especially since the beginning of the Intifada, although it is apparent that more funds are available. Over a three-year period, from 1986-1987 to 1989-1990, the government health care budget (general and development) for the West Bank decreased from 52.9 million New Israeli Shekels (NIS) to 46.5 million NIS.[47] In 1991, the Israeli government health system spent only US$ 30 per person in the Occupied Territories, while

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[46]Al-Haq, *A Nation Under Siege*, *supra* note 21, Chapter Five; Physicians for Human Rights, *Health Care in Detention: A Study of Israel's Treatment of Palestinians* (1990).

[47]Civil Administration: Judaea and Samaria, *Statistical Reports -- Health Services, Judaea and Samaria* (1987) p. 1; Civil Administration, *Health Services* (1988) *supra* note 20, p. 1; Civil Administration: Judaea and Samaria, *Statistical Reports -- Health Services, Judaea and Samaria* (1989) p. 1. According to the Civil Administration, "[b]etween 1987-89 the budget was decreased, ... During this period, there was also less money invested in the development of medical infrastructure." Quoted in "Medical Care," *Israel Children's Rights Monitor*, *supra* note 36, p. 54.

spending US$ 400 per person inside Israel.[48] In June 1992, it was reported that Israel spent $22 on each person in the West Bank, as compared to $500 on each person in Israel.[49]

Lack of sufficient funding for health care, the excuse commonly proffered by the Israeli authorities for deficient health services, appears disingenuous in light of the fact that Israel refuses to publish a full accounting of its income and expenditure in the Occupied Territories and appears to raise more money from Palestinians than it spends on services in the Occupied Territories. Israeli government health services are funded by a percentage of the military Civil Administration's general budget revenue which is gathered from Palestinian taxes and other income, including GHI premiums.[50] The Israeli administration refused to give any budget information regarding the Occupied Territories until 1992 and then released only partial information.

In 1992, for the first time, the Israeli government provided budget figures for the Occupied Territories. Of a total budget of 768 million NIS, 137 million NIS was the projected allotment for capital expenditures in health, with another 28.8 million NIS allotted to recurrent health expenditures. No accounting of how the funds were actually spent has been given.[51] The West Bank fraction of 137 million NIS appears to be 90 million NIS, with 80 million NIS of this to go towards salaries, maintenance, and medication, and the rest (10 million NIS) to go towards hospital development and

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[48] *Al-Fajr* English Weekly, 21 October 1991, p. 6 (citing Dr. Farouq Abd al-Rahim, director of al-Maqased Hospital).

[49] *National Health Plan* (1992), *supra* note 2, p. 1.

[50] Ministry of Health 1988-1989, *supra* note 1, p. 21; Ministry of Health for the State of Israel, *Health in Judea, Samaria, and Gaza 1987-1988* (Jerusalem: 1988) p. 29.

[51] Report of the Director-General, International Labor Conference, 79th Session (Geneva: 1992) Vol. II, p. 12.

equipment.[52] However, how the funds are allocated within these broad categories, or how the cost of referrals is dealt with remains unclear.[53]

Independent investigation indicates that Israel is not returning to the Occupied Territories all the revenue collected from Palestinians, although it is required to do so under international law. According to the United Nations Conference on Trade and Development, a large surplus in Israeli revenue from the Occupied Territories was evident in 1987, taking into account taxes on wages of Palestinians working in Israel, customs duties collected on imports from Israel and Jordan, value-added taxes on Israeli exports to the Territories, fees on permits to cross into Jordan, and various other levies.[54] Also in 1987, Meron Benvenisti's West Bank Data Base Project estimated that "at least $US 80 million of Palestinian contributions were directed to Israeli public expenditure..."[55] rather than to expenditure in the Occupied Territories. Although Israeli authorities complain that revenue has decreased since the beginning of the Intifada, there has been a commensurate increase in many fees, taxes, and the cost of basic services which would more than make up for the claimed decrease.[56] According to a Knesset member, "... the Israeli Knesset has been trying for years to get all

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[52]Meeting Notes, Defense for Children International -- Israel --, the Children's Rights Committee of the Association for Civil Rights in Israel, Health Administration of the Civil Administration --, 22 March 1992. The West Bank Civil Administration announced that its development budget for hospitals in 1993 will be 11 million NIS. "Civil Administration Development Budget Rises," *The Jerusalem Post*, 12 November 1992, p. 12.

[53]*Israel Children's Rights Monitor*, *supra* note 36, p. 56.

[54]Stephens, M., *Taxation in the Occupied West Bank 1967-1989* (al-Haq, 1990) p. 54, citing *The Palestinian Financial Sector Under Israeli Occupation*, UNCTAD/ST/SEU/3, 8 July 1987, p. 101.

[55]Benvenisti, M., *1987 Report: Demographic, Economic, Legal, Social and Political Developments in the West Bank* (Jerusalem: West Bank Data Base Project, 1987) p. 32; Vlessing, *MEI*, *supra* note 44, p. 18.

[56]Stephens, *Taxation*, *supra* note 54, pp. 55-56.

the data on government investments in the territories -- in vain."[57] The release of the 1992 budget illuminated little, as the specific figures for value added taxation, income tax, health insurance, customs duties, or national insurance were not published.

Israeli refusal to publish accounts of the funds collected from Palestinians who work within Israel fuels suspicion that more money is available for social services in the Occupied Territories but is being deliberately withheld and spent inside Israel. Palestinians who work inside Israel through the Labor Exchange have 12.43 percent of their wages deducted from their wages or paid by their employer for National Insurance (more is deducted for other social benefits[58]). However, only .98 percent of their wages is actually transferred for their benefit. Thus, they can only claim benefits ensuing from work accidents, maternity in the unlikely event that the birth occurs in Israel, and the bankruptcy of the employer, but are unable, due to the requirement that claimants must reside in Israel, to claim benefits such as old age, invalidity, survivors' (family members who survive a deceased worker), occupational diseases, nursing, family allowance, and unemployment payments.[59] Most of the remaining 11.45 percent of their wages deducted for purposes of National Insurance is supposed to be transferred to the Civil Administration inside the Occupied Territories to be used to promote investment and development in the Occupied Territories; however, it has been

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[57]Sarid, Y., "Fraud," *New Outlook Middle East Magazine* (March/April 1992) pp. 10, 11. Mr. Sarid was a Knesset Member for the Ratz party at the time.

[58]Altogether, in social deductions including those for National Insurance, industrial services workers have 18 percent withheld, agricultural workers have 25 percent withheld, and construction workers (in public enterprises) have 21.3 percent withheld. Construction workers in private enterprises have 43.3 percent withheld. Report of the Director-General, International Labor Conference 1992, *supra* note 51, p. 29.

[59]*Ibid.*

estimated that 80 percent of this fund is actually used within Israel.[60] The Civil Administration consistently refuses to account for any funds transferred to it.[61] According to the 1991 International Labor Conference:

> As regards the administration and expenditure of the fund which comprises certain social security deductions for the wages of workers from the territories employed in Israel, it would be desirable that a proper accounting of these resources be made public and that any suspicion or doubt about their utilisation dispelled. The total lack of transparency regarding the utilisation of this fund has long given rise to suspicion and even resentment on the part of the population of the occupied Arab territories. The removal of these suspicions and resentment would help to restore confidence in the social security system and in the broader advantages for the territories that are derived from the contributions paid by the workers concerned.[62]

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[60]Hiltermann, J., *Behind The Intifada* (Princeton: 1991) p. 22. The Kav La'Oved -- Workers' Hotline association, which works for the protection of workers' rights, estimates that at least one billion dollars have been collected from workers since 1970 and that most of this amount has remained in Israel, transferred to the Israeli Finance Ministry. The proposed "Equalization Levy" law now under discussion would, if implemented, transfer future deductions from workers' salaries to the Civil Administration, but would not remedy past injustices. "'Equalization Levy' -- New Law Proposed Concerning National Insurance," *Kav La'Oved -- Workers' Hotline* (December 1992 Newsletter) p. 1; Porshner, C., "At Least One Billion Dollars Collected From Territories Workers -- But They Will Not Get Pensions or Unemployment Benefits" *Davar*, 12 November 1992 (Hebrew).

[61]Appendix II: Report on the situation of workers of the occupied Arab territories, Report of the Director-General, International Labour Conference, 78th Session (Geneva: 1991) p. 18.

[62]1991 International Labour Conference, *supra* note 61, p. 43.

F. Summary

During 25 years of occupation, the Israeli military authorities have systematically adopted measures that have retarded and irrationalized the development of the entire health care system (including the part provided by the private or charitable sectors) in the Occupied Territories. Health services have deteriorated and health conditions, where improved, have done so relatively slightly and despite the Israeli occupation and the dependent medical system. Health experts suggest that improved health conditions are actually attributable to increased individual incomes. The state of health in the Occupied Territories is currently characterized by a lack of coordination among health providers and between health and social sectors; inequitable distribution of health services; selective, rather than comprehensive provision of services; uneven development; lack of standardization and quality control; too little emphasis on preventive health care and commensurate overemphasis on institutional care; long waits for specialized care; inadequately trained health work force; insufficient opportunity for health personnel to improve production and efficiency; lack of community participation in, or education about, health; and weak health infrastructure (such as water and sewage systems).[63]

The Israeli occupation authorities have actively created or exacerbated most, if not all, of these problems with measures including monopolizing decision-making regarding planning, financing, and administering the government health care system; limiting to a bare minimum the resources allocated to government health care; charging high fees; and using all available means such as regulations and taxation to curtail the medical activities of the charitable or private sectors and prevent them from expansion and development. Under such circumstances, the development of a comprehensive and rational health care system providing adequate health care accessible to the entire population becomes impossible.

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[63]Barghouti, "Palestinian Health," *supra* note 5, pp. 12, 15-16; Abdeen, Z., "A Health Strategy for the Occupied Territories" in *Palestine Development for Peace*, *supra* note 5, pp. 3-5.

Although in 1991, the Israeli Ministry of Health claimed that it "continued to provide needed health care, including preventive services and curative care,"[64] in reality, both the quality and quantity of many health services, facilities, and medical equipment have suffered substantially from Israeli measures. As a result, Palestinian health services have either deteriorated or made unsatisfactory progress relative to that inside Israel and in Jordan and Egypt, during various periods of the occupation.

Thus, a clear policy is evident on the part of the Israeli authorities to tightly control, direct, and restrict health care in the Occupied Territories and render it almost completely dependent on Israel's health care system for any highly specialized care. This policy has resulted in provision of minimal health services by the occupying Israeli government which assesses large payments from Palestinian consumers whose basic health needs remain unsatisfied.

[64]Ministry of Health 1990-1991, *supra* note 20, p. v.

II. Israeli Government Health Insurance

In addition to the deteriorating services and poor conditions of health care described above, health in the Occupied Territories is further undermined by lack of access to affordable health care for a sizable minority of Palestinians. A substantial reason for this inaccessibility is the problematic system of Israeli military government health insurance (GHI). Palestinians with GHI face problems such as lack of eligibility for some family members, delayed coverage, lack of government hospitals or clinics in the vicinity, lack of coverage, lack of information about GHI, failure to reimburse expenditures made outside the government system when the system's supplies are exhausted, failure to refer to Israeli hospitals even when critically necessary, and steadily rising costs. The result of the problematic GHI system is that less than 30 percent of Palestinians in 1992 held GHI. The only realistic alternative for most families is to remain, or become, uninsured. Taking into consideration the overlapping groups of people with health care provided either by GHI or UNRWA (to refugees), one may conclude that at least one-third of all Palestinians in the Occupied Territories, excluding East Jerusalem, has no access to affordable health care. The number of Palestinians in this predicament threatens to increase unless the health care system in the Occupied Territories, including GHI, is revised radically or changed outright.

The following discussion describes previous government health care systems in the Occupied Territories and then focuses on the GHI system and the domestic and international legal implications of such a system under occupation.

A. Government Health Care Laws Under Jordanian, Egyptian, and Israeli Rule

1. Jordanian and Egyptian Rule

Palestinians in the West Bank and Gaza Strip were eligible for heavily subsidized or free medical care prior to Israeli occupation in 1967. Under Jordanian rule (1949-1967), Palestinians in the West

Bank had no health insurance but relied instead on the heavily subsidized government health system,[65] which provided the majority of health services (UNRWA also provided some services for registered refugees).[66] Jordanian government regulations in 1966 created a four-tier system of payment for medical services: first, all poor people were treated free; second, mandatory insureds (most government employees) received most medical services free in return for a monthly deduction from their government salaries; third, voluntary insureds and beneficiaries (all dependent family members) of any insured paid a certain amount for all medical services; fourth, uninsured persons who were not beneficiaries paid 30 percent more than the voluntary insureds or beneficiaries.[67]

All insureds paid, or had deducted from their salaries, 500 fils (.5 Jordanian Dinars) each month. This represented, at most, six percent of a mandatory insured's salary (if paid the minimum 100 JD annually that government employees had to be paid if insurance was mandatory). Mandatory insureds were then entitled to receive general medical treatment, surgery, X-rays, lab tests, many special medical procedures, and dental treatment free. They paid 50 fils daily for food while in the hospital and 50 percent of the costs of artificial limbs and glass eyes. Voluntary insureds and all beneficiaries paid a specified amount for any treatment received. For instance, a visit to a clinic usually cost 100 fils but return visits, if prescribed by a physician, were free. A simple operation might cost between 100 fils and 1 JD, while major surgery cost 7 JD -- the largest single amount charged, according to the regulations. Hospital stays in rooms with six or more beds were free. Food cost 100 fils daily and full payment for artificial limbs and glass eyes was

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[65]Giacaman, R., "'Disturbing Distortions': A Response to the Report of the Ministry of Health of Israel to the Thirty Sixth World Health Assembly on Health and Health Services in the Occupied Territories, Geneva, May 1983" (Birzeit: 1983) p. 8.

[66]Katbeh, *Health Services, supra* note 11, p. 3.

[67]Jordanian Regulations for Health Insurance No. 146, 1966, issued pursuant to the Temporary General Health Law No. 43, 1966.

required.

The Egyptian government provided free medical care to every Gazan. According to reports, the standard of service, while not high, was better than in Egypt at the time.[68]

2. Israeli Military Orders 746 (West Bank) and 575 (Gaza Strip)

For the first few years after the West Bank and Gaza Strip were occupied by Israel in 1967, low-cost medical care was provided by the Israeli government. In 1973, by amending the existing law, Israel instituted a system of mandatory health insurance for government employees in the Occupied Territories, excluding East Jerusalem, and for Palestinian laborers living in the Occupied Territories but working inside Israel through the Labor Exchange.[69] In 1978, Military Orders 746 in the West Bank (reprinted in *Appendix I*) and 575 in the Gaza Strip made GHI (called the "Health Services Program" by the authorities) available to all other Palestinians, including organizations,[70] who wished to join voluntarily and pay premiums monthly or annually.[71] A small number of "social

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[68]MAP, *Health in Gaza*, *supra* note 1, p. 41.

[69]*See, e.g.*, General Health Law No. 43 - 1966 - Regulation Concerning Health Services (Reduction and Exemption) Judea and Samaria, signed 24 January 1973 and valid 25 March 1973, amended existing Jordanian law.

[70]Organizations enrolled voluntarily in GHI in 1991 included various Chambers of Commerce, the Bethlehem Water Company, and a Nablus quarrying company. Al-Haq Report 103/92.

[71]Military Order 746 -- Order Concerning Health Services -- Judea and Samaria 1978, signed 20 January 1978, valid 1 February 1978 (reprinted in *Appendix I*). The equivalent military order for the Gaza Strip is MO 575. MO 746 cancelled the 1973 Regulation Concerning Health Services (Reduction and Exemption) -- Judea and Samaria -- 1973, valid 1 March 1973, an amendment to the Jordanian General Health Law No. 43 -- 1966. The 1973 Regulation had created a system of mandatory insurance and also purported to cancel the Jordanian Regulations for Health Insurance No. 146, 1966. The validity of this latter cancellation is subject to humanitarian law which obligates an occupying power to maintain the laws in force on the eve of the occupation unless they

assistance cases" also received GHI without paying insurance premiums. Palestinians in occupied East Jerusalem were not included in this health care system. These changes effectively ended the previous low-cost health care system and replaced it with the problematic government health insurance system familiar to Palestinians today.

B. Israeli Government Health Insurance

Israeli government health insurance insures Palestinians living in the Occupied Territories, excluding East Jerusalem, who are over age 18 and who voluntarily enroll, work in Israel through the Labor Exchange, work for the Israeli military government in the Occupied Territories,[72] or receive social assistance.[73] In the West Bank in 1988, of persons with GHI, approximately 36 percent (19,000) were workers in Israel; 32 percent (17,000) had voluntarily joined GHI; 21 percent (11,000) were Israeli government employees; and 11 percent (6,000) were social assistance cases.[74] Young children receive free medical care in the government system. By 1992, the proportion of insureds who were workers in Israel, relative to other insured groups, had increased, at least in rural communities, and the

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constitute a threat to the occupying power's security or unless the laws discriminate against the occupied population. Geneva Convention Relative to the Protection of Civilian Persons in Time of War of August 12, 1949, entry into force 21 October 1950, 75 UNTS (1950) 287-417 (Fourth Geneva Convention), Article 64.

[72]These employees include teachers at government schools, employees of Local Refugee Councils and Village Councils, and employees at government medical facilities.

[73]Approximately 5,000 families (30,000 people) were receiving social assistance in 1992. May 1992 letter from the Civil Administration to ACRI, *supra* note 36.

[74]Civil Administration, *Health Services* (1988), *supra* note 20, p. 6. By the following year, the number of heads of households insured had dropped from 53,000 to 42,000. However, the 1989 government report did not itemize the occupation of these GHI holders.

number of voluntary insureds had decreased.[75] Some members of the immediate family of each insured are also covered by GHI, as discussed below.

GHI premiums are deducted from the salaries of workers or government employees and voluntary insureds make monthly or annual payments at the post office. Each insured must go to the specific government clinic mentioned in his or her insurance card. If hospital care is necessary, the clinic sends the insured to a government hospital; only in emergency situations may the insured go directly to the hospital without a preliminary visit to the clinic.[76]

1. Decreasing Enrollment

The number of Palestinians insured by GHI is decreasing. Less than 30 percent of the Palestinian population in the Occupied Territories is currently insured and the percentage could be closer to 20 percent.[77] Only 16 percent of the rural population of the West Bank is insured. Compared with over 80 percent insured in the Occupied Territories a decade ago, this dramatic decline primarily reflects a drop in the number of people voluntarily becoming insured.

According to officials in the Israeli government, the percentage of Palestinians with GHI declined from 83 percent in

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[75]Health Development Information Project, telephone interview, 29 June 1992.

[76]Al-Haq Report 48/92. Many patients arrive in the emergency rooms of hospitals but are not actually in need of emergency treatment. It is left to the discretion of individual doctors in the emergency rooms to decide whether to treat them or not.

[77]According to various Palestinian medical and public health experts, only 20 percent of the Palestinians in the Occupied Territories has GHI. *National Health Plan* (1992), *supra* note 2, p. 1; Nammari, R., "Hospitals and Their Problems in the West Bank and the Gaza Strip" in *Palestine Development for Peace*, *supra* note 13, p. 38.

1981, to 56 percent in 1985.[78] Various nongovernmental sources state that the percentage decreased from 40 in 1983,[79] to approximately 33 percent by 1988.[80] While the percentage of the population in the Gaza Strip holding GHI has always been higher than the percentage in the West Bank, it has declined more rapidly: from 80 percent in 1985,[81] to 40 percent in 1989.[82] During that same period, enrollment in the West Bank dropped from 38 percent[83] to 22 percent.[84] Thus, various estimates indicate that total Occupied Territories enrollment in GHI dropped from approximately 80 percent in 1981, to 30 percent by 1989. This is a decline in absolute numbers from approximately 996,500 people to 445,600 in an eight-year period, during which population increased.[85]

The number of insured patients at government clinics and hospitals has dropped particularly rapidly during the Intifada. In a 1991 survey of several clinics in the Gaza Strip, al-Haq found that

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[78]Cited in Roy, S. *The Gaza Strip Survey: A Demographic, Economic, Social and Legal Survey* (The West Bank Data Base Project, 1986), p. 107.

[79]Giacaman, "Disturbing Distortions," *supra* note 65, p. 8.

[80]Vlessing, *MEI*, *supra* note 44, p. 18.

[81]State of Israel Ministry of Health, *A Review of Health and Health Services in Judaea, Samaria and Gaza 1985-1986* (1986) p. 26.

[82]AIPHR, "Health Services in the Gaza Strip," *supra* note 8, p. 10.

[83]*Review of Health Services 1985-1986*, *supra* note 81, p. 26.

[84]Civil Administration, *Health Services* (1989), *supra* note 47, p. i.

[85]*Statistical Abstract* 1991, *supra* note 7, p. 710, states that in 1989, a total of 1,526,400 Palestinians lived in the Occupied Territories, excluding East Jerusalem, while 1,200,700 lived there in 1981. It has always been difficult to gather accurate statistics on population in the Occupied Territories. Dr. Meron Benvenisti, former vice-mayor of Jerusalem and former head of the West Bank Data Project, believes that the actual Palestinian population of the Occupied Territories is about 25 percent higher than that estimated by the Israeli Central Bureau of Statistics. Davidi, E., "Samir Khalaileh [sic], Industrialist from Al Bireh," *Davar*, 23 March 1990 (Hebrew).

the number of insured patients had dropped by anywhere from 20 to 90 percent since 1987 although the total number of patients had not declined. Specifically, one clinic that had had 150 insured patients in 1987, had only 15 by mid-1991. Another clinic's number of insured patients dropped from 400 to 40, and another's from 120 to 20. Three other clinics saw drops of about 20 percent in their insured clientele.[86] The number of persons with GHI attending the Bureij Refugee Camp government clinic declined from 1,200 in 1989, to 600 in 1990, and 450 in 1991.[87] In one West Bank government hospital (Ramallah), while the average number of patients treated rose during the Intifada compared to previous periods, the number of insured patients decreased by almost 51 percent during the first few years of the Intifada.[88]

After a sharp drop at the start of the Intifada, the percentage of insureds has remained relatively constant since 1989 at about 30 percent.[89] However, changing attitudes towards GHI, straitened economic conditions, and stricter Israeli policies regarding workers in Israel have altered the characteristics of those who are insured. Many voluntary insureds gave up their insurance during the Intifada, and more Palestinians working inside Israel became insured. The number of workers working inside Israel who have registered with the Labor Exchange, as opposed to those working in Israel without official Israeli permission, rose after the Gulf War and throughout 1992 (from an average of 42,000 workers per month to

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[86]Al-Haq Report 102/92.

[87]Al-Haq Report 104/92.

[88]Al-Haq Report 102/92.

[89]In 1992, the Civil Administration for the West Bank claimed that about 30 percent of the West Bank population was insured. DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52. However, Palestinian health experts contested that figure and believed that only 15 percent of the West Bank population was insured, while 30 percent was insured in the Gaza Strip. Barghouti, "Palestinian Health," *supra* note 5, p. 17.

about 70,000[90] in 1992) due to tightened registration controls on laborers. Meanwhile, many Palestinians voluntarily enrolled in GHI have given up their insurance due to financial difficulties resulting from economic restrictions imposed by Israeli authorities as a result of the Intifada, the devastating economic impact of the Gulf War which severely reduced remittances from abroad, and the decreased availability of work in Israel because of Jewish immigration and stricter labor controls. In addition, many Palestinians who voluntarily enrolled mainly for the benefit of referral to superior facilities inside Israel, allowed their insurance to lapse upon discovering that, when referral is needed, it is almost impossible to obtain.

Palestinians with GHI are concentrated in urban areas; few rural Palestinians are insured, even though they represent the majority of the population in the Occupied Territories. In 1986, although it was estimated that 80 percent of all Palestinians living in the Gaza Strip had GHI, one researcher found that only 35-40 percent of the population in outlying villages had insurance.[91] In 1992, 72 percent of the West Bank population lived in rural communities but only 16 percent of that rural population had GHI, while the estimated figure for overall enrollment in the West Bank was somewhat higher.[92] Of this 16 percent, even fewer -- only 11 percent -- had GHI *and* lived in a community with a government clinic. Thus, 84 percent of the rural West Bank population was without health insurance and a further five percent lacked immediate, physical access to government health services even though they had GHI. Some Palestinians without GHI are refugees and therefore have access to UNRWA services. Eighteen-and-a-half percent of the rural West Bank population are registered refugees (but only half have UNRWA clinics in their community). Assuming that no GHI members are also registered refugees, at most 34.5 percent of the rural West Bank population had access in 1992 to any

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[90]Porshner, *Davar*, *supra* note 60.

[91]Roy, *Gaza Strip Survey*, *supra* note 78, p. 107

[92]HDIP, 29 June 1992, *supra* note 75.

kind of subsidized medical care (GHI or UNRWA) and many of these people could not find that care in their own communities.[93]

In summary, enrollment in GHI has dropped dramatically in the last decade. Whereas only 17 percent of the Palestinians living in the Occupied Territories were without insurance in 1980, by 1992 at least 70 percent of the total population had no GHI; in rural communities, that figure was closer to 84 percent. Even with the broadest estimate of UNRWA medical coverage in rural communities, 65.5 percent of that population had neither UNRWA care nor GHI and was thus without any affordable health care in 1992. In Israel, by contrast, approximately 98 percent of Israeli Jews was enrolled in Israel's national health insurance program (the percentage was slightly lower for Palestinian Israelis) by the 1990s.[94]

2. Problematic Definition of "Family"

The insured and some members of her or his family are eligible for GHI. Those family members eligible in 1992 were: the insured's spouse, children under 18, and the insured's parents over 60. Parents under 60 could be included if one of them had a chronic illness and obtained a medical report from a doctor. This report could be obtained after an examination costing approximately 84 NIS (equivalent to about one monthly insurance fee); an additional, unofficial 50 NIS payment was sometimes necessary.[95] If a daughter married before she was 18 and her husband had health insurance that would cover her, then the daughter's insurance through her parents lapsed.

Over the years, Israeli military authorities have vacillated on the issue of which family members should be eligible for GHI, making GHI eligibility highly unpredictable. In the West Bank, for

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[93] *Ibid.*

[94] Reiss, N., "Processes Affecting the Distribution of Public Health Services to the Arabs in Israel," *Asian and African Studies* 23, No. 2, 3 (1989) p. 258.

[95] Al-Haq Report 58/92.

instance, when mandatory GHI was implemented in 1973, only the spouse and minor children (under 18) of the insured were eligible for coverage. In 1978, the definition of eligible family members expanded to include the spouse, minor sons, dependent women of any age, and minor dependent brothers of the insured. According to press reports, the Israeli authorities decided to reduce eligibility to just the spouse and minor children in April 1981, but then agreed to reverse their decision.[96] One year later, according to a new regulation, the parents of the insured or of the spouse, but not the parents of both, were covered, but again only minor children and minor, dependent siblings were covered. This rendered dependents over 18 ineligible unless they were the parents of one of the couple or had been eligible for GHI before 1 December 1981.[97] In August 1983, Military Order 1077 for the West Bank was issued, permitting all dependent relatives over 60 to become eligible for GHI, but only if they were enrolled by 30 September 1983. This order was only signed on 9 August 1983, but was made retroactively valid from 5 May -- thus giving subscribers less than two months to sign up their parents, while appearing to give them five.[98] In June 1984, family member eligibility was expanded to include relatives over 60 (with no deadline for enrolling) persons between 18 and 21, persons under 60 who were not working due to chronic illness, and female nursing students.[99] Although the regulation is unclear, it appears likely that only dependent 18 to 21-year-olds were eligible under this formula.

Since the mid-1980's, eligibility requirements appear to have stabilized and GHI eligibility is currently narrowly limited to the nuclear family and parents over 60; children over 18, and parents

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[96]*Al Anba'*, 27 April 1981 (Arabic).

[97]Military Order 984 -- Order Concerning Health Services (Amendment) Judea and Samaria 1982, signed 9 April 1982.

[98]Military Order 1077 -- Order Concerning Health Services (Amendment 2) Judea and Samaria 1983, signed 9 August 1983, valid 5 May 1983.

[99]Regulation Concerning Health Services (Amendment 17) Judea and Samaria 1984, signed 23 January 1984, valid 1 February 1984.

under 60 (unless chronically ill) are excluded. By contrast, the 1966 Jordanian regulations extended eligibility to *all* dependent family members and substantially subsidized their care. This more accurately reflects the actual composition and local conception of Palestinian families, most of whom include adult children, their spouses, aunts and uncles, and parents. Many of these family members are dependent on the insured and have no other source of income. Clearly the Israeli decision to provide only the narrowest definition of a "family member" with subsidized health care was made consciously by the Israeli authorities, even though such coverage is based on a family model more familiar to European societies than to Palestinian society. Under current GHI regulations, Palestinian families either endure limited eligibility, in which some but not all family members have affordable access to the government health care system, or they obtain a second health insurance policy, with overlapping eligibility and at additional expense.[100] Failure to cover children over 18 who are pursuing higher education makes the choice to study rather than work riskier. Limited eligibility may deter some families from subscribing to GHI at all.

3. Limited Information About GHI

Access to accurate information regarding GHI is extremely limited.[101] Many relevant laws, regulations, and GHI terms are unwritten, unpublished, or undistributed. Insurance holders do not know to what they are entitled. The example of limited family eligibility given above shows that the authorities are prone to change important insurance terms quickly and often, with little notice. In 1991, the age of children eligible for free medical care in the West

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[100]Al-Yazeji, *al-Nahar*, 23 January 1992 (Arabic).

[101]MAP, *Health in Gaza*, *supra* note 1, p. 11.

Bank was reduced from three to one-and-a-half;[102] yet hospital administrators still quote the former figure and the practice appears to be to treat children free up to the age of three for the time being.

The Israeli military Civil Administration's health services section prints the GHI membership and payment record slips which provide the only easily accessible information about GHI. Besides recording personal information about the insured and the account, the slips inform the insurance holder of the fee for GHI if paid annually and that this annual charge is discounted by 15 percent if paid by a certain date. The amount of the fee if paid monthly is usually left blank, indicating that frequent fee changes throughout the year are anticipated. The insurance slips state that the insured has the following rights if insurance payments are made promptly: the rights to receive free services at clinics from the date of registration for insurance and to be hospitalized overnight without charge after the first four months. The slips also state that delay in payment results in interest charges and that six months delay in payment results in cancellation of hospital privileges.

The rights and duties of GHI holders are not clearly stated anywhere. For example, the insurance slips which subscribers receive do not state that there is a charge for medication over and above the monthly premiums, nor do they inform the insured of the right to referral to Israeli medical facilities if treatment in the Occupied Territories is inadequate. Reference to the health insurance laws are not helpful. With an average of three to four amendments of relevant laws each year, often published or distributed only after delays of months or years, it is very difficult to find the most recent applicable laws and regulations. For example, an important 1981 regulation concerning fees which has been the basis of numerous amendments is not, to al-Haq's knowledge, available to the public. Once found, the laws and regulations are unclear. Whether reading the Hebrew or Arabic text

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[102]Order Concerning Health Services (Judea and Samaria) No. 746 5738-1978 Announcement Concerning Health Services Plan and Installment Payments for Health Services (Amendment 39) (Judea and Samaria), 5751-1991, 15 g (reproduced in *Appendix II*).

of, for example, any of the Announcements Concerning Health Services and Health Services Program (Judea and Samaria), it is impossible to tell whether some of the fees announced apply to uninsured, newly insured, or insured persons. Fees may be incorrectly translated in the Arabic version of regulations.[103] In fact, the best sources of information regarding GHI are informal announcements posted in health clinics, reports in the media, and other people with GHI who have previously discovered answers to their questions.

Al-Haq has found that many Palestinians with GHI are unsure when their hospitalization coverage begins, whether unmarried daughters over 18 are covered, or whose permission is needed in order to receive a referral to Israeli medical facilities. Failure to clearly inform GHI subscribers of the terms and conditions of GHI leaves them unsure of the terms of the contract they agreed to and pay for and allows the Israeli authorities to create or change terms and conditions at will, based on official convenience or whim, without any accountability.

4. Delayed Hospitalization Coverage

Although insured persons have the right to use clinics and visit hospitals as soon as they register for insurance, voluntary insureds do not have overnight hospital coverage until several months (currently four months in the West Bank) after their GHI begins.[104] In the interim, they must pay the same astronomical hospital fees charged to uninsureds. Government employees do not receive a GHI card until three months after their employment begins,[105] and it appears that workers must wait three months

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[103] *See, e.g.*, Announcement Concerning Health Services and Health Services Program (Amendment 13) Judea and Samaria 1984, signed 23 January 1984, valid 1 February 1984.

[104] Al-Haq Report 109/92(c).

[105] Al-Haq Report 104/92.

before they can be hospitalized.[106] Persons who have missed payment of anywhere from one to five premiums must also pay the uninsured hospital fee amount, and persons who have missed six payments or more must pay their debt first, before being allowed to enter the hospital and pay the uninsured hospital fee amount (they must then wait the prescribed number of months before a hospital stay would again be covered by GHI). Given these conditions, it is cheaper for persons with any insurance debts to enter the hospital as an uninsured, unless they have chronic medical conditions requiring ongoing care. The law makes no health care provision for persons who cannot pay their debts or the higher rates, and they can be denied access to government hospitals altogether unless they are able to obtain social assistance.

These provisions do not affect persons with illnesses or diseases which are treated free regardless of GHI,[107] such as

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[106]According to al-Haq Affidavit 3539 (25 July 1991), a Palestinian laborer working inside Israel with 80 NIS deducted monthly from his salary for social services (including health insurance), was told that he could not stay overnight in an Occupied Territories hospital until he had been working for three months, despite the fact that the examining doctor told him that he had a severe inflammation of the kidney and should stay at the hospital overnight. The laborer left the hospital and went to a clinic to obtain more medication.

[107]The following free health services are currently available in the West Bank regardless of insurance: treatment for contagious diseases, mother and child care centers, public health tests, school health services, cancer diagnosis, polio treatments, and care for children under one-and-a-half (except for innoculations to go abroad, blood bank services, and referrals to Israeli hospitals). Order Concerning Health Services 746, (Amendment 39) 1991, *supra* note 102; *Review of Health Services 1985-1986*, *supra* note 81, p. 26; Barghouti, M., Daibes, I., The West Bank Rural PHC Survey, (HDIP, 1991) p. 31. In reality, government health services are still offering free care for children up to the age of three. In 1992, several human rights organizations received assurances that children under the age of three and cancer patients could be treated in Israeli hospitals free of charge and regardless of insurance if they go through referral procedures. It remains to be seen whether these promises will be honored. In the Gaza Strip during 1992, similar free health services were offered and children were receiving free care until the age of three, except for payment for medicine. Al-Haq Report 102/92.

persons needing cancer diagnosis, or suffering from contagious diseases.[108] According to the Israeli Coordinator of Activities in the Occupied Territories, Danny Rothschild, cancer and kidney dialysis patients are exempt from the four-month waiting period after they pay their first premium.[109] Persons receiving social assistance do not need to wait for four months.[110] In the Gaza Strip, women in maternity wards can have the cost covered if they subscribe to GHI within two weeks.[111] In 1992, the Civil Administration showed a willingness in a very few cases to allow an already hospitalized patient in critical condition to begin paying insurance and have all of his or her hospital fees covered by GHI, thus effectively abolishing the delayed hospital coverage rule. However, it is far from clear that this instant coverage is actually offered in most cases.[112]

Clearly the motivation for these rules is financial and ensures that several months' payments have been received before a hospital stay is financed by the government. This discourages people from subscribing to GHI when a family member is in need of immediate hospitalization and serves as a harsh financial penalty on insured families who may have paid most past premiums but who have not had a steady source of income during the months preceding the time that hospitalization is necessary.

5. Medication Fees

Medicine was available in 1992 to insureds at a cost of 3 NIS

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[108]Al-Haq Report 57/92.

[109]"Rights and Abuses: Health Insurance in the West Bank and Gaza Strip," *al-Quds*, 23 November 1991 (Arabic).

[110]Interview with Danny Rothschild, Coordinator of Territories Affairs, the Ministry of Defence, *al-Quds*, 23 November 1991 (Arabic).

[111]Al-Haq Report 102/92.

[112]Undated letter (1992) from AIPPHR to al-Haq.

per unit.[113] A unit consists of 20 tablets for ordinary illnesses, or 30-60 tablets for chronic illnesses.[114] Five shots or suppositories are also considered one unit.[115] A unit of very expensive types of medicine may consist of only a few pills, shots, or suppositories.[116] On average, doctors prescribe about three units or types of medicine per illness. Thus, the average cost of medicine to insured persons in 1992 was 9 NIS ($3.75) per illness.[117]

The charge for a unit of medicine amounts to more than a nominal fee for several reasons. First, although the same fee is charged for each unit of medicine, a unit of more expensive medicine may contain fewer pills, forcing the insured to pay a higher fee for more expensive medicine. Moreover, the price for insureds is a substantial portion, often more than 50 percent, of the price charged for many common medications at a private pharmacy. For instance, according to one local West Bank pharmacist, in 1992 the average price of five of the most commonly bought medicines (in approximately the same quantities as that in one unit of medication obtained through GHI) was 5.70 NIS. In fact, the most common drug for pain relief (Acamol), actually cost less than 3 NIS in 1992.[118]

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[113]The price increased from 2.5 NIS on 10 March 1991. Order Concerning Health Services, Health Services Program and Payments in Return for Health Services (Amendment 33) (Judea and Samaria), 1991. The price in March 1993 had increased to 3.5 NIS although the new regulation increasing the price had not yet been distributed.

[114]Al-Haq Report 48/92.

[115]*Ibid.*

[116]*Ibid.*

[117]Al-Haq Report 57/92.

[118]According to a pharmacist at Silwadi Pharmacy, Ramallah, during 1992 the five most commonly used medicines were Amoxicillin cap. 500 (antibiotic)(16 capsules) for 9 NIS; Furamix Susp. (treats infant diarrhea)(bottle) for 5 NIS; Otocort ear drops for 5 NIS; Acamol (pain relief)(20 tablets) for 2.50 NIS; and Moduril (diuretic for hypertension)(20 tablets) for 7 NIS. The average price was

Shots may also cost less at private clinics.[119]

6. Shortages and Failure to Reimburse

If the patient is not staying overnight in a hospital, prescribed medicine must be bought in government clinics.[120] Medicine is delivered to clinics at a certain time each month and the supply is usually exhausted one to two weeks later.[121] Although clinics are then supposed to receive more medicine, typically, no more medicine arrives that month. Insureds in the Gaza Strip who cannot obtain prescribed medicine from their government clinic and whose doctor cannot prescribe a substitute medicine (or if it too is unavailable), must go to the Central Clinic in Gaza. If unavailable there, they must go to the storage room of al-Shifa Hospital. Only then might they be justified in buying it from a private pharmacy and applying for reimbursement -- an application which is usually unsuccessful,[122] because no reimbursement is possible unless permission to obtain medicine outside the system is received in advance.[123] Most patients simply buy the medicine at their own expense from a private pharmacy.[124] Even if the cost of the medicine is eventually reimbursed, there is no compensation

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5.7 NIS. These medicines are not necessarily on the list that doctors in government facilities must use to prescribe from. However, they are effective medications used to treat common problems.

[119]Al-Haq Report 100/92.

[120]Al-Haq Report 48/92. This poses an added difficulty for patients whose medicine is prescribed by a doctor at a hospital because they must make another trip to their clinic in order to obtain prescribed medicine unless they are extremely ill.

[121]Al-Haq Reports 57/92; 100/92; 101/92.

[122]Al-Haq Report 100/92.

[123]Al-Haq Report 109/92 (b).

[124]Al-Haq Report 104/92.

available for the time and travel costs expended in search of medicine which should have been made readily and quickly available to all holders of GHI.

Another type of problem encountered in the provision of medicines to insureds is illustrated in a case where al-Haq intervened on behalf of an insured woman who was referred to Hadassah Hospital in Israel for treatment of a chronic disease. The physician there prescribed a medication called "T. Losec" but her local government pharmacy did not carry it. Buying it in a private pharmacy would have cost her 380 NIS ($150) for 28 tablets -- and the doctor had prescribed a 120-tablet course. On 3 July 1992, al-Haq wrote to the officer in charge of medical services in the Civil Administration. The reply, dated 27 August, reached al-Haq on 28 September 1992. In it, an advocate in the Legal Advisor's office responded that the medication had not been approved by the "Committee of Medications for the Area" (even though it had obviously been approved in Israel). However, the advocate went on to say that the medication had been ordered for the patient and transferred to the health department in Hebron shortly after 20 July. Thus, it was only by the end of September, more than two months after the medicine had been transferred and many months after the medicine had been prescribed, that the patient was finally informed that she could obtain her medicine.[125]

7. Lack of Coverage

Israeli government health insurance does not cover treatment by a "specialist" other than one to whom the patient was referred by the assigned clinic.[126] The substantial (109 NIS or more) cost of ambulance transportation in the Gaza Strip is charged to the patient even if she or he is insured.[127] Not covered in either the Gaza Strip or the West Bank is the cost of medical reports which have

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[125]Al-Haq Legal Services Case No. 1459.

[126]Al-Haq Report 48/92.

[127]Al-Haq Report 102/92.

been prepared in government hospitals or clinics for submission to anybody other than an Israeli government office. The cost for these reports by December 1991 was 84 NIS.[128] Insureds must pay the full cost of innoculations (50 NIS in the West Bank and 62 NIS in the Gaza Strip in 1991) in preparation for travel abroad, although schoolchildren receive most routine innoculations free at school.

GHI does not cover dental care in the West Bank at all and there are substantial fees for dental work in the Gaza Strip.[129] Neither cosmetic surgery[130] nor various other treatments for such problems as infertility are covered anywhere in the Occupied Territories. Moreover, GHI does not cover the cost of medical apparati, even though the social assistance section or another office of the Civil Administration may be required to cover the cost.[131]

8. Restrictions on Medical Referrals to Israeli Hospitals

Referrals to Israel for hospitalization, ambulatory diagnostic, and day hospital care services are theoretically available to any insured if the medical treatment is necessary and unavailable in the Occupied Territories. The stated reason for having a referral policy to Israel is in order to avoid duplication of services in the Occupied Territories. In reality however, cases where referral is clearly necessary are often denied altogether[132] or delayed, sometimes fatally,[133] for many months.

Restrictions on referrals have troubled Palestinians for more

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[128]Order Concerning Health Services 746 (Amendment 39) 1991, *supra* note 102. The cost increased from 71 NIS in February of the same year.

[129]Al-Haq Report 102/92. One filling or extraction cost 17 NIS in April 1991. The uninsured cost was double that.

[130]Al-Haq Report 48/92.

[131]"Medical Care," *Israel Children's Rights Monitor*, *supra* note 36, p. 51.

[132]Al-Haq Report 109/92(c).

[133]*Ibid.*

than a decade. Since 1988, however, the problem has worsened, with medical referrals ultimately based on financial, rather than medical, criteria. While the problem is sometimes stated in terms of reductions in the number of hospital days allocated each month to Palestinians, or in terms of changes in the process of obtaining a referral, restricted funding remains the critical underlying issue. In the Civil Administration's own words, "[b]etween 1987-89 the budget was decreased, and there was a concurrent decrease in the number of patients referred to Israeli hospitals."[134] Given the coincidence of this change with the start of the Intifada and the excess income that the Israeli authorities collect in the Occupied Territories, it is difficult to escape the conclusion that funding for referrals is being deliberately and illegally withheld. Unreasonably restricted medical care is clearly being used as a weapon by Israeli authorities against Palestinians as a collective punishment for resisting occupation and as a way to cut the normal economic costs of government.

a. Referral Problems 1981-1987

Referral problems have plagued Palestinians in the Occupied Territories for many years. More than a decade ago, numbers of referrals allocated to each district in the Occupied Territories were so small that virtually no one benefitted.[135] For a period during 1981, Israeli authorities refused to allow even those patients who had successfully obtained permission and already had appointments in Israeli hospitals to be referred.[136] In 1982, Gaza Strip patients complained that the Health Department was not referring patients to Israeli hospitals, despite the fact that all of these patients had

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[134]Quoted in "Medical Care," *Israel Children's Rights Monitor*, *supra* note 36, p. 54.

[135]"West Bank Health Departments Continue Referring Patients to Israeli Hospitals," *al-Quds*, 10 December 1981 (Arabic).

[136]"Health Departments in West Bank: Authorities Remove Authorization To Refer Patients to Israeli Hospitals," *al-Quds*, 25 November 1981 (Arabic).

paid their insurance fees.[137] In 1984, West Bank hospital directors were forbidden to refer any patient for health care in Israel unless the director received a special referral permit beforehand; previously, the directors had been able to issue referrals themselves in critical cases.[138] The press reported that some West Bank residents were refused referrals in 1984, despite the fact that they were insured.[139] In at least one case, the Civil Administration required the referral to be specifically guaranteed by the Ministry of Finance before allowing it.[140] In 1985, *al-Quds* newspaper reported that patients were complaining that the Gaza Strip Department of Health was refusing to refer critical cases to Israeli hospitals, despite the fact that the patients were insured and had been referred by a medical committee.[141] That year, "the process [was] a lengthy one and the number of referrals [had] decreased over the [previous] two years due to a stated Israeli policy restricting such referrals."[142] The trend during those years was

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[137]"Health Department Refuses to Refer Gaza Strip Patients to Israeli Hospitals," *al-Quds*, 1 July 1982 (Arabic).

[138]"New Decision About Referring West Bank Residents to Israeli Hospitals," *al-Quds*, 15 October 1984 (Arabic).

[139]*See, e.g.*, "Suffering of a Child From Kufr Ra'i," *Al-Quds*, 29 October 1984 (Arabic) (although insured, child with severe spinal problems was refused referral by officers in charge of health matters).

[140]"Who Is Responsible and To Whom Shall We Go?" *al-Quds*, 30 October 1984 (Arabic). In this letter to the editor, 'Atta Muhammed Musleh stated that although he was insured and his daughter had been referred by Ramallah Hospital to Hadassah Hospital for an urgent head operation, the Civil Administration Officer for Health Services insisted that the referral could not take place until the Ministry of Finance had agreed to pay for the referral.

[141]"Complaints of Refusal to Refer Gaza Strip Patients to Israeli Hospitals," *al-Quds*, 9 February 1985 (Arabic).

[142]Roy, *Gaza Strip Survey*, *supra* note 78, p. 110, citing an interview with Field Officer for Health, UNRWA, and Civil Administration of Gaza, *18th Year of the Administration -- April 1984-March 1985*, (Gaza Strip: Civil Administration, 1985)

to focus more and more attention on the cost of referral, to the detriment of the urgent medical needs of the population.

b. Referral Policy Since 1988

Eight months after the beginning of the Intifada, in August 1988, the Israeli government issued orders to reduce significantly the number of referrals to Israeli hospitals[143] and the Defense Ministry reduced by two-thirds the funds available to hospitalize Palestinians in Israel.[144] Dr. Ram Yishai, chair of the Israeli Medical Association, reported that "the number of cases referred to hospitals in Israel was limited to 216 between the months of October - December 1988."[145] According to press reports:

> ...[D]ozens of residents of the West Bank have died since the start of the uprising, because of the drastic reduction in hospitalization days [in Israel] .... Three months after the start of the uprising, virtually all hospitalization of the West Bank residents [in Israel] ceased.... [A] whole category of persons with malignant illness -- who have paid government insurance in the West Bank -- are no longer arriving in Israeli hospitals, because of sanctions by the Civil

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p. 56.

[143]Union of Palestinian Medical Relief Committees, *Emergency Newsletter* No. 8 (September-October 1988) p. 2.

[144]Kedem, M., "Who's Responsible?" *al-Fajr*, 16 December 1991, pp. 10, 15 (Arabic).

[145]Quoted in AIPPHR, *Health Services in the Gaza Strip*, *supra* note 8, p. 30, from Dr. Yishai's 6 March 1989 (French) report to Dr. Andre Wynen, secretary of the World Medical Association, on his investigation of allegedly unethical incidents.

Administration.[146]

Despite strong protest, only half of this funding was restored in January 1989.[147] By November 1989, the West Bank Legal Advisor had admitted that there was a "quota of referrals" to Israel along with a "growing number of requests for special medical treatment in Israel."[148] In fact, the number of hospitalization referrals in 1990 dropped to 597 from 625 hospitalization cases in 1989,[149] and 649 in 1988.[150] Moreover, only 1,919

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[146]*Jerusalem Post*, 25 December 1988, p. 2, quoted in Barghouthi, M., Giacaman, R., "The Emergence of an Infrastructure of Resistance -- The Case of Health," in *Intifada -- Palestine at the Crossroads*, *supra* note 8, p. 82.

[147]Kedem, *al-Fajr*, *supra* note 144, pp. 10, 15.

[148]Letter from Captain Aliza Katz, Deputy Legal Advisor, on behalf of the Legal Advisor, Judea and Samaria Region, Israel Defence Forces, to Adv. A. Avram, ACRI, 20 November 1991.

[149]Ministry of Health, 1989-1990, *supra* note 17, p. 24; Ministry of Health, 1990-1991, *supra* note 20, p. 42.

[150]984 Palestinians from the West Bank alone had been referred in 1982. Civil Administration: Judaea and Samaria, *Statistical Report -- Health Services, Judaea and Samaria* (1982) p. 26. It is possible that some of the reduction in numbers of patients referred between 1982 and 1988 reflected an increase in the services provided in the Occupied Territories, however, it is unlikely that a similar significant improvement occurred between 1988 and 1990, given the decreased budget for health during those years.

The following figures are presented to provide a general idea of the ages and medical problems of people referred. Of the 649 Palestinians referred for hospitalization to Israeli hospitals in 1988, most were referred for urinary tract diseases, leukemia, Hodgkin's disease, and circulatory diseases. The greatest number of patients (430 of 649) were referred to Hadassah Hospital in Jerusalem. Most of the referred patients were between the ages of 1-9 (189), or 20-39 (174). Another 2,186 West Bank Palestinians were referred to Israeli hospitals for treatment and examination. Most of these patients were referred for diagnosis (513 of 2,186), or for treatment for urinary tract diseases (265), radiology (232), certain malignant tumors (221), nervous system disorders (211), and eye diseases and other problems (210). They were mostly in the 30-50 and 60-69 age range.

Palestinians were referred for treatment, diagnostic procedures, and laboratory tests in 1989,[151] compared with 2,186 in 1988.[152] By 1989, the hospital days per month allocated to Gaza Strip Palestinians for hospitalization in Israel had been reduced by 71 percent from the allocation in 1987 (from 2,800 to 800 patient days per month in 1989).[153] This applied to all patients, including those in critical condition.[154] Writing in 1992, Dr. Ruhama Marton, chair of the Association of Israeli and Palestinian Physicians for Human Rights (AIPPHR), calculated that referrals had decreased by 50 percent since the Intifada began.[155]

It is extremely unlikely that the declining number of referrals since 1987 has been due in any significant way to improvements in medical services offered in the Occupied Territories, as sometimes argued by government officials. Israeli Civil Administration representatives themselves have acknowledged the connection between the 1987-89 budget decrease and the reduced number of patients referred to Israeli hospitals.[156]

During 1989, procedures for deciding which patients could be referred became even more expressly financially-determined. Previously, a committee of physicians considered referral requests and made decisions based on medical considerations, although still

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[151]Civil Administration, *Health Services* (1989), *supra* note 47, p. iii.

[152]3,660 West Bank Palestinians had been referred in 1982. Civil Administration, *Health Services* (1982), *supra* note 150, p. 26.

[153]AIPPHR, *Health Services in the Gaza Strip*, *supra* note 8, p. 11.

[154]Bellisari, *Health and Medical Care*, *supra* note 22, p. 5.

[155]Marton, R., "Health and Human Rights in the Occupied Territories," *American Israeli Civil Liberties Coalition*, Vol. XIII No. 2 (Winter 1992) pp. 2, 8.

[156]DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52.

constrained by a maximum number of referrals per month.[157] According to new rules promulgated in 1989, however, if referral was considered necessary by the patient's doctor, the head of the relevant hospital section and the director of the hospital[158] filled out a referral form to "approve that the details of this referral are correct" and "approve that the reason for the referral is justified and cannot be done in our hospital." An appointment was then made at the headquarters of the Civil Administration.[159] The doctor's medical report and the referral form were reviewed by the Civil Administration's medical referral committee who approved, disapproved, or found the case "exceptional -- to be decided by the Field Officer of Health." The medical referral committee as constituted from 1989 on, has included Palestinian doctors, the Civil Administration staff health officer, and the financial officer of the Civil Administration.[160] It is the financial officer who makes the final referral decision, according to Dr. Ruhama Marton, chair of the AIPPHR.[161] Hospital administrators report that the head of referrals in the Civil Administration of the West Bank is not medically trained, has very little medical knowledge, and often makes bad decisions.

The current criteria for referrals are the budget, number of patients in need of treatment, and the type of treatment that they

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[157]AIPPHR, *Health Services in the Gaza Strip*, *supra* note 8, p. 11. In the Gaza Strip, for instance, a medical referral was obtained from a government medical board with the endorsement of the Chief Medical Officer in the Gaza Strip. Roy, *Gaza Strip Survey*, *supra* note 78, p. 110.

[158]The involvement of the director of the hospital may legitimately reduce the pressure to refer that a patient and family may bring to bear on a doctor in cases where referral is not necessary.

[159]Al-Haq Report 109/92(c).

[160]Kedem, *al-Fajr*, *supra* note 144, p. 10; al-Haq Report 110/92.

[161]Kedem, *al-Fajr*, *supra* note 144, pp. 10, 15; Al-Haq Report 100/92.

require.[162] The medical referral committee decides not only whether to refer the patient but how many "referral days" in the Israeli hospital to alot the patient. A total number of hospital days per month or year are allocated to the Gaza Strip and the West Bank. Therefore, each case is evaluated and referred for a specified number of days, based on what is left in the quota. Patients may not overstay the number of allocated days in the Israeli hospital.[163] According to the West Bank Civil Administration's own account of its referral procedure, any patient who requests treatment in Israeli hospitals must go through Dr. Yitzhak Sever, Staff Medical Officer at the Administration's headquarters. Dr. Sever checks the diagnosis of the patient and decides whether to authorize referral according to whether the patient has outstanding insurance debts. According to the Civil Administration, a patient with insurance is entitled to service, but the relationship of insurance debts to referrals has not been clarified. Although the Civil Administration stated that there was never a "no budget" situation, it also stated that if it had more money, it would refer more patients.[164]

By 1991, the result of the new referral procedures were apparent to a pediatrician working in an Israeli hospital (Sha'are Zedek) in West Jerusalem who noted that she was no longer seeing any insured families at the hospital.[165] The National Council for the Child noted in late 1991 that:

> [C]hildren requiring treatment and hospitalization in hospitals in Israel are turned away by the civil administration, which refuses to issue their parents with the referral forms without which they have no

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[162]"Medical Care," *Israel Children's Rights Monitor*, *supra* note 36, p. 55.

[163]Al-Haq Report 101/92.

[164]DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52.

[165]Summary of meeting organized by Defense for Children International, 24 October 1991, p. 4.

chance of being admitted to hospitals in Israel.

> So that there be no doubt on the matter, we must emphasize that these rejections were encountered even by parents who are covered by medical insurance, and even in cases of extremely serious illness and cases of mortal danger, when there was no possibility of receiving appropriate medical treatment for the child anywhere other than Israeli hospitals.[166]

In 1991, the need for referrals so outstripped financial allocations that in November the Israeli Civil Administration exceeded its budget/quota for referrals by the first or second workday of the month. The deputy medical officer admitted that "due to a budget shortage the civil administration can no longer provide guarantees this month."[167] Referrals were refused to all insured persons, apparently regardless of whether lives were endangered by the refusal or whether a patient had been referred regularly for treatment in the previous months. It appears that only patients who were able to enlist the aid of Israeli human rights groups were able to obtain referrals that month.[168] According to a press report in December 1991, dozens of seriously ill patients

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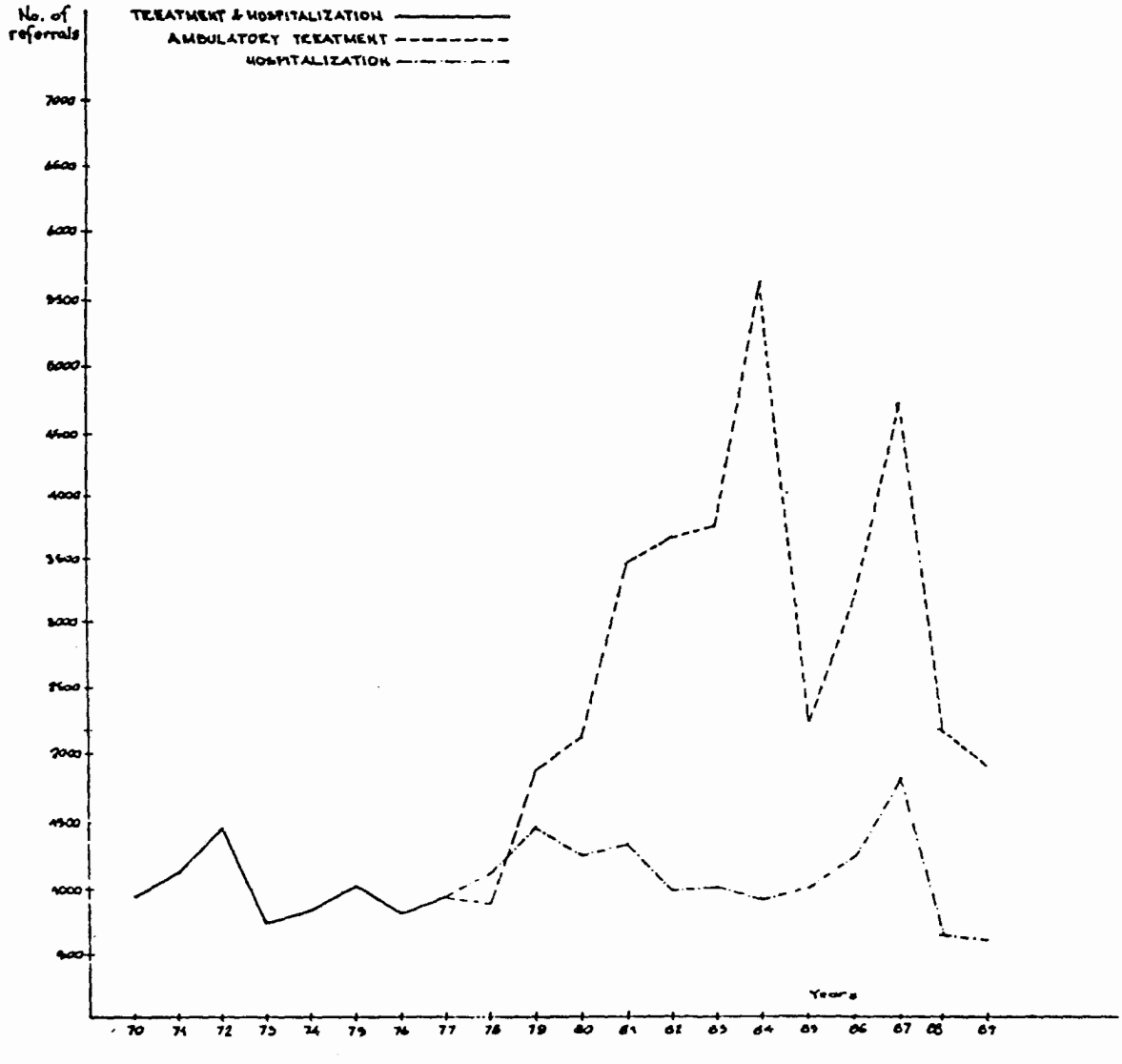
[166]Letter from Dr. Yitzhak Kadmon, Director, National Council for the Child, to Brig. Danny Rothschild, Coordinator of Territories Affairs, the Ministry of Defence, 19 November 1991. The National Council reported that it had been assured "that all children requiring medical treatment and hospitalization in cases of serious illness and complicated injuries which could not be adequately treated in the hospitals in the territories, would be granted full medical treatment in hospitals in Israel." However, AIPPHR established a fund in March 1992 for urgent treatment of sick and disabled children to meet the high demand "for aid in ensuring medical care for children who are not receiving the required medical treatment due to bureaucratic obstacles." AIPPHR, *Report of Activities* (May-June 1992).

[167]Letter from Adv. Avram, ACRI, to Captain Aliza Katz, Deputy Legal Advisor, The Office of the Legal Advisor for the West Bank Region, 6 November 1991.

[168]See Activity Report of the Association of Israeli and Palestinian Physicians for Human Rights (December 1991) p. 4; al-Haq Report 57/92.

may have lost their lives because their referrals were delayed in this manner.[169]

Referrals of West Bank Palestinians to Israeli Hospitals 1970–1989 For Treatment and Hospitalization



Source: Civil Administration, *Statistical Report, Health Services, Judaea and Samaria*, 1989, p. 47.

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[169]Kedem, *al-Fajr*, *supra* note 144, p. 10

Content of Part of a Referral Form
Used by the Israeli Civil Administration:

Part II:

1. I approve that the details of this referral are correct.
2. I approve that the reason for the referral is justified and cannot be done in our hospital.

Signatures:

Head of the Section _____ Director of the Hospital _____

Part III:

The Committee Decision:
Approved/Not approved/Exceptional — to be decided by the F.O.H.

Part IV:

(For exceptional cases): Decision of F.O.H.
My decision for this case is:
Approved/Not approved

Sig. of the Field Officer of Health
_____

Despite all the factual evidence to the contrary, the Civil Administration continues to insist that it has a fair and generous referral policy. The Ministry of Defense continues to assert that persons with GHI and "exceptional cases" are entitled to have the cost of hospitalization in Israel covered by the Civil Administration.[170] The Coordinator of Judea, Samaria and Gaza Affairs claims that the Civil Administration has been instructed to issue referrals to any person insured by GHI "and for whom the treatment is essential, in the absence of any alternative in the region, on the basis of an examination and confirmation by a regional medical officer...."[171] In a deft example of circular reasoning, the Ministry of Health insists that referrals are available to all insured persons if the services are unavailable locally and the patient is referred.[172] Insureds who are not referred but who are brought to an Israeli hospital by Israeli military personnel are also supposed to be covered; one government hospital administrator noted that any Palestinian injured by soldiers is treated free in government hospitals in the Occupied Territories and may be referred freely to Israeli hospitals.[173] Israeli authorities also claim that uninsured persons, while not guaranteed referral, are treated on a case-by-case basis but should receive referrals in life-or-death situations. Cancer patients receive immediate insurance coverage (including

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[170]Letter from Lieutenant Colonel Shmuelik Ozenboi, Aide to the Coordinator, Office of the Coordinator of Judea, Samaria and Gaza Strip Affairs, Ministry of Defense, State of Israel, to Dr. Yitzhak Kadman, Director of the National Council for the Child, 7 July 1991.

[171]Letter from M.K. Ovadia Eli, Deputy Minister of Defence, to M.K. Haim Oron, 26 December 1991. This position was confirmed in the May 1992 letter from the Civil Administration to ACRI, *supra* note 36: "Everyone who is insured by health insurance and requires health services which are not available in the area is sent to Israel after an investigation by the staff medical officer."

[172]Ministry of Health, 1989-1990, *supra* note 17, p. 24.

[173]Al-Haq information, confirmed by interview with the Israeli Coordinator of Territories Affairs, the Ministry of Defense, Danny Rothschild, *al-Quds*, 23 November 1991 (Arabic).

hospitalization) when they subscribe to GHI.[174] The Coordinator of Activities in Judea, Samaria and Gaza stated that he had instructed the Civil Administration that "[a]ny urgent case in which [referral]... is required [for uninsured persons]... shall be thoroughly examined by the regional medical officer."[175] According to Yosef Shechter, Administrator of Health Services for the West Bank: "When it is a matter of life or death for a patient who is not insured, s/he is sent to an Israeli hospital and, afterwards, we try to find the means to cover the expenses."[176]

In March 1992, the Civil Administration assured two concerned human rights groups that government doctors have the authority to decide whether referral is necessary in an emergency and, if necessary, refer patients to Hadassah-Hebrew University Hospital. The Israeli government has promised Hadassah that it would provide coverage.[177] In January 1991, the Director of Government Hospitals in the West Bank announced that there was a more streamlined referral process available in cases of emergency. Al-Haq's information indicates that, while such a procedure does exist, it still requires the permission of the hospital director and the Civil Administration referral officer by telephone and the decision to refer is by no means certain.[178]

The number of reported problems with referrals decreased in 1992, probably both because the referral situation improved and because expectations, GHI enrollment, and therefore demand, for referrals decreased. Defense for Children International -- Israel

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[174]DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52.

[175]Letter from M.K. Eli to M.K. Oron, 26 December 1991, *supra* note 177.

[176]May 1992 letter from the Civil Administration to ACRI, *supra* note 36. Shechter states that uninsured persons requiring emergency hospitalization in Israel who cannot pay are referred to social assistance services for aid.

[177]DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52.

[178]Al-Haq Reports 105/92, 109/92(c).

reported receiving news of only one referral problem.[179] The Association for Civil Rights in Israel received only a couple of cases in 1992 in which referral was at issue.[180] HaMoked (Hotline -- Center for the Defense of the Individual) had dozens of cases in 1991 but no longer takes referral cases; instead it passes them on to AIPPHR. AIPPHR only pursued a few cases in 1992. Hospital administrators believe that referrals at the beginning of 1993 are up to 70-80 percent of the pre-Intifada levels and that the situation is improving. Whether or not the number of reported problems has decreased, the problematic policy of referrals based on artificial financial constraints rather than on legitimate financial limitations and medical needs remains.

c. Specific Referral Problems

Analysis of specific referral cases that have occurred since 1990 reveals a number of problematic practices by the Civil Administration. Among them are:

- Denying referral for follow-up care or a second operation after allowing referral of the initial operation;

> For example, in 1991, after being referred for an operation for kidney stones at Assouta Hospital in Israel, an insured from the Gaza Strip required a second operation. However, the health officer at the Civil Administration told him, "you should undergo these operations once at the expense of the Government Health Insurance and once at your own expense..., since you have undergone many operations." The operation was so expensive in Israel that the insured eventually travelled to Jordan to have it done

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[179] 18 August 1992 telephone conversation with representative of DCI -- Israel.

[180] 9 August 1992 telephone conversation with Adv. Elihu Avram.

at his own expense.[181]

- Delaying referral decisions or failing to come to a decision at all;

> In April 1990, a woman with rheumatism was advised by a West Bank hospital to have an operation in Hadassah Hospital in Israel. However, the Civil Administration told her to wait for one month; when she returned, it refused to cover the cost. The Civil Administration refused again to allow referral in August. The woman then appealed to HaMoked (Hotline), a human rights organization. Over the course of several telephone calls between a HaMoked representative and the Legal Advisor, it became clear that cost was the major concern: the Civil Administration claimed that the operation cost more than 5,000 NIS in Israel and only 1,000 NIS in the Occupied Territories. Only after the doctor scheduled to perform the surgery at Hadassah called Dr. Sever of the Civil Administration Health Office, was the woman promised a voucher for the operation. She received this voucher in November -- six months after doctors initially recommended that she have the operation.[182]

- Bargaining to cover some, but not all, of the costs of referral or rescheduling referral into the following financial year due to financial difficulties;

> In the case of a 50-year-old insured invalid who needed a hip operation in order to walk, the Civil Administration agreed to cover his operation in an Israeli hospital, but not the cost of the hip implants.

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[181]Al-Haq Report 55/92.

[182]HaMoked: Center for the Defense of the Individual (Hotline) File No. 1480.

On 27 August 1991, he was informed that his insurance did not cover the implants. No law or regulation was cited as a basis for this decision. In a letter dated 24 September 1991, the Civil Administration advised him to seek financial help from the Social Assistance office. That same letter informed him to come to the health office because the operation might not take place as scheduled on 7 October 1991 because of financial difficulties. Eventually, the operation was postponed until 1992 with the Health and Social Assistance Offices agreeing to share the cost of the 10,000 NIS implants.[183]

- Allowing financial considerations to influence critical medical decisions;

In one ongoing case where many of these patterns appear evident, the insured received a referral to remove a tumor in Assouta Hospital in Israel on 4 June 1991. Three days after the operation, she was transferred to Ramallah Hospital and then released. She soon began to feel very poorly and contacted the doctor she had originally been referred to for the tumor treatment. He examined her and ordered immediate hospitalization for five days in Assouta, together with the cessation of treatment in Ramallah. Assouta was apparently the only hospital where the doctor, a specialist, could treat her. Ten days of follow-up care in Hadassah Hospital were also ordered.

The Civil Administration refused to cover the costs of the hospitalization in Assouta the second time, even though it had covered the cost of the original operation. On 17 November 1991, an employee of the Civil Administration told the patient

[183]HaMoked (Hotline) File No. 2309.

that coverage might be possible in 1992 but that the Administration was not then financing high cost treatment. Later, the Administration agreed to pay for the ten-day treatment in Hadassah but not for the five-day hospitalization in Assouta. In a letter to HaMoked (Hotline), the Legal Advisor's office asserted that the patient had been advised to enter the Ramallah hospital by her doctor in Ramallah but had refused and gone to Assouta instead. HaMoked's 8 May 1992 letter to the Legal Advisor contested this version of the facts and noted that the patient had clearly not received adequate treatment in Ramallah and that the hasty transfer back to the Occupied Territories after the first operation when the patient's prescribed number of Israeli hospital days were exhausted may have damaged her health. That letter had not been answered by April 1993 and the patient is still waiting to find out whether her hospitalization fees will be covered. Clearly, finanical considerations motivated the attempts to postpone or reduce insurance coverage in this case.[184]

- Refusing to cover the cost of a part to be transplanted into the body, even while covering the cost of the surgery itself;

In a September 1992 case handled by AIPPHR, the Civil Administration first refused to refer a patient to Israel to recapulate his knee. An army spokeswoman told a *Hadashot* journalist that it did not refer this kind of operation. After intervention by AIPPHR, and one day after the surgery had been scheduled to take place, the Administration agreed to refer the patient but refused to pay for the part to be transplanted into the patient's knee.[185]

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[184]HaMoked (Hotline) File No. 2287.

[185]4 October 1992 letter from AIPPHR to al-Haq.

- Taking action only after human rights organizations have taken up the case;

> On 3 November 1991, the administration refused a referral request for an essential monthly blood transfusion -- a request that had been granted once monthly for the previous year to an insured, seven-year-old boy with a serious blood disorder (telesemia) who had been receiving the transfusions at Hadassah Ein Karem Hospital in East Jerusalem. His father was told "there are no more guarantees [of medical cost coverage]." The father was one of the first to request a referral that day, a Sunday. Given the fact that the Civil Administration was closed as usual on Saturday (2 November), either the monthly referral quota was already exhausted by the second workday of the month or the annual referral quota was exhausted nearly two months before the end of the year. Intercession by the Association for Civil Rights in Israel with the medical officer had no effect but the Legal Advisor finally granted the referral, although with no guarantee that the problem would not recur.[186]

- Issuing "incomplete" referrals, that is, ones with no financial backing which are therefore refused at the hospital;[187]

- Refusing to refer because the insured patient had been in prison;

> An insured prisoner (the son of a teacher in a government school) developed cancer of the kidney. His condition deteriorated to such an extent that he was finally transferred to a prison hospital and then,

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[186]Letter from ACRI to Legal Advisor -- West Bank, 6 November 1991; Letter from Legal Advisor to ACRI, 20 November 1991.

[187]Al-Haq Reports 55/92; 54/92.

after intervention by several human rights and peace groups in the Occupied Territories and Israel, to a civilian hospital. He was released from prison and continued to receive treatment at a hospital in the Occupied Territories but showed no signs of improvement after two months. The Director of Hospitals in the West Bank, Muhammed Said Kamal, requested a referral from the Civil Administration. However, the Head of Referrals for the Civil Administration, David Tzadok, at the headquarters of the Civil Administration in Beit El, refused to refer him. The father then took his son to an Israeli hospital at his own expense. There, the doctors confirmed that the son was receiving inadequate treatment in the Occupied Territories hospital. However, the cost of treatment at the Israeli hospital, without the required referral, was prohibitive. The father was again refused referral by the Civil Administration, which implied that because the son had been a prisoner, he could not be referred. The son continued to be treated at the Israeli hospital at his father's own expense until he died in November 1991. The final bill for the treatment was 9532 NIS (about $4000).[188]

- Issuing referrals only after the patient had exerted "wasta" (personal influence);[189]

- And mischaracterization of the facts of the case by the Civil Administration in order not to refer.

Once a treatment for a disease becomes available in the Occupied Territories, referral for alternative methods of treatment becomes virtually impossible, even if the alternative treatment is superior or has fewer side effects. In one case, an insured woman

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[188]Al-Haq Affidavit 3472.

[189]Al-Haq Reports 110/92; 54/92.

with recurring disc cancer submitted a letter from a doctor in Israel willing to treat her with new medication, along with a complete referral request to the Civil Administration on 4 September 1991. The Civil Administration responded by telling her to return on 15 September. Her condition deteriorated and she was treated in the West Bank and later transferred at her husband's request and expense to an Israeli hospital. She died in late November. The Civil Administration refused to cover the costs of the treatment in Israel, due to budget constraints and the fact that treatment for cancer is available in the West Bank.[190]

d. Corruption and Other Difficulties

Great difficulty in obtaining referrals, and the potentially fatal consequences of refusal, are elements which encourage the existence of corruption within the referral system. In 1989, the former Assistant Health Officer for the Civil Administration in the Gaza Strip and then Director of the Central Committee to Treat Gaza Residents in Israeli Hospitals was convicted of receiving a 900 NIS bribe to refer a patient.[191]

Another case illustrates the difficulties of persuading doctors to recommend referral. Various nonmedical criteria, including the slim chances of obtaining a referral, enter into what should be a certification by the hospital based completely on medical need. When an insured father took his baby daughter to Ramallah for a checkup, he was told that she had a congenital heart disease and needed immediate heart surgery. The Ramallah doctor advised an operation in Ramallah, however other doctors whom the father consulted warned against the location, noting that Ramallah Hospital did not have a pediatric intensive care unit. A second Ramallah doctor refused to recommend referral because he believed that the Civil Administration would not agree to refer the operation and it would have to be done in Ramallah anyway. HaMoked (Hotline)

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[190]HaMoked (Hotline) File No. 2338.

[191]"Civil Administration Employee Accused of Receiving Bribes For Referrals From Gaza to Israel," *al-Hamishmar*, 14 September 1989.

persuaded the Civil Administration to cover the operation in Israel and it was set for 30 October 1991. The operation actually occurred in 1992.[192]

e. Problems Faced By Those Receiving Referrals

The referral system is plagued by problems even for those who successfully obtain referral. Despite the claim by the Civil Administration that cancer patients who travel to Israeli hospitals can sleep in organized hostels or be treated in outpatient clinics,[193] referred patients from the Gaza Strip have not been permitted to stay overnight inside Israel. Those who receive radiation therapy, for example, must travel to and from Israel each day, suffering from long days and uncomfortable transportation which exacerbate their illness and the side effects from the therapy.[194] Often cancer patients require more than 15 radiation

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[192]HaMoked (Hotline) File No. 2114.

[193]DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52.

[194]Kedem, *al-Fajr*, *supra* note 144. According to Dr. Martin Rubenberg:

> A usual course of radiation therapy entails treatment five or six days a week for a period of four to six weeks.... In the absence of a local radiation therapy unit, the patient must get up at 4:00 am to be transported by pick-up to an Israeli hospital, a journey of perhaps anywhere from 30 to 50 miles, on roads which are by no means superhighways, for the purpose of receiving approximately 10 to 15 minutes of radiation therapy -- and remember, we are talking about a patient who has a malignant tumor. And then, because such persons cannot stay overnight in an Israeli hospital or even a boarding house, they must be transported back to their residence in the Gaza Strip and must repeat this same routine on a daily basis six days a week for four to six weeks. Now, this is under ideal circumstances... if there is a curfew, that individual cannot leave the camp. If the entire Gaza Strip is sealed off, nobody can leave.... In addition to this, ... in the latter part of any treatment with radiotherapy, there are

treatments to complete their therapy.[195] Under the current system, patients are required to seek individual referral permission for each treatment session even if it is all part of a single course of treatment.

f. Discussion

A longstanding justification for the underdeveloped health facilities in the Occupied Territories has been that referral to better-equipped Israeli hospitals was possible, and duplication of services was unnecessary.[196] If this justification were sincere, then all Palestinians would have easy, affordable access to the Israeli health care system when necessary. In fact, the theoretical possibility of referral seems to be no more than an excuse for underfunding and underdevelopment; even the most critical referral requests are sometimes denied and even insured Palestinians do not have necessary access to Israeli medical facilities. The situation in recent years has deteriorated, and, as a reflection of that, voluntary enrollment in GHI has dropped. Palestinians have realized that referral, a major reason for subscribing to GHI, cannot be relied upon.

The policy of referrals appears to be not only an excuse for perpetual underdevelopment, but also a means of tightening control on the population of the Occupied Territories when necessary. Although Israeli refusal to permit referrals is a longstanding policy which began years prior to alleged budgetary problems in 1988, Israeli authorities restricted referrals even further with the advent of the Intifada. Individual referral decisions which are ultimately based on financial or political criteria, regardless of medical

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side effects which might include diarrhea, vomiting, difficulty in breathing, ...

Ahmad, *American-Arab Affairs*, *supra* note 16, p. 71 .

[195]AIPPHR, *Health Services in the Gaza Strip*, *supra* note 8, p. 11.

[196]UPMRC, *Newsletter*, *supra* note 10, p. 2.

necessity, are inhumane. While some financial constraints on a medical system are always a fact of life, the financial constraints imposed by Israeli authorities appear to be artificial, a result of the policy to collect revenue from Palestinians in the Occupied Territories but not to spend it there. With funding available and lives and people's well-being hanging in the balance, the degree of restrictiveness on referrals found in the Occupied Territories at present is unacceptable.

Within the current system of referrals, several improvements could be made. First, as previously discussed, budgetary allocations should be made in order to finance all necessary referrals. Second, decisions regarding whom to refer should be based on medical need, with all those whose lives or health are seriously endangered being assured of referral. Third, once referral is granted and a process of treatment is begun, the entire process, regardless of number of visits, should be regarded as one referral to ensure that the treatment is completed. Patients should not have to reapply for each visit. The number of days that patients stay in Israel for treatment should be decided by the attending doctor during treatment, not by a committee of officers before treatment has begun.

More fundamentally, however, the underdeveloped medical system in the Occupied Territories must undergo radical change in order to obviate the need for referrals. Reliance on referral to the hospitals of another country as a routine aspect of a country's health care system must be seriously questioned. Lives are lost because obtaining a referral and physically transferring a patient take too much time. The medical system in the Occupied Territories could have developed all needed services long ago if the occupation authorities had shown the concern for the welfare of the population required under international law. The situation should be redressed immediately by developing the health care system in the Occupied Territories with the welfare of Palestinians in mind, through consultation with and participation by representatives of all concerned.

9. The High Cost of GHI

Israeli government health insurance fees are high and have increased rapidly, especially during the 1980s. While many of the increases only kept pace with the rate of inflation, wages did not and many Palestinians have found themselves struggling to afford the basic necessities of life, including GHI. Between April and November 1985, for example, the fees doubled, only to increase again in January 1986:

TABLE C[197]
Monthly GHI Premiums in Israeli Shekels (IS)

Type of Insured:	April 1985	Nov 1985	Jan 1986
Government employee	8.97	18.4	19.35
Worker registered in Israel	10.76	18.4	23.20
Voluntary subscriber	12.56	25.70	27.00

According to official Israeli figures, in 1985, Gaza Palestinians registered to work inside Israel were making 9.08 IS per day, while West Bank workers made 10.04 IS.[198] Even assuming that an average Palestinian worker was employed all month and made approximately 260 IS, health insurance payments in April 1985 would have represented four percent of the worker's income, while by November the payments were claiming seven percent of the same income and, by January 1986, nine percent.

In early 1988, a Palestinian family in the Occupied Territories

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[197]Roy, *Gaza Strip Survey*, *supra* note 78, p. 106. New Israeli Shekels had not yet been introduced.

[198]Central Bureau of Statistics, *Statistical Abstract of Israel* No. 37 (Jerusalem:1986) pp. 707, 710.

could obtain GHI for approximately US$ 160 (320 NIS) per year.[199] The cost increased by 15 percent during 1988[200] and by June of 1989 insurance costs had doubled, to US$ 320. In 1991 and 1992, the cost continued to escalate. The August 1991 monthly payment was 14 percent more than the one in January.[201] While the cost of GHI has increased steadily, income has fallen, especially since the Intifada began. The personal income of many Gaza Strip families fell by as much as 75 percent from 1987 to the end of 1989.[202] The Gross National Product (GNP) of both the West Bank and the Gaza Strip is estimated to have declined by over 30 percent since 1987.[203] The decline in GNP is attributable to several factors, including reduction in the number of Palestinian workers in Israel; the 75 percent decline in remittances from the Gulf after the Gulf War; reduced trade between Israel and the Occupied Territories; constraints and restrictions imposed by the Israeli authorities on the development of Palestinian export markets; disengagement from Jordan; Israeli military curfews and closures; Palestinian strike days; and the decline in the value of output in most sectors.[204] The rate of unemployment in the Occupied Territories varies widely depending on political and military policies implemented by Israel; during the end of 1991 and much of 1992, however, the unemployment rate was estimated at higher than 35

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[199]AIPPHR, *Health Services in the Gaza Strip*, *supra* note 8, p. 10.

[200]Stephens, *Taxation*, *supra* note 54, p. 55, citing 'Atef Alawna, "Israel's Direct and Indirect Benefits from the West Bank and Gaza Strip," *al-Katib*, October 1988 (Arabic).

[201]For the first six months of 1991, payment was 56 New Israeli Shekels (NIS) per month; the price increased to 60 NIS in June and to 64 NIS per month from August until the end of the year.

[202]Roy, S., "The Political Economy of Despair: Changing Political and Economic Realities in the Gaza Strip, *Journal of Palestine Studies* XX, No. 3 (Spring 1991) p. 61.

[203]*Ibid.* p. 62.

[204]*Ibid.* pp. 58-69; 1992 International Labor Conference, *supra* note 51, p. 8.

percent.[205]

The Ramallah-based Palestinian Center for Rehabilitation and Labor Studies estimated that the average monthly income of a family of four to six persons was 1,245 NIS in November 1991. The 64 NIS monthly GHI cost at that time represented approximately five percent of that income, which is commensurate with the greatest fraction of income contributed to mandatory health insurance under Jordanian rule before 1967. While five percent of income expended on health insurance falls within acceptable limits according to health and economics experts, the monetary amount needed for necessary expenditures, including health, far exceeds the meager income of most Palestinian families. The study mentioned above estimated that a family's necessary expenditures in 1991 (2,139 NIS) were almost double their income.[206] If anything, the economic situation deteriorated in 1992. Faced with such impoverishment, many Palestinians have foregone health insurance.

Due to Israeli residency and citizenship requirements which Palestinian workers working through the Labor Exchange in Israel[207] are unable to fulfill, they are only entitled to three of the 12 benefits offered under Israeli national insurance.[208] Thus, workers have high fees deducted for benefits that they never receive. Palestinian workers must also pay outstanding health

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[205]Palestine Human Rights Information Center, *The Impact of the Work Permit System on Palestinian Workers in Israel* (Jerusalem:1992) p. 2. According to PHRIC's survey of 385 West Bank and Gaza Strip workers in September 1991, 36 percent of the work force was unemployed. In 1993, the unemployment rate soared with the enforced separation by the Israeli authorities of Israel and occupied East Jerusalem from most Palestinian workers in the rest of the Occupied Territories.

[206]"Study Says Palestinian Families Earning Less Than Half What is Needed for Survival", *al-Fajr* English Weekly, 3 February 1992. The Center assumed that a family had 1.5 wage earners, and that the average monthly wage was 830 NIS.

[207]There were 74,000 such workers in December 1991, according to the Ministry of Labor and Social Affairs of Israel. 1992 International Labor Conference, *supra* note 51, p. 100.

[208]PHRIC, *Work Permit System*, *supra* note 205, p. 10

insurance fees to the health department when they are in need of hospitalization.[209] At the very least, their wage deductions for national insurance should cover their complete health insurance costs, including monthly premiums when they are unemployed.

In 1992, married Palestinians voluntarily enrolled in GHI paid 90 NIS ($38) per month for the first four months of the year; in May, this increased to 95 NIS ($40). Single subscribers paid 79 NIS ($33).[210] Persons over 60 years of age could obtain GHI at government employee prices (64 NIS until May, and then 67 NIS). Representatives of the Civil Administration have stated that there is a 15 percent discount for adolescents and the chronically ill;[211] however, administrators in government hospitals claim that there is no such discount in practice, only a slight discount in the medication provided to the chronically ill. In addition to the monthly premium, there is a one-time registration fee for GHI which was 79 NIS ($33) in May 1992. The replacement charge for a lost card was 67 NIS ($28).[212] Many GHI subscribers consider the monthly charge expensive and not worth the value of the services received.[213] As previously discussed, fewer and fewer people are voluntarily enrolling in GHI.

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[209]DCI, ACRI, Civil Administration, Meeting Notes, 22 March 1992, *supra* note 52. The Civil Administration's 10 May 1992 response to the summary did not revise this statement. It is unclear what these payments might be, unless they refer to monthly insurance premiums for months when the worker was unemployed.

[210]Al-Haq Report 109/92 (c). The annual fee in 1992 was 1080 NIS (approximately $450, calculated at 2.4 NIS to one US dollar, which was the rate for most of 1992). Most Palestinians pay monthly; they do not have the money or inclination to pay the one-time annual fee.

[211]DCI, ACRI, Civil Administration Meeting Notes, 22 March 1992, *supra* note 52.

[212]By March 1993, the payments were: 100 NIS for a married insured; 84 NIS for a single insured; 71 NIS for Israeli government employees, seniors, and physically challenged persons; 84 NIS for the registration fee; and there was a 71 NIS charge to replace a lost card.

[213]Al-Haq Report 58/92.

Late payments are subject to interest and treatment is not available until all debts are paid. If the debts cannot be paid, then the insured can receive treatment only if she or he pledges to pay the money within two weeks.[214] An insured person desiring to cancel his or her insurance must first pay all debts. Failure to pay results in transferring the case to the Civil Administration Central Treasury in the case of the West Bank. Tax officers, soldiers, or the General Prosecutor may then demand that the insured pay the debt.[215] Enforcing these rules may be up to individuals at hospitals, clinics, or offices, with varied results.[216] In one incident in 1992, a voluntary insured from the Gaza Strip was denied his magnetic card until he paid ten months (594 NIS) of back GHI premiums. The magnetic card is one of the documents necessary for a Palestinian male living in the Gaza Strip to travel to Israel, East Jerusalem, and to the rest of the West Bank. This card is most vital if the man works outside the Gaza Strip and needs it to travel daily to and from work to support his family. In this incident, the insured was unable to afford the amount and returned home without his magnetic card, thus deprived of the chance to earn money to pay off his debt.[217] This severe and extrajudicial punishment meted out to those who fail to pay GHI debts violates fundamental notions of fairness.

10. Israel's Duty to Perform the Terms of Its GHI Contract and Local Remedies: The Claims Committee or the Civil Court

General principles of law include good faith and the legal validity of agreements.[218] The exact terms of the Israeli

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[214]Al-Haq Report 58/92.

[215]Al-Haq Report 103/92.

[216]Al-Haq Report 103/92.

[217]Al-Haq Affidavit 3652.

[218]Brownlie, I., *Principles of Public International Law*, (Oxford: 1979) 3rd ed., p. 19.

government health insurance contract are not written in any single source and are shrouded in mystery so that the average GHI holder has little idea what his or her rights are. The terms can be gleaned from the written regulations, official Israeli reports on health, and public statements made by Israeli government representatives. The agreement formed between each insurance subscriber for consideration of monthly payments, and the Israeli government includes, at a minimum, fulfilling the conditions stated in this paper, including provision of certain services for free or at a reduced price, provision of prescribed medicine at the currently stated cost, and referral when necessary. In failing to reimburse GHI holders for medicine when bought on the private market through no fault of the holder, the Israeli government is breaching its contract. In failing to refer patients with GHI to Israeli hospitals when medically necessary, the Israeli government is also breaching its GHI contract.

Neither the laws, nor the regulations, nor the information distributed to GHI holders informs them of their legal remedies should they need to enforce their rights under GHI or obtain compensation for damage caused by violation of their rights. Israeli government health insurance was established by an Israel Defense Forces (IDF) military order which delegated charge of the program to the Officer in Charge of Health Affairs, a branch of Israel's military Civil Administration. Military Order 164,[219] issued in 1970, restricts the cases or types of cases that may be lodged in any court against the state of Israel, the IDF, or persons assigned by or serving them in the Occupied Territories to those cases where permission to sue is granted. The jurisdiction of the civil courts has thus been severely limited and most claims against the Israeli government are taken either to the Objections Committee, created by MO 172,[220] or the Claims Committee, created by MO

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[219]"An Order Concerning Local Courts" (The IDF Command) (amendment)(Judea and Samaria)(number 164) of 5730-1970, signed 12 May 1970.

[220]"An Order Concerning Committees for Appeals" (Judea and Samaria)(number 172) of 1967, signed 22 November 1967.

271.[221] The Objections Committee, which makes nonbinding recommendations to the IDF regional commander, only hears certain types of cases detailed in various amendments to the order and GHI cases are not, to date, among them.

GHI holders may therefore appeal either to the civil court, if permission is granted, or to the Claims Committee. But this latter alternative is also conditioned on receipt of permission from Israeli authorities. The Claims Committee hears appeals on the rulings of the Officer of Litigations Staff. Cases heard by this Officer are ones in which Palestinians living in the Occupied Territories claim that a loss was caused by, among others, a civilian who works in the service of the IDF. A case may only be filed if the commander of the region grants permission; no guidelines are given in the law for when the commander may withhold permission. MO 1101 adds that no litigation may be lodged or compensation given if "the commander of the IDF in the region endorsed in a certificate that the claimed damage was caused as a result of a military operation which was carried out on account of military necessity."[222]

In practice, Palestinians with a GHI problem have been most successful applying for advice to human rights organizations such as al-Haq, HaMoked (Hotline), ACRI, DCI, or AIPPHR. These groups have experience presenting such cases and submit all relevant documents and arguments to the Legal Advisor at the Civil Administration headquarters in Beit El[223] or Gaza. Sometimes, the Legal Advisor will reverse a negative decision, solving the problem. If the Legal Advisor does not reverse the decision, however, GHI holders may appeal according to MO 271 (concerning the Claims Committee). Such appeals should be addressed to the Legal Advisor and are then supposedly transferred to the Officer of

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[221]"An Order Concerning Litigations" (Judea and Samaria) (number 271) of 5128-1968, signed 18 August 1968.

[222]Military Order 1101 "An Order Concerning Litigations" (Amendment 4) (the West Bank) of 1984, signed 15 March 1984.

[223]The officer dealing with GHI in the West Bank is currently Aliza Katz, telephone: 02-843251.

Litigations Staff.[224] Recently, however, such submissions regarding other types of cases have resulted in no response. No cases involving GHI are known to have been appealed to the Claims Committee so the likelihood of success is unknown.

As an alternative to appealing to the Claims Committee, petitioners may seek permission according to MO 164 to sue the government in civil court. Again, no such cases are known to have occurred. Enforcement of a judgment against the Civil Administration is problematic; Israeli military authorities have shown little desire in the past to enforce judgments against themselves for the benefit of Palestinians. Palestinians may be choosing not to appeal negative decisions by the Legal Advisor because of their understandable suspicion of the legal system as it has been shaped and controlled by the Israeli government as a tool to exercise its authority, rather than to dispense justice.[225]

C. Alternatives to GHI

The major alternatives for Palestinians to Israeli government health insurance in obtaining access to health services include: no insurance, private insurance, or UNRWA subsidies for registered refugees. A brief analysis of these options shows that they do not, in most cases, provide adequate medical expense coverage for the population.

1. No Insurance

Fees for government health services (consisting of the majority of the hospital facilities and a substantial number of clinics in the Occupied Territories) without the benefit of some insurance or subsidy are astronomical and beyond the reach of most Palestinians. Private or charitable facilities, while cheaper, cannot

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[224]Telephone conversation with Aliza Katz at the West Bank Legal Advisor's office, 20 April 1993.

[225]Bisharat, G., *Palestinian Lawyers and Israeli Rule: Law and Disorder on the West Bank* (Austin:1989) pp. 125-144.

by themselves meet the entire population's need for their services. Uninsured persons who go to a government clinic or hospital must pay cash for each service provided.[226] In 1992, for instance, uninsured persons paid 36 NIS per unit of medicine bought from government clinics,[227] 12 times the price of medicine for GHI holders. A single consultation with a doctor at a government clinic cost at least NIS 42 ($18). An emergency room visit cost 48 NIS. X-rays cost 50 NIS. A medical report cost 84 NIS. Uninsured Palestinians paid 514 NIS ($214) for overnight hospitalization in government hospitals (100 NIS in a maternity ward),[228] which is only slightly less than the cost to stay in much better-equipped Israeli hospitals. By contrast, in a private hospital such as the Anglican Hospital in Nablus, during 1992 a one-night stay in the hospital cost 6 Jordanian Dinars ($10) in a three-person ward and 24 JD ($40) in a private room. Surgery cost between 50 to 130 JD.[229]

As a result of the high fees charged to uninsureds for government health services, one doctor estimated that 90 percent of the patients who are admitted to a typical West Bank hospital have GHI; only 10 percent do not.[230] Therefore, the approximately

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[226]MAP, *Health in Gaza*, *supra* note 1, p. 37. Government hospitals have demanded payment from injured patients before treatment since the Intifada began. In late 1988, the Civil Administration of the West Bank ordered that uninsured persons could only be admitted if they paid for three days of hospitalization in advance and if the Director of Hospitals was informed. Apparently, however, the order has not been followed and patients are admitted without payment in some cases. Al-Haq Report 103/92.

[227]Order Concerning Health Services 746 (Amendment 39) 1991, *supra* note 102; al-Haq Report 48/92.

[228]May 1992 letter from the Civil Administration to ACRI, *supra* note 36. By March 1993, prices had risen slightly: medicine cost 38 NIS/unit; consultation with a doctor or treatment in the emergency room cost 50 NIS. Hospitalization for the uninsured cost 623 NIS/night. Al-Haq Report 15/93.

[229]These were the prices as of 10 July 1992.

[230]Al-Haq Report 48/92.

two-thirds of the hospitals that are government-run (14 of 23 hospitals) are available to only the one-third (or less) of the population which has GHI. And even those patients with GHI, if they are suffering from Intifada-related injuries, may prefer to go to a non-government hospital to decrease the chances of arrest by Israeli authorities. In many cities, such as Ramallah, Hebron, and Jericho, there is no alternative to a government hospital; the patient must travel 30-60 minutes to Jerusalem or Nablus or Bethlehem to find private hospitals.

As previously discussed, private and charitable facilities are unable to provide health care for the entire population of the Occupied Territories -- especially in the case of the Gaza Strip, where there is only one private hospital. While the occupancy rates at government hospitals were often less than 65 percent, in some private or charitable hospitals (Maqased in East Jerusalem, for instance) they were more than 100 percent in 1992.[231] When Palestinians from the rest of the West Bank and Gaza Strip are denied access to East Jerusalem, however, these occupancy rates drop steeply, but not due to preference. Moreover, while the prices at private facilities in the Occupied Territories are substantially lower than at government ones, many Palestinians, living at or near subsistence level, cannot afford to pay even these lower prices. When these patients do end up in hospital, many cannot cover their medical expenses and many non-government hospitals are therefore barely able to cover their running costs.[232]

Government clinics are also inaccessible to the uninsured (these comprise a sizeable minority of clinics in the Occupied Territories; in the rural areas of Nablus district, for instance, they comprise 31 percent of the clinics).[233] The Health Development

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[231]Barghouti, "Palestinian Health," *supra* note 5, p. 14; Nammari, R., "Hospitals and Their Problems in the West Bank and Gaza Strip" in *Palestine Development for Peace, supra* note 13, p. 38.

[232]Nammari, R, "Hospitals and Their Problems in the West Bank and Gaza Strip," in *Palestine Development for Peace, supra* note 13, p. 39.

[233]Barghouti, *Rural PHC Survey, supra* note 107, p. 54.

Information Project "has reason to believe that government curative services were not accessible to the section of the population who were not enrolled in the government health insurance scheme. This is due in particular to the prohibitively high consultation fees in government clinics for uninsured patients."[234] Charitable societies attempting to provide cheaper alternatives often have their services restricted by the Occupation authorities.[235]

Israeli hospitals are even more expensive and financially inaccessible to uninsured Palestinians than government facilities in the Occupied Territories;[236] besides, many Palestinians are prevented by Israeli authorities from entering Israel for any reason.

2. Private Insurance

There are only a few private insurance companies in the Occupied Territories and most only insure institutions and companies, not individuals. The Jerusalem Insurance Agency, Ltd. is typical of insurance agencies that do not usually insure individuals except through institutions. In 1992, the agency insured more than 15 institutions in the Occupied Territories, covering employees, spouses, and their children under 18. Hospitalization was immediate and not restricted to the Occupied Territories. The Arab Insurance Company is one of the few companies that insures individuals as well as institution employees. The company insures only the nuclear family and rarely insures new applicants if they are over 45. The

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[234] *Ibid.* p. 21.

[235] For instance, the Gaza Red Crescent Society operates three Gaza Strip clinics which provide medicine at about one-fifth the cost charged by a private clinic. Israeli authorities have limited the services that the Society is able to provide by refusing to license a third ambulance and refusing a proposal to build a hospital; its staff is also harassed daily. MAP, *Health in Gaza*, *supra* note 1, p. 47.

[236] In Sha'are Zedek Hospital, for example, Israeli patients are charged one of two rates while Palestinians are charged a third, highest, "tourist" rate, which cost 1,000 NIS per day of hospitalization in 1992. 24 October 1991 meeting, DCI, *supra* note 165, p. 3.

cost is calculated per person, so larger families pay more. The cost in September 1992 was 88 JD per person annually (approximately $140). Therefore a family of five would pay 440 JD per year (approximately $700) for this insurance, as compared to 1120 NIS ($448) per year for voluntary GHI in 1992.

Representatives of these insurance companies report that persons who let their voluntary GHI lapse are not seeking private health insurance as an alternative. This is not surprising, given that the private insurance rates are higher for an average family than GHI rates. Moreover, virtually all private insurance holders reside in urban areas. Rural inhabitants are rarely enrolled in private health insurance schemes.[237]

Some institutions offer private health insurance, either through local companies or acting as their own insurers. For instance, Bir-Zeit University acts as its own insurer.[238] But most Palestinians do not work for these institutions and consequently do not have access to such health insurance schemes.

3. UNRWA

UNRWA offers a free alternative to government health care to the approximately one million registered refugees in the Occupied Territories,[239] who account for between 50 to 66 percent of the population in the Occupied Territories. Some aspects of UNRWA

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[237]29 September 1992, telephone conversation with Manager of the Arab Insurance Company, based in Nablus.

[238]Positive aspects of Bir-Zeit's health insurance scheme include the fact that spouses, children under 18, and children under 25 who are still in school are covered; and that insurance fees are tied to salary brackets. However, in 1992 there was a medical cost ceiling of 1,350 JD for adults and 675 JD for children; this low a ceiling would only cover the cost of kidney dialysis for one week. Moreover, the first 50 NIS of medical expenses were not covered (with some humanitarian exceptions). Bir-Zeit insurance does not cover dental or optical expenses but six dental offices and an optician center give 30 percent fee reductions to the scheme's members.

[239]UNRWA -- West Bank and Gaza, *supra* note 6.

health care are superior to GHI. All registered refugees[240] receive some free medical care from UNRWA, including curative and preventive services in clinics and hospitals. Examinations, medicine, X-rays, labwork and ambulance services are all free. Hospital stays (UNRWA subsidizes beds in certain hospitals) and surgery costs are free, with the exception of tertiary care. Thirty percent of charges for tertiary care (highly specialized medical procedures such as neurosurgery and cardiosurgery) at Maqased and Hadassah Hospitals in Jerusalem (for West Bank patients) and Tel Hashomer Hospital in Israel (for Gaza Strip patients) are charged to the refugee, unless he or she is a certified "special hardship" case. At Augusta Victoria Hospital, East Jerusalem, the only charge in 1992 was a 10 NIS registration fee. However, access to all these hospitals during periods of closure is difficult or impossible to obtain. Refugees can be referred to Israeli hospitals by insuring themselves through GHI and having UNRWA pay the premiums. Referrals to Israeli hospitals however remain subject to the usual and problematic GHI referral process.[241]

UNRWA health services suffer from many of the same difficulties that the rest of the health system in the Occupied Territories suffers from, another casualty of Israeli occupation policies of underdevelopment, restriction, and harassment. UNRWA's shortcomings include: inadequate facilities in the face of demand; inadequate supplies of medicine;[242] shortage of trained nurses, physiotherapists, and psychiatric staff; long delays in repair of important medical equipment due to lack of local technicians and reluctance of Israeli technicians to travel to the Occupied Territories; lack of resuscitation equipment in ambulances; limited lifesaving training for ambulance staff; refusal of the military

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[240]This includes "N" category refugees whose UNRWA services were reinstated in 1992 following the harsh economic conditions that resulted from the Gulf War period.

[241]Interview with Dr. A. Hidmi, Field Health Officer, West Bank -- UNRWA, 1 July 1992.

[242]Roy, *Gaza Strip Survey*, *supra* note 78, p. 113.

authorities to allow ambulances to carry sirens or radios; and shortage of ambulances exacerbated by refusal of Israeli authorities to issue curfew or closure passes.[243]

Not all refugees are entitled to use UNRWA's health care services. Under UNRWA's eligibility requirements prior to January 1993, the children of registered refugee women who had married non-registered men were not eligible for registration as UNRWA refugees, unless their mothers were divorced or widowed, and were therefore not eligible for any UNRWA services, including health care. As of January 1993, registered refugee women who marry non-registered men also lose their eligibility for UNRWA services, including health care.[244]

4. Discussion

Approximately 30 percent of the West Bank population has no GHI or access to UNRWA.[245] That percentage is similar in the Gaza Strip. Private insurance covers only a small fraction of the population. Private and charitable attempts to bring free or low-cost health care to the population are thwarted systematically by the authorities and affordable access to Israeli facilities is virtually nonexistent. Thus, approximately one-third of all Palestinians in the Occupied Territories, mainly in rural areas, do not have access to *any* affordable, comprehensive health care.

The lack of affordable, comprehensive health care forces some Palestinians to seek medical care outside the Occupied Territories and Israel, but even that is very difficult. Patients needing to travel outside for medical treatment are sometimes refused permission to travel for no stated reason, or permission is needlessly delayed by the Civil Administration. Moreover, patients who request permission to travel abroad are often pressured to sign a promise that they will not return for two to three years.

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[243]MAP, *Health in Gaza*, *supra* note 1, p. 41.

[244]Al-Haq information.

[245]DCI, ACRI, Civil Administration meeting, 22 March 1992, *supra* note 52.

Additionally, friends or relatives accompanying patients whose medical condition renders them immobile without help may be refused permission to travel, effectively denying the patient permission to travel.[246]

III. Israel's International Legal Obligations to Provide Adequate Health Care

International human rights and humanitarian law applicable to the Occupied Palestinian Territories obligate the Israeli government to provide accessible and adequate medical services and medical care to Palestinians and to develop and maintain these services without discrimination of any kind.

While international conventions do not automatically form a part of Israeli law, Israel remains bound on an international plane to apply its treaty obligations and implement their terms, as well as to implement international customary law. The following discussion focuses on both the humanitarian (the laws of war, including the law of belligerent occupation) and human rights (such as the United Nations Covenant on Economic, Social and Cultural Rights) obligations that Israel has incurred. Al-Haq recognizes that there is a growing convergence of these two bodies of public international law. Many scholars and jurists hold the view that standards of human rights, as well as the more minimal humanitarian standards, are applicable in cases of belligerent occupation, especially as an occupation becomes prolonged. As Adam Roberts has noted:

> ...concerning the applicability of the international law of human rights to military occupations generally. Suffice it to say that *(a)* this question is but a part of the larger one of the applicability of multilateral conventions in occupied territories; *(b)* the main impetus for UN action after 1945 to develop human rights law was the near-universal reaction against Nazi

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[246]Al-Haq Legal Services Program information.

> oppression in Germany and in German-occupied territories in World War II; *(c)* the scope-of-application provisions of human rights accords do not exclude their applicability in principle, even if they do, as noted below, permit certain derogations in time of emergency; *(4)*[sic] the idea of 'respect for human rights in armed conflicts' has been stressed in numerous UN and other resolutions since at least the late 1960's; and *(5)* in some decisions, international courts and tribunals have affirmed the applicability of human rights law in occupied territories either implicitly (Namibia) or explicitly (Cyprus).[247] (footnotes omitted)

Humanitarian law, contained in the Fourth Geneva Convention and the 1907 Hague Regulations for example, attempts to create a balance among the competing interests of 1) the welfare of the occupied population and 2) the security interests of the occupier. The law attempts to preserve the *status quo ante* until the occupier withdraws. However, preserving this status could, in the long-term, also lead to the political, civil, and/or economic underdevelopment of the occupied population, thus undermining one of the fundamental goals of humanitarian law which is the protection of the population under occupation. The body of human rights law, which places greater restrictions on any measures by a government taken against persons under its control, could protect the occupied population by providing appropriate standards for the behavior of the occupier during prolonged occupation as it takes on more of the powers and responsibilities of a government.[248] Of course, whether a particular humanitarian or human rights treaty ratified by Israel applies to the Occupied Territories depends on its precise wording, as explored below.

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[247]Roberts, A., "Prolonged Military Occupation: The Israeli-Occupied Territories 1967-1988" in Playfair, E., ed., *International Law and the Administration of Occupied Territories* (Oxford: 1992) pp. 53-54.

[248]*Ibid.* pp. 33-34.

A. United Nations Charter and the Universal Declaration of Human Rights

Article 55(c) of the Charter of the United Nations obligates signatories to universally respect and observe "human rights and fundamental freedoms for all without distinction...." UN General Assembly Resolution No. 273 (III) of 11 May 1949 admitted Israel to membership in the UN "*Noting* ... the declaration by the State of Israel that it 'unreservedly accepts the obligations of the United Nations Charter and undertakes to honour them from the day when it becomes a Member of the United Nations.'" The Universal Declaration of Human Rights (UDHR) describes the human rights and fundamental freedoms mentioned in the Charter in more detail.

Although not itself considered a legally binding document by most scholars, the UDHR is generally recognized as prescribing rights and freedoms which are obligatory. In the 1968 Proclamation of Teheran, adopted by the International Conference on Human Rights, the Conference agreed that "the Universal Declaration of Human Rights states a common understanding of the peoples of the world concerning the inalienable and inviolable rights of all members of the human family and constitutes an obligation for the members of the international community." According to some international law scholars, some or all of the provisions of the UDHR set forth binding customary international law. Alternatively, the UDHR represents an authoritative interpretation of the binding human rights provisions of the UN Charter.

According to Article 25 of the UDHR, Palestinians have a right to be able to afford adequate medical care and necessary social services:

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself [sic] and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability,

widowhood, old age or other lack of livelihood in circumstances beyond his control.

(2) Motherhood and childhood are entitled to special care and assistance....

Article 2 emphasizes that everyone is entitled to the rights and freedoms set forth in the UDHR "without distinction of any kind", whether on the basis of political opinion, national, or social origin, or on the basis of the status of a "territory to which a person belongs...." Yet, as the discussion above indicates, many Palestinians cannot afford even the minimal health services that the Israeli government provides.

B. International Covenant on Economic, Social and Cultural Rights

In al-Haq's view, until Palestinians attain the right to pursue their own economic, social, and cultural development, the occupying Israeli authorities are responsible in the Occupied Territories for "achieving progressively the full realization of the rights recognized" in the International Covenant on Economic, Social and Cultural Rights (ICESC).[249] Israel ratified the ICESC on 3 October 1991 with no reservations, and guaranteed that the rights enunciated in the Covenant would be exercised without discrimination of any kind "as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." (Article 2 (2))

The ICESC leaves open the question of territorial applicability and thus whether Israel is bound to apply the treaty in the Occupied Territories. According to the Vienna Convention on the Law of Treaties, Article 29, "[u]nless a different intention appears from the treaty or is otherwise established, a treaty is binding upon each party in respect of its entire territory." From the preparatory work

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[249]Annex to General Assembly Resolution 2200, 21 GAOR, Supp. 16, U.N. Doc. A/6316, at 49 (1966) (Articles 1 (1), 2 (1)).

for the Vienna Convention indicating that "entire territory" incorporated territory for which a state party was internationally responsible, it is possible to conclude that Israel is bound to apply the ICESC to the Occupied Palestinian Territories. However, because occupied territories were never specifically discussed during the extensive conferences and work done in preparation for the Convention, Article 29 of the Vienna Convention may not be applicable to this situation. In that case, the International Court of Justice has suggested that where the issue is illegally-occupied territories and multilateral treaties concluded by the occupier, those conventions with a humanitarian character, the "non-performance of which might adversely affect the people of [the occupied territory]", might be applicable to the occupied territory.[250] Even if Israel's sustained occupation is considered legal, despite repeated United Nations Security Council resolutions such as Resolution 242 (1967) calling for withdrawal of Israeli armed forces, there is no reason why multilateral humanitarian conventions should not apply, according to the Court's reasoning, if their nonapplication and nonperformance might adversely affect the occupied population. By "humanitarian", the Court may have been referring to conventions on both human rights and the laws of war.

Article 12 of the Covenant sets forth the right to the "highest attainable standard of physical and mental health" and the State obligation to create "conditions which would assure to all medical service and medical attention."[251] These rights may only be

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[250] *Legal Consequences for States of the Continued Presence of South Africa in Namibia (South West Africa) notwithstanding Security Council Resolution 276 (1970)*, ICJ Yearbook 1970-1971 No. 25, pp. 100-108. See also Roberts, in Playfair, *International Law and the Administration of Occupied Territories*, *supra* note 247.

[251] Article 12, in full, states:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present

subject to limits that are determined by law "solely for the purpose of promoting the general welfare in a democratic society" (Article 4). As long as affordable, comprehensive health care is unavailable to at least one-third of all Palestinians while the health system is restricted unnecessarily by policies of underdevelopment, underfunding, and harassment, Israel remains in violation of its obligations under the Covenant to work toward providing the highest attainable standard of health for the population in the Occupied Territories, assuring medical services and attention to all.

C. International Convention on the Elimination of All Forms of Racial Discrimination

Israel's ratification of the International Convention on the Elimination of All Forms of Racial Discrimination (CERD),[252] obligated it to immediately adopt policies eliminating racial discrimination in all of its forms (Article 2(1)). "Racial discrimination" is defined by Article 1(1) as:

> [A]ny distinction, exclusion, restriction or preference based on race, colour,

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> Covenant to achieve the full realization of this right shall include those necessary for:
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> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
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> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical services and medical attention in the event of sickness.

[252]Adopted and opened for signature and ratification by General Assembly Resolution No. 2106A (XX) of 21 December 1965 and entered into force with regard to Israel on 2 February 1979.

> descent, or national origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.

Thus, racial discrimination under CERD would include discrimination against persons on the basis of their Palestinian descent or national origin.

While there is no general territorial applicability clause in CERD, several articles refer to State Parties' obligations "in territories under their jurisdiction" (Article 3, condemning racial segregation and *apartheid*) or to "everyone within their jurisdiction" (Article 6, establishing effective protection and remedies), which would make Israel's treatment of Palestinians in the Occupied Territories subject to its obligations under CERD. There is general agreement that "occupants who are parties to human rights conventions that apply 'within their jurisdiction' are also bound by these Conventions in their activities in the occupied area."[253] Moreover, in December 1991, the Committee charged with monitoring and reviewing actions by States to fulfil their obligations under CERD, issued its conclusions on the reports of Israel, and "reiterated that the Government of Israel had implemented in the Occupied Territories neither the [Fourth Geneva Convention] nor the [CERD]. The Committee expressed great concern about the situation in the Occupied Territories."[254] Israel has not submitted another report since then, and the Committee members have considered the issue only once more, on 5 February 1992 in CERD/C/SR.931, pp. 5-7, when they reiterated the same concerns.

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[253]Benvenisti, E., "Ratification: What It Implies For Human Rights in Israel," *Israel Children's Rights Monitor*, *supra* note 36, p. 26.

[254]Committee on the Elimination of Racial Discrimination, Fortieth Session, Provisional Summary Record of the 936th Meeting, CERD/C/SR.936, p. 2, 4 December 1991.

The comments of the vast majority of the members of the Committee in response to Israel's fifth and sixth reports, due on 2 February 1988 and 1990 respectively, clearly showed their belief that Israel had a responsibility toward Palestinians in the Occupied Territories and that the standards of CERD should be implemented there:[255]

> the members of the Committee had decided to question the Israeli delegation on Israel's compliance with the Convention in all the territories under its control, including the occupied territories, since article 3 ... committed...[Israel to eradicate] discriminatory practices in all territories under [its] jurisdiction. He wished to make it clear that the Committee's consideration of the situation in the territories had no implications in terms of recognition of the occupation of those territories.[256]

Article 5 of CERD obligates Israel to "guarantee the right of everyone ... to equality before the law, notably in the enjoyment of the following rights:"

> ....
> (e) Economic, social and cultural rights, in particular:
> ...
> (iv) The right to public health, medical care, social security and social services;
> ....

Insured Palestinians in the Occupied Territories experience much poorer services, medication, and sanitary conditions than they would in Israel, even though the Israeli government is ultimately

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[255]*See* records of the fortieth session of the Committee on the Elimination of Racial Discrimination. CERD/C/192/Add.2; CERD/C/SR.929-932, 936.

[256]Summarized comments of Mr. de Gouttes, from France, SR.929, p. 9.

responsible for administering both systems.[257] Comparison of GHI with medical care and the health insurance system within Israel is beyond the scope of this study; however, a clear pattern of discrimination against Palestinians in the Occupied Territories emerges at only a brief glance. Although Israel has no general health insurance law, 98 percent of Israeli Jews were insured in 1989[258] and an estimated 77-80 percent of Israeli Palestinians were insured.[259] By contrast in the Occupied Territories, Israel has changed the previous health care systems operated by the Jordanians and Egyptians which provided for most or all of the population and implemented a health insurance scheme unaffordable to most Palestinians. The pattern of discrimination is also clearly illuminated by the fact that referral to Israel's better-equipped hospitals has become a privilege that very few insured Palestinians receive, even when the need is critical, whereas insured Israelis have the unquestioned right to care in these same hospitals. Israel also spends much less money per person on health in the Occupied Territories than in Israel despite the availability of funds in the Occupied Territories for more health spending. In creating and maintaining a relatively inferior medical system in the Occupied Territories and severely restricting, by law, Palestinian access to the superior Israeli medical system, Israel has breached its international obligation under CERD to provide everyone in territories under its jurisdiction with an equal right to public health and medical care.

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[257]Al-Haq Report 57/92.

[258]Reiss, "Health Services to the Arabs in Israel," *supra* note 94, p. 258. Of these, 75-80 percent were insured by the Histadrut's (Association of Hebrew Workers) Sick Fund, renamed the General Sick Fund (GSF) in 1976, while the remainder were insured by three other sick funds. The quality of health services provided by GSF to both Jewish and Palestinian Israelis has been criticized for lack of evening and night services, lack of specialists, inefficiency and long waits for referrals, absence of prescription medication in pharmacies, insufficiency of dental services, and the lack of preventive and educational health care.

[259]Of these, 70 percent were insured by the GSF. *Ibid.* pp. 258, 267.

D. United Nations Convention on the Rights of the Child

Israel's ratification of the United Nations Convention on the Rights of the Child on 3 October 1991 with no reservations obligated it to assure to all children (persons under 18 in the case of the Occupied Territories) in its jurisdiction, without discrimination (Article 2(1)), the rights to survival, physical and mental development, the highest attainable standard of health, and access to health care services.

Article 6(2) obligates the State Party to guarantee "to the maximum extent possible the survival and development of the child." A child also has the right "to a standard of living adequate for the child's physical, mental, spiritual, moral and social development", according to Article 27(1). Most specifically with regard to health, Article 24 states that:

> 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health services.
>
> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
> (a) To diminish infant and child mortality;
> (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care:
> (c) To combat disease and malnutrition including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
> (d) To ensure appropriate pre-natal and post-natal

health care for mothers;
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents, and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.

4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

The Israeli government health care system in the Occupied Territories, with its unsatisfactory health insurance scheme, its limited facilities and services, its unreasonably restricted referral service to Israeli hospitals, and its restrictions on UNRWA and the private and charitable sectors, is hardly conducive to Palestinian children's enjoyment of the "highest attainable standard of health." The age at which free medical care is no longer available for children has now been legally reduced from three years to one-and-a-half in the West Bank; although at present children up to three are still being treated free, the practice could change at any time. The legal change reflects an attitude of neglect towards children's health. In the Occupied Territories, poor environmental conditions, poor nutrition, an infant mortality rate higher than in Israel, and less health funding per person than in Israel or Jordan, all provide evidence of ongoing and systematic violations by Israel of its

obligations under this Convention.

E. Fourth Geneva Convention

It is almost universally agreed that the Geneva Convention Relative to the Protection of Civilian Persons in Time of War of 12 August 1949 (Fourth Geneva Convention) applies to the Occupied Territories; Israel alone dissents.[260] Article 56 of the Fourth Geneva Convention requires Israel, as the occupying power, to maintain health services in territories which it has occupied:

> [T]o the fullest extent of the means available to it, the occupying power has the duty of ensuring and maintaining, with the cooperation of local authorities, the medical and hospital establishments and services, public health and hygiene in the Occupied Territory, with particular reference to the adoption and application of the prophylactic and preventative measures necessary to combat the spread of contagious diseases and epidemics.

According to the authoritative International Committee of the Red Cross Commentary to the Fourth Geneva Convention, Article 56 stresses the fight against epidemics and contagious diseases, and clearly envisages the work of the occupying power as encompassing:

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[260] *See* UN General Assembly Resolution No. 35/122 A, 1980 which affirmed the applicability by a vote of 141 in favor (Israel voted against and Guatemala abstained). Recently, Security Council Resolution No. 681 (1990) urged that Israel accept the application of the Fourth Geneva Convention to the Occupied Territories and was adopted unanimously. When Israel first occupied the West Bank and Gaza Strip in 1967, it issued several military orders which clearly stated that the Fourth Geneva Convention applied to its occupation. Over the next three years, however, Israel amended these orders or issued orders superseding the previous ones, deleting references to the Convention. Israel now only states vaguely that it will apply the humanitarian provisions of the Fourth Geneva Convention. In al-Haq's opinion, all the provisions of the Convention are humanitarian and therefore, even by its own reasoning, Israel has a duty to apply the Convention in its entirety.

> supervision of public health, education of the general public, the distribution of medicines, the organization of medical examinations and disinfection, the establishment of stocks of medical supplies,..and the opening of new hospitals and medical centres. (page 314)

Article 55 requires the Occupying Power to import necessary medical supplies "such as medicaments, vaccines, and sera, when the resources of the occupied territory are inadequate."[261]

Attempting to provide for the general protection of populations against certain consequences of war, Article 16(1) of the Fourth Geneva Convention states that "[t]he wounded and sick, as well as the infirm, and expectant mothers, shall be the object of particular protection and respect." According to the ICRC Commentary, "protection and respect" means to spare, help, and support, thus creating an obligation to give any care needed by the sick and wounded, infirm, and pregnant.[262] "Hospitals, clinics, sanatoria, health centres, opthalmic, psychiatric or child clinics"[263] are all to be respected and protected, as are staff members who are "regularly and solely" engaged in working at these facilities (Articles 18(1), 20). All land and sea convoys and any aircraft transporting the wounded, sick, infirm or maternity cases are also protected, according to Articles 21 and 22. Article 76 reiterates that detainees "shall receive the medical attention required by their state of health" and Articles 91 and 92 call for adequate medical care for internees.

In general, therefore, the Fourth Geneva Convention imposes

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[261]Pictet, J., ed., *Commentary: Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War* (Geneva: ICRC, 1958) p. 314.

[262]*Ibid.* p. 134.

[263]*Ibid.* p. 145. Protection afforded these facilities may only cease if "they are used to commit, outside their humanitarian duties, acts harmful to the enemy" (Article 19, para. 1), and then protection may cease only after due warning has been given and if the acts have not ceased.

a positive obligation on Israel to help and support all protected persons (Palestinians) in the Occupied Territories who need medical care, and to ensure and maintain the entire health care system in the Occupied Territories. Under the Convention, it is clearly not enough to merely tolerate the existence of health facilities; rather, Israel must open new facilities and import supplies as necessary. Israel's restrictions on, and underdevelopment of, the health care system within the Occupied Territories violate these obligations.

Israel's obligations must be fulfilled in a nondiscriminatory manner:

> Without prejudice to the provisions relating to their state of health, age and sex, all protected persons shall be treated with the same consideration by the party to the conflict in whose power they are, without any adverse distinction based, in particular, on race, religion or political opinion. Article 27 (3)

The Commentary clarifies that "race, religion or political opinion" are given only as examples of impermissible distinctions:

> The criteria of language, colour, social position, financial circumstances and birth might be added.... It should be noted too that the prohibition of all adverse distinctions in the treatment given to protected persons is not merely a negative duty. It implies an active role.[264]

Thus, the discrimination evident in the current system directed against individual Palestinians on the basis of their alleged political opinions (arresting Intifada victims from hospitals, for example) or their financial status (placing GHI and uninsured prices for government health care beyond the reach of many Palestinians), is impermissible under the Fourth Geneva Convention.

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[264] *Ibid.* pp. 206-7.

F. 1907 Hague Regulations

The Hague Regulations are annexed to the 1907 Hague Convention (IV) Respecting the Laws and Customs of War on Land which was expressly recognized by the International Military Tribunal at Nuremburg in 1946 as declaratory of customary international law. The Supreme Court of Israel has held that:

> In respect to Israel's belligerent occupation, and in the absence of legislation which internalizes the principle norms of the laws of war relating to belligerent occupation, [the rules in force] are those included in the [Hague] Regulations ... Even though the Hague Regulations serve as an authority in this respect, the accepted attitude -- which has also been accepted by this court -- is that the Hague Regulations are declarative in nature and reflect customary international law, applicable in Israel without an act of Israeli legislation.[265]

Thus, the Israeli authorities do not dispute that the Hague Regulations embody customary international law and apply to the Occupied Territories. Article 43 of the Regulations obligates Israel to restore and ensure order and communal life ("l'ordre et la vie publics" in the official French version) to the Occupied Territories. That phrase has come to be accepted as meaning that Israel must ensure the welfare of the population to the highest possible degree while it is empowered to take measures necessary for its own security. According to the same article, Israel must, unless absolutely prevented, respect the laws already in force in the country. Articles 48 and 49 impose on Israel the duty to defray the expenses of administering the occupied territory "to the same extent

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[265] *A Teachers' Housing Cooperative Society v. The Military Commander of the Judea and Samaria Region*, HC 393/82, PD 37 [4] 785, 793, quoted in Qupty, "The Application of International Law in the Occupied Territories as Reflected in the Judgments of the High Court of Justice in Israel," in Playfair, *International Law and the Administration of Occupied Territories*, *supra* note 247, p. 90.

as the legitimate Government was so bound," assessing taxes according to rules already in force, as far as possible, and levying other contributions solely for the administration of the territory or the needs of the army.

During its occupation of Palestinian territories, Israel has consistently eschewed any notion of balance between welfare and security; it has ignored Palestinian welfare and imposed disproportionate security measures on the community. It has changed the laws in force on the eve of the occupation, including health insurance laws, beyond recognition to the detriment of the population and without any legitimate security rationale, and has often forcefully assessed high taxes but withheld much of the income gathered from Palestinians from beneficial use in the Occupied Territories. In addition, Israeli occupation authorities have frequently obstructed ambulance transportation and imposed curfews and military closures as illegal collective punishments on the Palestinian population; these punishments often prevent those in need of medical treatment from receiving it. Moreover, the recent March 1993 closure of East Jerusalem to the rest of the population of the Occupied Territories has prevented most access to the best medical care available to the population. All of these illegal measures have had a considerable and negative impact on health care for Palestinians.

CONCLUDING REMARKS

Israel's international treaties obligate it to help and support Palestinians in need of medical care and to ensure and maintain adequate health conditions in the Occupied Territories. Israel's responsibilities include provision of adequate medical establishments, including new facilities when necessary, medical assistance and health care, health education, and adequate environmental conditions such as clean drinking water. Israel has fallen short of meeting these obligations, however; health conditions are relatively poor in the Occupied Territories and services are deteriorating. Spending only a fraction per person of what it spends on its own citizens for health, while continuing to assess high taxes with no accountability, Israel presides over an ailing health care system in the Occupied Territories, characterized by a lack of adequate facilities, equipment, medicine, and specialists; a relatively high infant mortality rate; decreasing availability of hospital beds; and poor environmental and nutritional conditions. Medical conditions in prisons fall well short of international minimum standards and have inspired repeated condemnation from numerous human rights organizations.

Through military orders and regulations amending existing laws, the Israeli authorities have altered beyond recognition the system of affordable health care that existed in both the West Bank and the Gaza Strip in 1967; the laws now in force do not ensure that all Palestinians receive affordable health care that is either adequate or meets the standards existing within the state exercising jurisdiction over the territories. The official claims that the current voluntary health insurance scheme improves the quality of health services[266] are disingenuous; it is clear that the services offered under the current system are unsatisfactory. Israeli government health insurance and government health services for the uninsured are expensive, and many families cannot afford them, unless they are mandatorily enrolled in GHI. There are few alternatives for

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[266]Ministry of Health, *Review of Health Services 1985-1986*, *supra* note 81, p. 26.

these families unless they are refugees with access to UNRWA services. While private or charitable institutions may be able to provide some subsidized or free services, their own facilities are restricted by the Israeli government and are too few to meet all needs. Palestinians with GHI find that not all of their family members are covered, and that those who are covered receive poor services in an underdeveloped medical system which requires additional payments for medicine and innoculations. This makes onerous financial demands on families whose monthly expenditures are already, in many cases, higher than their income. The result is that approximately one-third of all Palestinians have no access to affordable, comprehensive health care, and many more have only unsatisfactory access to a poor system.

Health in the Occupied Territories has become a privilege, doled out parsimoniously, rather than a right for the entire population. Radical changes in the entire system of health care in the Occupied Territories are imperative. A rational health care system that gives priority to the population's health needs must be implemented. Access to that system should be by provision of affordable universal health insurance with reasonable coverage and terms. Although adoption of a universal health insurance scheme in the Occupied Territories was recommended in 1985 and adopted in the Israeli Health Ministry's plan in 1986,[267] universal health insurance has not been implemented and is now no longer mentioned as a goal.[268]

The serious problems with provision of medical care exposed in this discussion of GHI have plagued Palestinians in the Occupied Territories for more than a decade, and, in some cases, since

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[267]The Israeli Ministry of Health admitted that hospital utilization in Gaza had decreased at least partly due to the lack of universal health insurance. Ministry of Health 1989-1990, *supra* note 17, p. 24. The other reason given was changing patterns of disease. Ministry of Health 1990-1991, *supra* note 20, pp. 38, 41.

[268]Ministry of Health, *Review of Health Services 1985-1986*, *supra* note 81, pp. 29, 32. The Joint Planning Committee for Health Services in Judaea and Samaria (the "Adler Committee") recommended that universal health care be adopted in the Occupied Territories; this report was adopted by the Civil Administration and the Israeli Ministry of Health as the basis for health planning in 1985-1990.

occupation began. The problems must begin to be redressed immediately or the situation will deteriorate rapidly at the expense of the physical and mental health and well-being of the present and future generations of Palestinians in the Occupied Territories.

Appendix I

(Unofficial Translation by al-Haq)

Israel Defense Forces
Order For Health Services (Judea and Samaria) No. 746 - 1978

On the basis of my authority as the commander of the region and due to my belief that the order is imperative for the interests of the region's population, I hereby issue the following order:

1. Definitions:

In this order, a "public employee" is a resident of the area who is one of the following:

1. An employee of any authority of the IDF in the region.
2. An employee of a local authority of the IDF to which this order was applied by the person in charge and approved by the commander of the region.
3. A "retired" person -- an employee of the government or of a local authority who is retired and has the right to a pension according to the Civil Pension Law No. 34 of 1959; or according to Pension and Recompense Regulations of Municipal Employees No. 2, 1955.

"Health Services" are those provided by the person in charge or under his patronage, as must be detailed in an announcement by the person in charge which must be put in his office and at offices of health services in locations where they are provided.

"Health Services Program" is the program providing health services in return for membership fees which is administered by the person in charge as detailed in an announcement on behalf of the person in charge and put in his office and at offices of locations where health services are provided according to the program.

"Family Members" are the insured and his spouse (the couple); their minor children; his parents; and his minor brothers and sisters; in cases where they are dependent on him.

A "minor" is a person who has not reached 18 years and includes a single woman who has completed 18 years as long as she is still dependent on her father or brother.

"Person in Charge" is the Health Affairs Officer at the region's Command.

"Employer" -- of an employee of an authority of the IDF in the region -- is the commanding officer of the administrative staff at the region's Command.
-- of an employee of a local authority which is the municipal council or village council;
of a retired person --
is the administration of the fund according to Civil Pension Law No. 34 of 1959 or the administration of the fund according to the Regulations of Pension and Recompenses of Municipal Employees No. 2, 1955.

"Employee in Israel" is a region's resident who works in Israel through the Labor Exchange Office and who has worked through this office not less than 10 days per month.

2. Health Services

A. A resident of the region is entitled to receive health services for fees which are to be detailed in an announcement on behalf of the person in charge, and subject to the regulations in this order.

B. In the announcement, mentioned above in subsection (a), it is possible to decide on health services that will be provided free of charge.

3. Exemptions From Payment For Health Services

Public employees or employees in Israel and their families are exempted from payments for health services that are provided in the framework of the health services program in accordance with

regulations in Article 4 of this Order.

4. Membership Fees

A. Public employees and employees in Israel must pay fees for membership in the health services program at rates to be detailed in regulations.

B. The employer of a public employee must deduct compulsory membership fees from the salary of the employee each month. He must transfer these to the person in charge or to someone to whom authoritiy has been delegated in writing.

C. Membership fees of employees in Israel will be transferred by him to the person in charge or to someone to whom authority has been delegated in writing in a way to be decided by him in regulations.

D. For this article, the pension given to a retired person will be regarded as his salary.

5. If a couple is entitled to be exempted from paying fees for health services on the basis of Article 3, membership fees according to Article 4 must be paid only by the husband.

6. A. A resident of the region who is not exempt can join the health services program according to this order.

B. If a resident of the region has joined as above, he and the members of his family is entitled to be exempted from paying for the provided health services in the framework of the health services program as long as he is paying membership fees according to regulations.

C. Ways of registering for the health services program, paying membership fees, cancelling membership and lapsed membership will be established through regulations.

D. The person in charge is entitled to determine in regulations the registration fees which are to be paid upon joining.

7. Exemption From Paying Membership Fees

The Commanding officer for the social welfare affairs at the region's Command is entitled to provide exemptions from paying membership fees.

8. Stamps and Health Services Card

The person in charge is entitled to issue a health services card and health services stamps to be used for paying fees of membership in the health services program and for the sake of identifying those who are entitled to exemptions from payment for health services.

9. Tampering and Changing Are Forbidden

A. No person can introduce changes in a health services card, cancel or destroy part or all of the card, or mark the card, or add any details to it without permission of the person in charge.

B. It is forbidden for any person to forge the health services stamp or to possess forged health services stamps or instruments or equipment that could be used to forge health services stamps without permission of the person in charge.

C. Any person who commits any of the acts mentioned above without the permission of the person in charge will be violating the law and liable for three months of imprisonment or 10,000 Israel Lira fine or both penalties.

10. Payment for Prescription

Despite Article 3 above, the person in charge has the right to fix an obligation for paying in return for every prescription issued by a physician.

11. Regulations

The person in charge shall be entitled to issue regulations to implement this Order.

12. Cancellations

Regulations for Health Insurance No. 146, 1966 and Regulations Regarding Health Services (Exemptions and Discounts) (Judea and Samaria 1973) are cancelled.

13. This order shall take effect on 1 February 1978.

14. Title

The title of this Order will be "Order for Health Services (Judea and Samaria) No. 746-1978."

General David Hgoel
Commander of Judea and Samaria Region

Appendix II

(Unofficial Translation by al-Haq)

Order Concerning Health Services (Judea and Samaria) No. 746
5738-1978

Announcement Concerning Health Services Plan and Installment Payments for Health Services (Amendment 39) (Judea and Samaria), 5751-1991

According to the authority vested in me by Article 2 in the Order Concerning Health Services (Judea and Samaria) No. 746, 5738-1978, I announce the following:

1. In this Announcement, "the original announcement" is the "Announcement Concerning Health Services, Health Services Plan, and Payments for Health Services, 1981."

2. Replace the appendix to the original announcement with the appendix to this announcement.

3. Effective date. This announcement shall come into effect on the date of the signature.

4. Title. This announcement will be called: "Announcement Concerning Health Services (Amendment 39) (Judea and Samaria), 5751-1991."

Appendix

Column A Health Services	Column B Tariff
1. Hospitalization: Tariff description for anyone who is not insured, or who is insured but has not exceeded 120 days from the day of registration, or who has delayed payment, or who has not paid or who was late by six installments when	

he was admitted for hospitalization.

a. One day hospitalization in a government hospital	NIS 514
b. One day hospitalization for mothers in a maternity ward in a government hospital	NIS 100
c. One day hospitalization in Israel according to a referral issued by the health affairs officer	Israeli tariff
d. One day hospitalization in a mental hospital	NIS 146

2. Tests in hospital after hospitalization:

a. Test by a doctor in an outpatient external clinic or in hospital sections by a doctor after a stay in the hospital	NIS 48
b. Treatment by a nurse in an allergy clinic or in an external clinic	NIS 19

3. Medicine

a. For each medication for uninsured	NIS 36
b. For each medication for insured	NIS 3

4. Emergency Room

a. Treatment and tests that do not result in hospitalization:

1. Registration and admission fees to hospital and doctor's exam	NIS 76
2. X-Rays	See Article 5
3. Lab Tests	See Article 12

b. Treatment and tests that result in hospitalization in one of the sections of the government hospital or transfer to hospitalization in another government hospital in the area. Payments mentioned in

subsection a above are credited to the patient's hospitalization expenses according to the tariffs described in Article 1.

5. X-ray tests:
Description of tariffs for uninsured patients and insured patients who have been referred by a private doctor.

a. Each X-ray (Rontegen)	NIS 50
b. Exam of Rontegen x-ray	NIS 50
c. Contrast Rontegen test	NIS 100
d. Deposit for the films	NIS 50
e. Ultra-sound	NIS 100

6. Cancer

a. Cancer diagnosis	Exempted
b. Ray treatment	Reimbursement of treatment expenses in Israel
c. Chemotherapy (per day)	NIS 180

7. Physiotherapy — NIS 50

8. CT Scan (per scan) — NIS 50

9. Vaccination for travelling abroad (including insured persons) — NIS 50

10. Ambulance Services

a. Within municipal boundaries	NIS 54
b. Outside municipal boundaries (each additional km)	NIS 3

11. Treatment at a General Clinic

a. Treatment at a doctor's clinic NIS 48
b. Treatment by a nurse NIS 19

12. Laboratory test, tariff for uninsured and insured who was transferred by a private doctor (per sample) NIS 50

13. Blood Bank, tariff for uninsured and insured who was not transferred by a government hospital

a. Unit of blood (100 cc) NIS 50
b. Blood unit refill NIS 50
c. Blood test NIS 50

14. Medical Documents

a. Medical Report (including insureds) NIS 170
b. Summary of illness (including insureds) NIS 84

15. Health Services -- free of charge

a. Health services related to contagious diseases, or illnesses that may endanger people's lives, according to the list of diseases issued by the responsible official.
b. Treatment at Mother-child centers.
c. Tests initiated by the Health Department concerning public health.
d. Treatment and tests carried out at schools by the Health Services in the schools.
e. Cancer diagnosis.
f. Article 7 concerning polio (infantile paralysis).
g. Health services for children aged one and a half years or younger, excluding Articles 9 [innoculation for travel abroad], 13 [blood bank], and 1. c. [referral to Israeli hospitals].

Date: 17 December 1991
Signed: Dr. Yitzhak Sever
Position: Officer in Charge (Health Affairs)