



PHYSICIANS FOR **دُكَّائِمِ أَطْبَاءَ**
HUMAN RIGHTS **لِزَنْوِيَّاتِ أَدَمَ لِحَقُوقِ الْإِنْسَانِ**
ISRAEL **إِسْرَائِيلَ**



DIVIDE & CONQUER: INEQUALITY IN HEALTH

JANUARY 2015

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1.

Abstract

The "Divide and Conquer" report analyzes the gaps between health indicators and social determinants of health in Israel and the Occupied Territories and demands health service equality between Israelis and Palestinians in light of Israel's control of these factors. Several of the focal data points presented in the report:

- Infant mortality stands at 18.8 per 1,000 births in the Occupied Territories, in contrast with 3.7 in Israel.
- The maternal death rate in the Occupied Territories is 28 per 100,000 births, in contrast with 7 in Israel.
- The average life expectancy of Palestinians residing in the Occupied Territories is about 10 years lower than average life expectancy in Israel. In recent years, the life expectancy gap between Israel and the Occupied Territories has increased.
- The incidence of infectious diseases such as hepatitis B is higher in the Occupied Territories than in Israel.
- There are inoculations that are given in Israel and not given in the Occupied Territories: hepatitis A, chickenpox, pneumonia, rotavirus, and human papillomavirus.
- Far fewer medical professionals serve the Palestinian population of the Occupied Territories than the population inside Israel.
- There are 1.6 times more doctors to serve the population in Israel than in the Palestinian territories, and only one eighth as many specialists in the Occupied Territories: 0.22 per 1,000 residents of the Occupied Territories and 1.76 in Israel. There are 1.9 nurses per 1,000 residents in the Occupied Territories, and 4.8 in Israel.
- Domestic and industrial water consumption among Palestinians in the West Bank is 73 liters per person per day – less than the minimum recommended by the World Health Organization (100 liters per person

per day); in contrast, domestic consumption in the Jewish settlements is five times as high, and in Israel itself, average daily per capita consumption is 242 liters – 3.3 times higher than in the West Bank.

- The national per capital health expenditure in the Palestinian territories is about one eighth of the expenditure for Israelis. The public expenditure for health in the Occupied Territories constitutes only a relatively small part of the total expenditure for health (37%), which is low both as compared to Israel (61%) and to other countries in the world.

The report analyzes the control mechanisms through which Israel influences health in the Occupied Territories. Effectively, these mechanisms prevent the Palestinian Ministry of Health from providing full health services to the residents of the Occupied Territories. There are several central obstacles, not including the failings of the Palestinian Authority itself:

- Israeli limitations on the freedom of movement of patients, medical professionals, ambulances and medications between the Gaza Strip, the West Bank, and East Jerusalem, as well as within the West Bank.
- Israeli control of the Palestinian Authority budget, including the health budget.
- Limitations on the scope of medical personnel permitted to work in East Jerusalem (which is where the six central Palestinian hospitals are located) and on the scope of medical personnel permitted to come into Israel for training.
- Making the departure of patients from the Gaza Strip for medical treatment conditional upon undergoing GSS (Shabak) security questioning.

The principled demand that arises from the analysis of the gaps and control mechanisms is equality in health between Israelis and Palestinians. For years, Physicians for Human Rights – Israel has been demanding that Israel bear the responsibility for the health of the Palestinian population due its being the occupying power, and by force of the laws of occupation and the fact of it being an occupation that has been going on for many years. The occupation has long since transitioned from a temporary situation to an ongoing reality – a reality characterized by the colonialist settlement

of Israeli citizens in the Occupied Territories, in the creation of facts on the ground involving the utilization of Palestinian natural resources and land, and in recent years, also in proposals by government ministers to annex Area C - in such a way that will make permanent the Palestinian enclaves that have been formed, and will prevent any continuous territory and independent governance. Against the background of all these facts, the nature and depth of Israeli responsibility toward the residents of the Occupied Territories must be re-examined. In practice, two populations groups are maintained under Israeli rule; one of which has excess privileges. For this reason, we can no longer suffice with only pointing at specific responsibilities of Israel. Instead, full equality between the two groups must be demanded. It is the duty of the Palestinian Ministry of Health to provide health services to the population to the best of its ability, but it is Israel's obligation to provide all of those services that exceed the ability of the Palestinian Ministry of Health, so that a Palestinian child and an Israeli child, who may live only a few hundred yards apart, receive the same level of medical care.

The Government often answers its critics by saying that Africans in South Africa are economically better off than the inhabitants of the other countries in Africa. I do not know whether this statement is true and doubt whether any comparison can be made without having regard to the cost of living index in such countries. But even if it is true, as far as the African people are concerned it is irrelevant. Our complaint is not that we are poor by comparison with people in other countries, but that we are poor by comparison with the White people in our own country, and that we are prevented by legislation from altering this imbalance.

**Nelson
Mandela,**
in the opening remarks
during his 1964 trial.

2.

Introduction and Historical Overview

The Palestinian health system is in a state of chronic crisis, which does not allow it to provide an appropriate response to the population's needs. The health system has been struggling for years with shortages of medication and medical equipment, alongside a shortfall in specialist doctors and medical staff in general. Due to the financial difficulties facing the Palestinian Ministry of Health, medical workers are not paid regularly, which often leads to workers' strikes, and to the transitioning to a three-day working week, instead of five days. The cost of referrals is added to these difficulties: Every year, many patients who require treatments that are not available in the Palestinian public health system are referred, at high cost, to the private health system, to the six Palestinian hospitals in East Jerusalem, and as needed, also to hospitals in Israel, Egypt, and Jordan.

The crisis situation engulfing the Palestinian healthcare system was not created in a single day, and it is closely related to the Israeli control of the Occupied Territories. Over the years, changes have occurred in Israel's understanding of the extent of its responsibility for the health situation in the Occupied Territories. When these territories were occupied in 1967, Israel saw itself as responsible (if only to a limited degree) for the continued functioning of healthcare services there. This limited responsibility was put into practice by a staff officer responsible for health-related matters under the Military Governor, and later under the (military) administration of Palestinian civilian affairs (the "Civil Administration"), and not through the Israeli Ministry of Health. The Palestinian healthcare system was administrated as a closed economy, separate from the system that served the citizens of Israel. A special

emphasis was placed on public health and healthcare for mothers and children, and not on development and on the closing of the gaps with the Israeli system. Over the years, the budget itself came to rely increasingly on taxes collected from the residents of the Occupied Territories, and it was managed in a non-transparent manner that made it impossible to examine its allocation. Israel created a health insurance that included Palestinian Civil Administration employees, but when its authorities were transferred to the Palestinian Authority within the framework of the Oslo Accords, this insurance was summarily canceled.¹

In 1987, with the outbreak of the first Intifada, Israel had reduced its commitment to providing healthcare in the Occupied Territories, and drastically reduced the scope of referrals to treatment in Israel. Despite the fact that this was incontrovertibly a punitive step, the Israeli army's claim was that there had been a significant drop in tax collection from the residents of the Occupied Territories, so that there was no source of funding for these referrals.²

Within the framework of the Oslo Accords, which were signed in 1993-1994, the responsibility for the Palestinian healthcare system was entirely removed from Israel and transferred to the Palestinian Ministry of Health, a part of the Palestinian Authority that was established pursuant to these accords. Although it was clear that the healthcare system was in chronic deficit and that the cost of operating it was very high, the Palestinian Authority accepted the responsibility as a symbol of its sovereignty, without also securing for itself the control of the many fields that are vital to the operation and planning of an independent healthcare system. Israel chose to transfer to the Palestinian Authority a field that involves great expenses, even at the price of a certain decrease of control of the population, and simultaneously guaranteed its continued control of all other fields, including border crossings, foreign relations, water resources, land, and so forth, and thus retained political and economic control.

1 Hadas Ziv, "Organized Injustice: The right to health in the Occupied Territories, under closure and siege," PHR-IL November 2002.

2 Id.; "Health Services in the Gaza Strip," August 1989, Association of Israeli-Palestinian Physicians for Human Rights.

In this report we will review the healthcare situation in the Occupied Territories,³ using health indicators such as life expectancy and infant mortality, which provide an overview of the health of the residents of the Occupied Territories, as well as social and economic indicators, which influence the residents' ability to exercise their right to health.⁴ We will also analyze the mechanisms by which Israel controls and influences the health of the Palestinian population. Our claim is that Israel exercises a direct influence on the healthcare situation in the Occupied Territories. This is expressed both in its control of crossings, checkpoints, and traffic, and Israel's ability to prevent, for example, the travel of a patient from the Gaza Strip to the West Bank for medical treatment, and also - and primarily - in Israel's control of social health determinants such as housing, nutrition, and water.

After presenting the information, the medical and economic indicators for the Palestinian residents will be compared to those of Israel in order to demonstrate the inequality of the healthcare situations in the Occupied Territories and in Israel. We want to challenge the claim that there is no point in comparing the healthcare situation in Israel and the Occupied Territories, an argument that relies on the misrepresentation that these are two separate entities, each of which would be free to make decisions about its economy, budget, and the manner of developing and operating its healthcare system.

The Oslo Accords created the illusion, or the hope, that the separation constituted a step on the road to establishing two states. In practice, a reality has been in place for two decades in which the characteristics of colonialism and of separation based on national affiliation have grown deeper. Two populations live in a single territory, ruled by the same government - with different rights. Is it not time to demand equality for these two populations?

³ The term Palestinian Territories in this report refers to the West Bank and the Gaza Strip. The report will not consider East Jerusalem, as the Israeli National Health Insurance Act applies to its residents. The data applies to the period prior to Operation Protective Edge in Gaza in the summer of 2014.

⁴ Most of the healthcare indicator data is correct for 2011, as information could be gathered for that year both relating to Israel and to the Occupied Territories.

3.

Social and Economic Determinants of Health

The state of healthcare cannot be separated from the state of the economy. In 2003, the World Health Organization published a report demonstrating that the economic and social conditions in which people live, such as their employment and income level, have a decisive effect on their health.⁵ In another World Health Organization report from 2008,⁶ which deals with the "inequity in health," which they define as "avoidable health inequality," it states as follows:

"Even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich. Not only are these differences to health an important social injustice, they have also drawn scientific attention to some of the most powerful determinants of health standards in modern societies. They have led in particular to a growing understanding of the remarkable sensitivity of health to the social determinants of health."⁷

The report ends with a recommendation to fight inequalities in health around the world by raising the level of education and welfare and improving the living and working conditions for all people.

Therefore, to present a full picture of health conditions in the Occupied Territories, it will be impossible to ignore the social and economic conditions that are causing it, whose importance is no less than that of the health indicators themselves.⁸

⁵ Social Determinants of Health – The Solid Facts
http://www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf

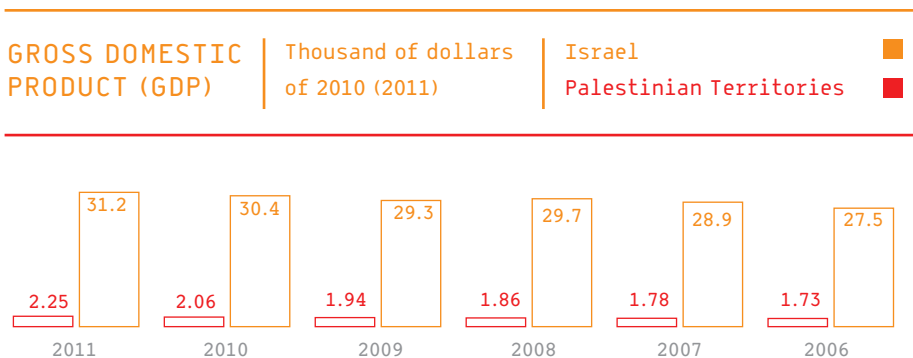
⁶ Closing the Gap in a Generation
http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf?ua=1

⁷ Social Determinants of Health – The Solid Facts, page 7.

⁸ Unless otherwise indicated, this chapter is based on data from the Israeli Central Bureaus of Statistics (CBS) and from its Palestinian counterpart. The Israeli data is also based on data from the National Insurance Institute.

Gross Domestic Product (GDP)

The gross domestic product of the Palestinian economy in 2011 was approximately USD 9.3 billion. The number of residents in the Occupied Territories was approximately 4.1 million. The per capita income is therefore estimated to be approximately USD 2,250. This is a low figure, according to which the Palestinian Territories rate among the poorest countries in terms of standard of living. The Palestinian GDP is 93% lower than the GDP in Israel, where the per capita income for 2011 was estimated at USD 31.2 thousand.



The growth rate of the Palestinian economy is also low, and indicates that the gap in standard of living between residents of Israel, including the Jewish residents of the West Bank, and the Palestinian residents in the Occupied Territories have not been closed. In 2000–2011, the per capita income for the Occupied Territories grew at a rate of only 1% per year – a very low rate compared to that of developing countries at similar income levels. For example, over the same period, the average growth per person in Middle Eastern and African countries stood at 2.9% per year. In Israel, the growth per person came to 1.7% over the past decade – a rate similar to that in countries with similar income levels. This situation is unusual, since faster growth is generally observed in poor countries, with a gradual reduction of the gap between them and the wealthy countries.

Employment Rate

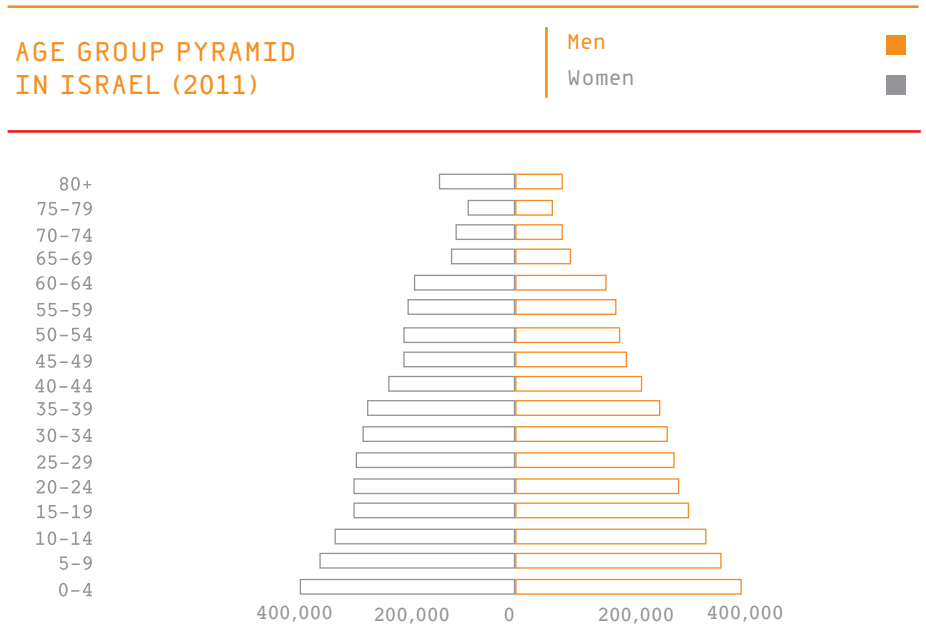
The employment rate is the percentage of persons in a general population who have employment. This indicator expresses the economic dependence relationships inside a society: the number of breadwinners as compared

to the total population: the lower the employment rate, the greater the dependence on breadwinners, and the harder it is to maximize growth potential. The employment rate depends on the age group structure, on the participation rate, and on the unemployment rate.

In the Palestinian Territories, the potential for employment is not exhausted due to the low participation of women in the workforce and to an underdemand for employees, which is expressed in a high rate of unemployment.

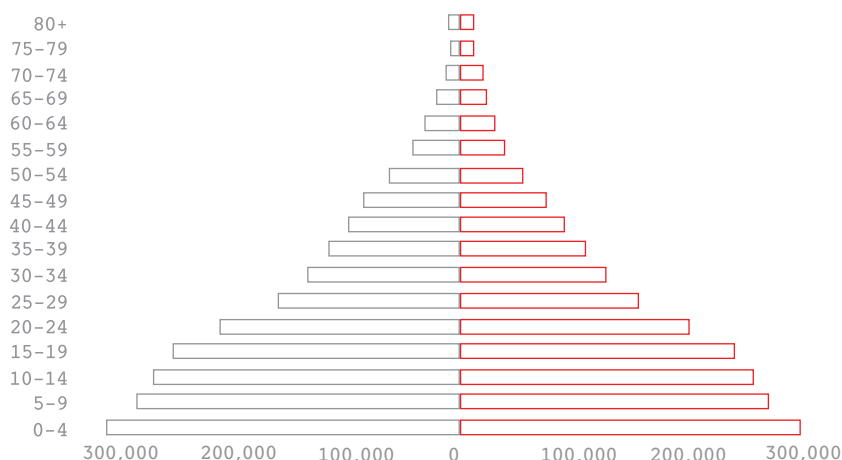
Age group structure

The Palestinian population is very young: Children under the age of 14 comprise 40% of the population, as compared with 28% in Israel. The large number of children leads to an increased burden on the working population, which must provide for many people.



AGE GROUP PYRAMID IN THE PALESTINIAN TERRITORIES (2011)

Men
Women



Workforce participation rate

The rate of participation in the Palestinian population is low as compared to Israel (43% as compared to 64%). Participation rates are similar in the population of men (69%), but among women the participation rates are significantly lower relative to Israel (17% versus 58.1%). A low participation rate often expresses a situation where workers have despaired of finding work, after having failed to do so for a long time. The low participation rate further increases the burden on the working population, which is already providing for children and non-working women.

Unemployment rate

Of the employment-seeking population, about 28% are unemployed; this is one of the primary problems of the Palestinian economy. This rate of unemployment is high, indicating that beyond the low participation rate by women, men seeking employment have difficulty finding work as well, as a result of a long list of obstacles. This is one of the factors that explains the low per capita income.

Capital stock per worker

The capital stock is the total of all the assets that participate in the production process, including buildings, equipment, machines, vehicles, etc. The capital stock per worker is the total of all assets at the disposal of each employee in the production process. This is one of the central factors affecting the per capita income. When no information is available about the capital stock, electricity consumption data can be used as an indirect measure of capital stock: the more machines and equipment a factory has, the greater its consumption of electricity will be.

As there is no readily available data about the capital stock per worker in the Palestinian Authority as compared to Israel, we will use data relating to electricity consumption. Per capita electricity consumption in the Palestinian territories came to 1,200 kWh in 2011. In contrast, per capita electricity consumption in Israel that year came to 7,900 kWh. The gap in electricity consumption testifies to the low capital level in the Palestinian economy, as well as to the low degree of industrialization. This becomes even more clear when comparing the consumption data of electricity for domestic use, which indicates a smaller gap (2,160 kWh per household in the Occupied Territories, as compared with 6,470 in Israel), meaning that the industrialization of factories in the Palestinian territories is significantly lower than in Israel. A low level of industrialization (which testifies to a low per capita capital stock) is one of the primary causes of the low per capita income.

Foreign Investment

Foreign investments are one of the primary sources for expanding an economy's production capacity (along with private savings). The direct foreign investments in the Palestinian economy in 2012 came to only 204 million dollars, as compared to approximately 9,481 million dollars in Israel.

Population Density

Population density is a demographic figure which is usually included in an economic overview, as it affects the economic efficiency of production, the housing market, the transportation infrastructure, agriculture, trade, and social relationships. The population density in the Palestinian territories stands at 724 people per square kilometer (475 in the West Bank, 4,583 in the Gaza Strip), as compared to 347 people per square kilometer in Israel.

The Poverty Rate

The poverty rate measures the number of families beneath the poverty line. In the Palestinian territories, approximately 25% of families are below the poverty line, as compared with 19.9% in Israel. It is important to stress that this is a relative measure: the poverty line is defined as 50% of the median per capita disposable income. In Israel, the median disposable income in 2011 stood at NIS 4000, so that the standard poverty line stood at NIS 2,000 per person. During the same period, the poverty line in the Palestinian territories stood at NIS 458.60 per person per month.

Education

In 2013, the average number of years of education for the Palestinian population in the Occupied Territories stood at 8 years of school, as compared to 12 years of school in Israel.⁹

Inequality

Inequality is measured using the Gini Coefficient, which measures the inequality of income distribution in countries, with 0% indicating equality and 99% indicating inequality. The Gini Coefficient comes to approximately 40% for the Palestinian territories, as compared to 35.9% for Israel.

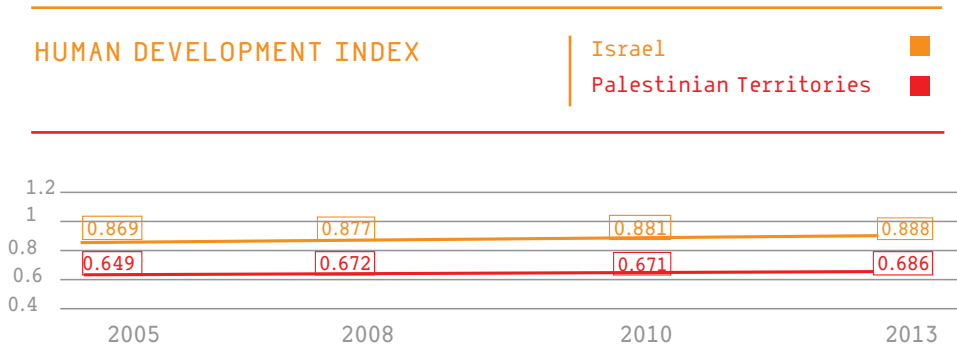
Human development index

The human development index is published by the United Nations Development Program (UNDP). The purpose of this index is to evaluate the quality of life in each country, based on several basic data points relating to education, health, and income. In 2013, the human development index for the Palestinian territories was 0.686, and they ranked 107th in the world, while the index for Israel is 0.888, which ranks 19th in the world.¹⁰ From 1990 to 2013, Israel dropped from the 18th to the 19th place in this global ranking, while Palestine climbed one rank, from the 108th to the 107th,

⁹ United Nations Development Program. The data for Israel is taken from <http://hdr.undp.org/en/countries/profiles/ISR>
The data about the Palestinian Territories are taken from: <http://hdr.undp.org/en/countries/profiles/PSE>

¹⁰ Ibid.

between 2005 and 2013 (no data exists for prior years). Israel's ranking is in the very high group, while Palestine is ranked in the middle group. It should be noted that the gap between Israel and the Occupied Territories has remained similar throughout this past decade.



Access to lands

In the 1993 Oslo Accords, the Palestinian territories were divided into areas A, B, and C. Area A territories were defined in the Accords as being under full Palestinian control, Area B territories as being under Palestinian civic control and Israeli control for security matters, and Area C territories are under full Israeli control. 60% of the territory in the West Bank, and most of the open land in it, are defined as Area C. Palestinian construction on about 70% of the Area C lands was sweepingly prohibited by Israel, claiming that these were shooting ranges, state land, survey land, national parks, and so forth. Construction in the remaining Area C lands also depends on authorization from the Civil Administration, which is granted only in a small number of the cases. According to the assessments of human rights organization "BIMKOM - Planners for Planning Rights," Palestinian construction is permitted in practice only in about half of one percent of Area C. This policy also significantly affects life in Areas A and B, where most of the Palestinian residents of the West Bank reside: These areas are in fact comprised by 165 separate "islands", surrounded by Area C lands; thus, the land reserves for most Palestinian towns and cities are in Area C, but due to the stringent construction restrictions in these areas, the Palestinian Authority cannot use them appropriately for expansion and development.¹¹

¹¹ "As if it were its own: Israel's police in the C Area of the West Bank", B'tselem, June 2013.

In 2013, the World Bank published a report about the Palestinian economy, which focused on Area C territories.¹² According to the evaluation presented in that report, the limitations that Israel imposes on the Palestinians, which prevent the use and development of Area C lands, cost the Palestinian economy about 3.4 billion dollars per year – about 35% of the GNP.

Access to Water

The primary water sources in the West Bank – the Jordan River and the Mountain Aquifer – are under Israeli control. The water systems in the West Bank are managed by the Israeli governmental water corporation, "Mekorot", which provides nearly half of the water consumed by residents of the West Bank. A Palestinian Water Authority (PWA) was established following the Oslo Accords, but this authority cannot produce a sufficient volume of water, and must purchase water from the Mekorot corporation, due to the fact that Israel retains control of the Jordan River and most of the water in the aquifer, and prevents the establishment and maintenance of a Palestinian water infrastructure in Area C by systemically refusing to grant construction permits.¹³

The result is that domestic and industrial water consumption among Palestinians in the West Bank is 73 liters per person per day – less than the minimum recommended by the World Health Organization (100 liters per person per day). In contrast, domestic consumption in the settlements is five times higher. In Israel, average daily consumption per person is 242 liters – 3.3 times higher than in the West Bank.

The Gaza Strip, which has been disconnected from the West Bank, remains with one single source of water, the Coastal Aquifer, which is partially in the Gaza Strip and partially inside Israel. The water and sewage infrastructure in the Gaza Strip do not function properly, as they have suffered from the financial situation, from Israeli limitations on the importing of construction material, and have been damaged by electricity shortages, as well as by attacks by the Israeli army over the years, which have caused damage that has not yet been repaired. Furthermore, the excessive extraction of water by Israel as well as by the government in

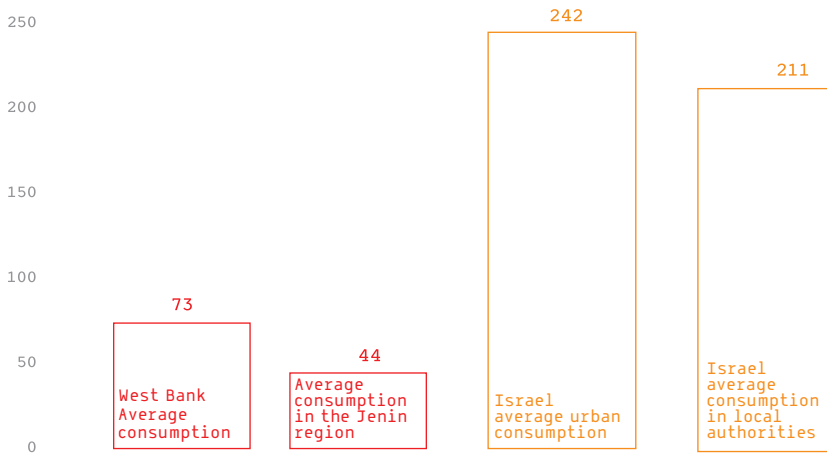
¹² West Bank and Gaza, Area C and the Future of the Palestinian Economy, World Bank, October 2013

¹³ Water for One People Only: Discriminatory Access and "Water Apartheid" in the OPT, Al-Haq, 2013.

Gaza has led to the contamination of the aquifer, to the point where 90–95% of the water in it are not fit for drinking.¹⁴

WATER CONSUMPTION PER PERSON PER DAY (LITERS)

Israel ■
Palestinian Territories ■



14 http://www.btselem.org/hebrew/water/consumption_gap

4.

Health Indicators

In this chapter we will present health data from the Occupied Territories and compare them to data from Israel (including the settlements), using several primary indicators. Wherever data is available, we will consider the Gaza Strip and the West Bank separately. The information about Israel is primarily based on data from the Israeli Central Bureau of Statistics (CBS), the Israeli Ministry of Health, and on international organizations (the World Health Organization, and others). The information about the Occupied Territories is based on the Palestinian Central Bureau of Statistics, the Palestinian Ministry of Health, and on international organizations. In certain instances, information was generated especially for the purpose of preparing this paper. For example, the rates of mortality from heart diseases by age in Israel, which were calculated by the Health and Natural Population Movements section of the Israeli CBS, based on age ranges used by the Palestinian Ministry of Health, in order to make a comparison of the figures possible.

Leading causes of death

In Israel:¹⁵

1. Cancer (26.3%)
2. Cardiac and coronary diseases (17.2%)
3. Diabetes (5.8%)
4. Strokes and cranial vascular diseases (5.8%)
5. Renal diseases (3.8%)
6. Accidents
7. Sepsis
8. Chronic illness of the lower respiratory system
9. Pneumonia and flu
10. Hypertension

In the West Bank:¹⁶

1. Cardiac and coronary diseases (22.4%)
2. Cancer (12.4%)
3. Strokes & cranial vascular diseases (10.3%)
4. Diabetes (8.6%)
5. Respiratory diseases (7%)
6. Neonatal and prenatal diseases
7. Sepsis
8. Renal diseases
9. Accidents
10. Senility

¹⁵ Leading causes of death in Israel

http://www.health.gov.il/PublicationsFiles/leading-causes_2010.pdf

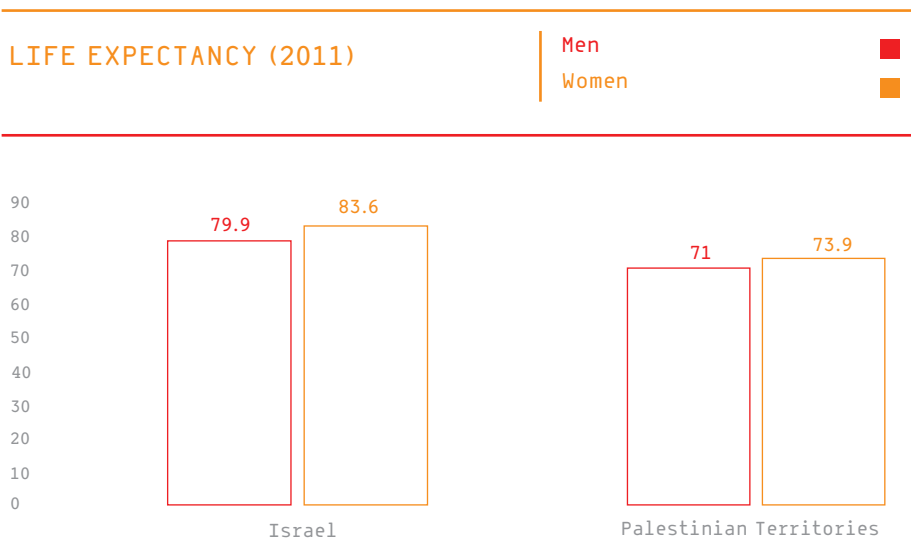
¹⁶ The Palestinian Ministry of Health, 2011 Annual Report, p. 40:

<http://www.moh.ps/attach/440.pdf>. There is no data about the Gaza Strip.

In Israel, cancer has been the leading cause of death among men and women over the past decade, having "overtaken" death from cardiac and coronary illnesses, among other things due to primary and secondary prevention. In the Palestinian territories, in contrast, the rate of cancer incidence is lower than in Israel, and it is the second highest cause of death. Additionally, infectious diseases, primarily of the respiratory system, are ranked higher (5 as compared to 8), as are infant illnesses and prenatal illnesses (ranked 6th in the Occupied Territories, while they are not even in the top ten leading causes of death in Israel.) These are two additional fields where prevention plays a critical role in reducing mortality.

Life expectancy

Life expectancy, which measures the average length of people's lives, is the most common indicator of health. Life expectancy is also recognized by the United Nations as an indicator of the level of health in a country, although it only measures the length of people's lives and not the quality of their lives.¹⁷ The data in the following graph are for 2011.¹⁸



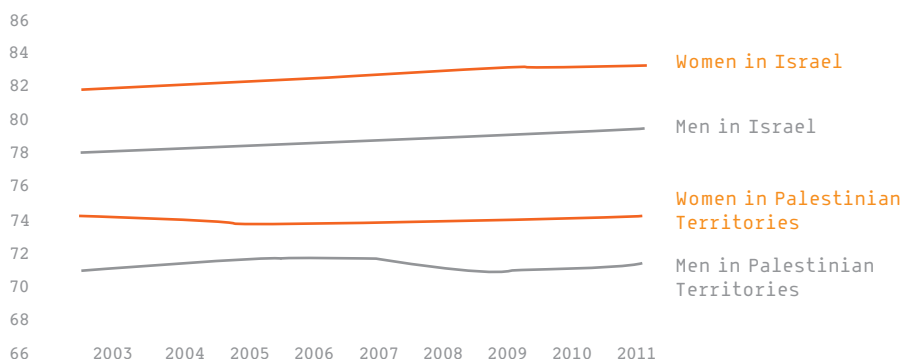
¹⁷ OECD Better Life index, <http://www.oecdbetterlifeindex.org/topics/health/>

¹⁸ WHO Country Statistical Profiles, http://applications.emro.who.int/docs/RD_Annual_Report_2011_country_statistics_EN_14587.pdf

The graph shows that life expectancy in Israel is about ten years higher than in the Palestinian territories. The gap in life expectancy derives primarily from gaps in the health determinants (see pages 10–18 of this report.) In the Palestinian territories, the life expectancy gap between men and women is one of the lowest in the world and stands at 2.9 years; in Israel it stands at 3.7 years, which is also considered very small, relatively. It is possible that the low life expectancy gap between men and women in the Palestinian territories indicates a high degree of inequality between men and women, as in most countries around the world the life expectancy gap between men and women is much higher.

Data from the past decade indicates that the life expectancy gaps between Israel and the Occupied Territories are increasing, for women and men alike:

LIFE EXPECTANCY (2003–2011)



While in Israel life expectancy of women increased by 1.8 years between 2003 and 2011, and life expectancy of men increased by 2.3 years,¹⁹ the respective numbers for the Occupied Territories are only 0.1 and 0.3.²⁰ The result is that the life expectancy gap between Israel and the Occupied Territories has grown over these years from an 8 years to 9.7 years for women, and from 6.9 years to 8.9 years for men. The fact that despite the generally increase in life expectancy, the gap in this field between Israel and the Occupied Territories has not decreased, but rather increased, over

¹⁹ Ibid.

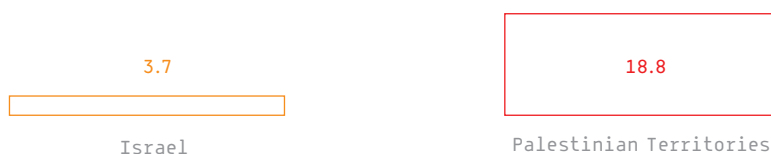
²⁰ According to the annual reports from the Palestinian Ministry of Health, 2003–2011. The data from 2002 and 2008 were not available.

the years, indicates a deterioration of the life expectancy of residents of the Occupied Territories, relative to that of residents of Israel.

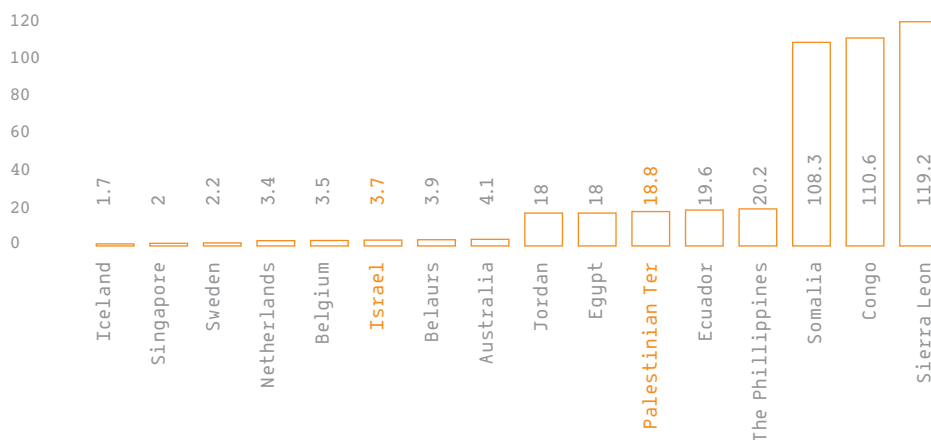
Infant mortality

Infant mortality measures the number deaths of babies under the age of one year, per one thousand live births. This is an important metric, and is accepted as one that measures the quality of health in a country. The following figures are for 2011:²¹

INFANT MORTALITY PER 1,000 LIVE BIRTHS (2011)



INFANT MORTALITY PER 1,000 LIVE BIRTHS (2011)



²¹ WHO Country Statistics, Occupied Palestinian Territory, http://applications.emro.who.int/docs/RD_Annual_Report_2011_country_statistics_EN_14587.pdf

The Palestinian Central Bureau of Statistic, A Press Release on the Eve of the World Health Day, <http://www.pcbs.gov.ps/site/512/default.aspx?tabID=512&lang=en&ItemID=757&mid=3171&wversion=Staging> Ministry of Health, Palestine, annual report 2011 <http://www.moh.ps/attach/440.pdf> pg.40

CBS, Annual Statistics Yearbook for Israel, 2012: http://www.cbs.gov.il/shnaton63/st03_11x.pdf.

Child Mortality Estimates, a database based on the research of the UN Inter-agency Group for Child Mortality Estimation <http://www.childmortality.org/index.php?r=site/index>

The infant mortality gap between the Palestinian territories and Israel is most significant: they differ by a factor of almost five. While the rate of infant mortality in Israel is one of the lowest in the world, infant mortality rate in the Palestinian territories is similar to infant mortality rates in countries with a mid-range development index, such as Egypt, Jordan, or the Philippines.

Similar to infant mortality data in Israel, most cases of death in the Palestinian territories, about two thirds of them, occur in the neonatal period, while the minority of deaths occur more than a month beyond birth, during the post-neonatal period.²² In contrast, and very differently from the situation in Israel, infant mortality in the Palestinian territories mostly involves infectious diseases (approximately 55%) and only few cases (some 16%) relate to preterm birth. The relatively high rate of infant mortality in context of infectious diseases, which is a preventable phenomenon, explains most of the gap between infant mortality in the Palestinian territories and Israel.

Low birth weight

This indicator relates to the percentage of infants born weighing less than 2500 grams, out of all births.²³ Low birth weight could have long-term health implications, including mortality, disability, and depression in infants and children. It could also impact health conditions at maturity. Insufficient diet in the course of pregnancy affects not just the health of the mother but could also have negative implications relating the infant's weight and early development. Care for low-birth weight infants involves a significant burden upon the health system.²⁴ The figures below are for 2011.²⁵

²² Ministry of Health, Palestine, annual report 2011
<http://www.moh.ps/attach/440.pdf>

²³ MEETING OF ADVISORY GROUP ON, MATERNAL NUTRITION AND LOW BIRTHWEIGHT, Geneva, 4-6 December 2002, WHO, http://www.who.int/nutrition/publications/advisory_group_lbw.pdf

²⁴ Nutrition, Feto-maternal nutrition and low birth weight, WHO, http://www.who.int/nutrition/topics/feto_maternal/en/index.html

²⁵ The figures for Israel were provided to PHE-IL by the CBS in an email correspondence on 18 April 2013. The figures for the Palestinian territories are taken from: Palestine country profile, 2011, WHO, <http://rho.emro.who.int/rhodata/?theme=country&vid=21500#>

RATE OF INFANTS WITH A BIRTH-WEIGHT BELLOW 2,500 GRAMS (2011)

Pre-term births



Non pre-term births



The graph shows that the rate of children born at low birth weight is higher in Israel than in the Palestinian territories. However, it should be taken into account that 6.1% of all births in Israel and some 80% of the infants with a birthweight lower than 2,500 grams are premature babies (born before the 38th week.)²⁶ One of the reasons for this is the extensive use of fertility treatments in Israel. It is likely that low birthweight premature babies born in the Occupied Territories do not survive due to lack of medical expertise and appropriate equipment. These figures could explain both the gap in low birthweight infants between Israel and the Palestinian territories and the high infant mortality rate for babies born in the Occupied Territories.

Maternal death

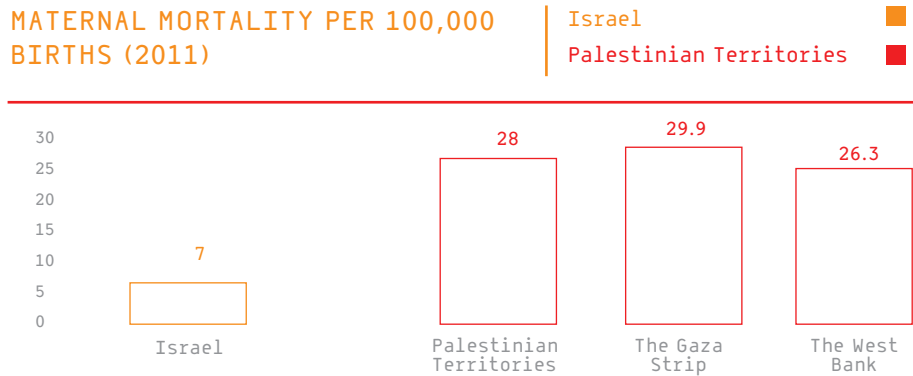
Maternal death is a customary indicator for evaluating the health status and level of healthcare services in a country, and it is defined as the number of deaths of mothers as a result of complications during pregnancy or during delivery out of 100,000 births. Between 1990 and 2010, the rate of maternal death dropped by almost 50% around the world,²⁷ and almost all cases of maternal death today occur in "third world" countries. Maternal death is higher among women living in rural areas and in poor communities, and there is a direct link between the mother's educational attainment and maternal death: the higher the mother's educational attainment, the lower the risk of mortality. Maternal death is considered to be a phenomenon

²⁶ Based on CBS figures, email correspondence from 27 May 2013.

²⁷ WHO, *Maternal Mortality*, May 2012:

<http://www.who.int/mediacentre/factsheets/fs348/en/index.html>

that can be significantly prevented: professional medical care before, during, and after delivery can save the lives of almost all mothers and their infants. In the graph below, the figures for Israel are for 2010,²⁸ and the figures for the Palestinian territories are for 2011.²⁹



The graph shows that maternal mortality in the Palestinian territories is four times higher than in Israel, and also that there is a gap between the maternal mortality rates in the West Bank and in the Gaza Strip. The leading cause of maternal death as reported for the West Bank is pulmonary embolisms (23.5% of the cases). There are no detailed figures relating to the causes of death in the Gaza Strip. It should be noted that according to official data from the Palestinian Ministry of Health, all births in the Palestinian territories take place under care of a medical team.³⁰

²⁸ World Health Organization, Israel <http://www.who.int/gho/countries/isr.pdf>

²⁹ Ministry of Health, Palestine, annual report 2011

<http://www.moh.ps/attach/440.pdf>

WHO Country Statistics, key health related statistics, Occupied Palestinian Territory http://applications.emro.who.int/docs/RD_Annual_Report_2011_country_statistics_EN_14587.pdf

³⁰ Palestine, Country Statistic, World Health organization

<http://rho.emro.who.int/rhodata/?theme=country&vid=21500>

Vaccinations

The routine vaccinations given as part of a national program in the Palestinian territories and in Israel are:

Vaccination	Palestinian Territories	Israel
	2011	2013
Hib – DPT (Diphtheria, Pertussis, Tetanus)	Yes	Yes *
Polio (OPV+IPV) (Polio)	Yes	Yes **
MMR (Measles, Mumps, Rubella)	Yes	Yes
Varicella (Chicken pox)	No	Yes
HBV (Hepatitis B)	Yes	Yes
HAV (Hepatitis A)	No	Yes
PCV13 (Pneumonia)	No	Yes
Rota (Rota virus)	No	Yes
HPV (Human Papiloma Virus)	No	Yes

* In Israel, the pertussis component of the vaccination is acellular pertussis (aP). This vaccination is significantly more expensive and carries significantly fewer side effects than the vaccination administered in the Palestinian territories.

** In Israel the OPV vaccination (live attenuated polio vaccine) was recently returned to use due to an outbreak of the virus, after it had been removed from the vaccination program in 2005.

According to the Palestinian Ministry of Health, the scope of vaccinations administered is high, and they are administered on average to more than 99% of the population.³¹ It should be noted that within the framework of the Oslo Accords, Israel insisted that the Palestinian Authority undertake to vaccinate its residents with the vaccinations indicated in the agreement.³²

Infectious diseases

Infectious diseases constitute a significant cause of morbidity and mortality. The Palestinian Ministry of Health has successfully brought diseases such as bilharzia, leprosy, diphtheria, polio, and rabies under control, but is still working to control other contagious diseases such as meningococcal meningitis, brucellosis, AIDS/HIV, hepatitis, pulmonary and extra-pulmonary tuberculosis, diarrhea, and pneumonia.³³

The figures presented hereunder are taken from publications by the Palestinian Ministry of Health and the Israeli Ministry of Health.³⁴

Rate of infectious disease cases per 100,000 persons:

	Palestinian Territories 2011	The West Bank 2011	The Gaza Strip 2011	Israel 2010
Hepatitis B	0.6	0.9	0	0.6
Hepatitis A	23.1	21	26.6	0.7
Pulmonary and extra-pulmonary tuberculosis	0.8	0.3	1.4	4.6 *
Meningococcal meningitis	3.6	0.04	9.5	0.7
Brucellosis	4.3	6.7	0.4	1.8

* Data correct for 2009.

31 Palestinian Ministry of Health report, 2011, page 27.

32 Hadas Ziv, "Organized Injustice: "The right to health in the Occupied Territories, under closure and siege," PHR-IL November 2002.

33 Ibid.

34 The figures for the Occupied Territories are from a report by the Palestinian Ministry of Health, 2011, page 24: <http://www.moh.ps/attach/440.pdf>. The figures for Israel are taken from: "Infectious Diseases Require Notice in Israel: 60 years of Monitoring, 1951-2010": http://www.health.gov.il/PublicationsFiles/Disease1951_2010.pdf

The occurrence of hepatitis A, meningococcal meningitis, and brucellosis are clearly higher in the Palestinian territories than in Israel. It is important to note that vaccinations against hepatitis A and meningococcal meningitis are relatively expensive, and that in Israel vaccinations against these diseases began in the nineteen nineties. It can be assumed that the higher incidence of both diseases in the Occupied Territories is an indicator for the population's lack of access to vaccination, as they are not included in the national vaccination program.

HIV/AIDS

7,517 new cases of HIV carriers and AIDS patients were discovered in Israel in the years 1981 through 2012.³⁵ In the Palestinian territories, only 72 new cases were discovered between 1981 and 2011, of which 60 had AIDS and 12 carried HIV,³⁶ but it can be assumed that the incidence of the disease is underreported.

Hereunder follows the breakdown of methods of contagion with the virus:

	Palestinian Territories (72 cases)	Israel (7,517 cases)
Heterosexual sexual relations	55.5%	* No Valid data
Homosexual sexual relations	5.5%	22.6%
Syringes and needles	4.1%	13.8%
Mother to child contagion	2.7%	2.9%
Blood/Blood products	5.5%	1.4%
HIV endemic in country of origin	*	39.6%
Partner with HIV	*	3.5%
Other/unknown	26.3%	15.9%

³⁵ HIV/AIDS in Israel: Periodic epidemiological roper, 1981-2012, Ministry of Health http://www.health.gov.il/PublicationsFiles/AIDS_PeriodicReport2013.pdf

³⁶ Palestinian Ministry of Health report, 2011, page 36: <http://www.moh.ps/attach/440.pdf>

Diabetes

Diabetes is one of the most prevalent diseases in the world and one of the most common causes of mortality worldwide.³⁷ The information is based on data from the International Diabetes Federation, and is correct for 2012.³⁸

	Palestinian Territories	Israel
Number of cases of diabetes between the ages of 20 and 79, in thousands	129.89	436.73
Percentage of diabetes patients in the general population	9.15%	7.85%
Undiagnosed cases of diabetes, in thousands	72.39	181.55
Percentage of undiagnosed patients of the total number of diabetes patients.	35.8%	29.4%

The table shows that diabetes is more prevalent in the Palestinian territories than in Israel. It should be noted that the prevalence of diabetes is rising throughout the world at this time, even among younger age groups than previously, due to lifestyle changes (transition to a sedentary lifestyle) and nutrition (transition to a diet consisting primarily of processed foods, rich in sugars and fats). Transitional societies, which are undergoing a modernization process, tend to be characterized by a higher incidence of diabetes. There is also a link between low socio-economic status and higher prevalence of diabetes: people in a lower socio-economic status have less access to healthy food and to physical activity.

Diabetes is underdiagnosed in Israel as well as in the Occupied Territories, so that it can be presumed that the disease is actually more prevalent than reflected in the table. However, the problem is less severe in Israel due to

³⁷ Moshe Philip and Shlomit Stein, *Juvenile Diabetes*, Ministry of Health, Mother, Child, and Adolescent Department, articles.
<http://www.old.health.gov.il/pages/default.asp?maincat=35&catId=101&PageId=845>;
World Health Organization, *Health topics, Diabetes*:
<http://www.emro.who.int/health-topics/diabetes/>

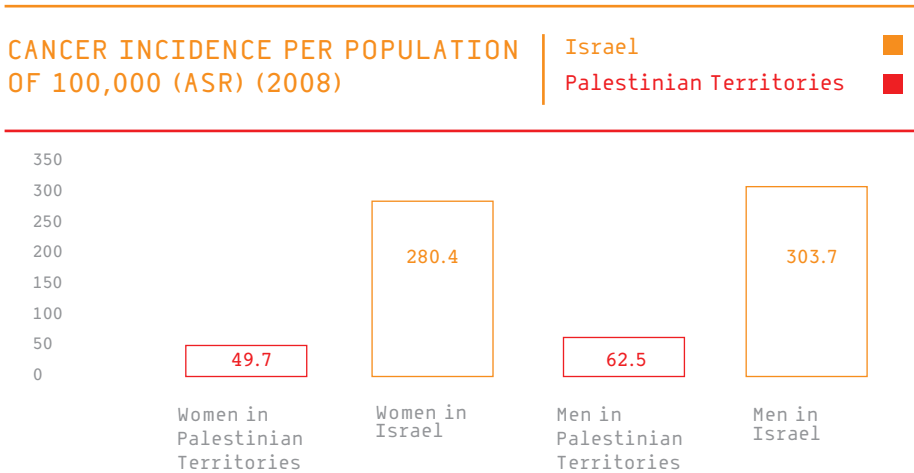
³⁸ International diabetes Federation, *Atlas, 5th addition, 2012: The International Diabetes Federation is an umbrella organization of 200 diabetes organizations that operate in more than 160 countries. The federation is affiliated with the United Nations Public Information Department and has official contacts with the World Health Organization.*

a more efficient use of the healthcare services.³⁹ Thus the table indicates that the estimated percentage of undiagnosed patients out of the total number of diabetes sufferers is higher in the Palestinian territories than in Israel.

It should also be noted that diabetes treatment in the Occupied Territories is insufficient, which in many cases leads to complications of the illness. For example, diabetes that is not diagnosed early enough and not treated appropriately could lead to retinal damage and sometimes even to loss of sight.⁴⁰

Cancer

Cancer incidence is measured as the number of new cases recorded per year in a country per 100,000 residents.⁴¹ This rate provides an estimate of the risk of cancer.⁴²



The figures for 2008 show that in Israel, the rate of cancer patients is higher than in the West Bank and in the Gaza Strip. The main reason for this is that the population of Israel is significantly older than the population

³⁹ Consultation with Dr. Keren Turjeman, Endocrinologist.

⁴⁰ John Talbot, St. John of Jerusalem Eye Hospital: <http://www.stjohnseyehospital.org/diabetes-opt>

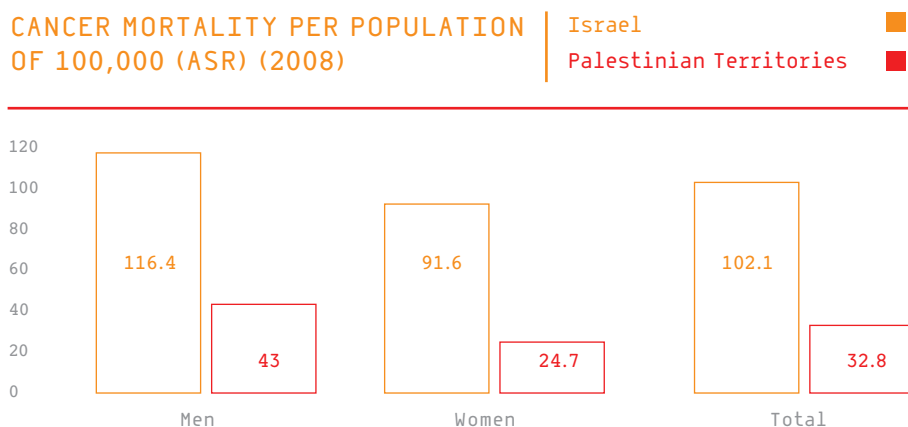
⁴¹ OECD data, Health at a Glance: Europe 2012, Cancer Incidence: 1365685=expires?pdf.8112121ec016/download/docserver/org.ilibrary-oecd.www//:http1CD04FEDBD64F8193CC932A2EF42442=checksum&quest=accname&id=id&346

⁴² GLOBCAN 2008, <http://globocan.iarc.fr/>

of the Occupied Territories. Moreover, it can be assumed that there is a significant under-diagnosis of the disease in the Palestinian territories, and that the actual figures are higher.

Cancer mortality

Cancer mortality rates are measured by the number of deaths of cancer patients per year, per 100,000 residents.⁴³ As of 2012, cancer is the second leading cause of death in the territories controlled by the Palestinian Authority.⁴⁴ The data in the following graph are for 2008.⁴⁵



The graph shows that death from cancer is higher in the Palestinian territories than in Israel. Cancer deaths increased in the West Bank in 2011, as compared to previous years.⁴⁶ In Israel, cancer has been the leading cause of death since the late nineteen nineties, and accounts for about a quarter of all deaths.⁴⁷ It should be noted that a high rate of cancer mortality

⁴³ <http://globocan.iarc.fr/>

⁴⁴ Palestinian Ministry of Health report for the first half of 2012: www.moh.ps/attach/453.pdf, P.8

⁴⁵ <http://globocan.iarc.fr/factsheet.asp> International Agency for Research on Cancer, World Health Organization . 2008 is the last year when an international comparison was made on this issue.

⁴⁶ According to the Palestinian Ministry of Health, cancer mortality rose in 2011 as compared to 2007 and from 10.3% in 2007 to 10.8% in 2010 and to a total of 12.4% 2011: <http://www.moh.ps/attach/440.pdf>,p.41

⁴⁷ Israeli Ministry of Health report, "Leading causes of death in Israel: 2000-2010", February 2013: http://doctorsonly.co.il/wp-content/uploads/2013/03/10032013_leading_causes%20of%20death%20in%20Israel_2010.pdf

indicates a high level of health in a country, as it indicates a reduced mortality from other primary preventable causes, such as complications of diabetes, cardiac diseases, and so forth.

Death rates due to cardiac diseases

Cardiac and coronary diseases are the leading cause of death in the West Bank (22.4% of deaths) while in Israel, heart diseases constitute the second cause of death. The following chart describes the death rates from heart disease per 100,000 persons, comparing men and women in different age groups. The information about the Occupied Territories is based on a Palestinian Ministry of Health report and the information about Israel was calculated by the CBS for this paper, based on the Palestinian data standards.⁴⁸ All figures are for 2011.

Number of deaths from cardiac diseases per 100,000 residents, 2011:

Age group	The West Bank			Israel		
	Men	Women	Total	Men	Women	Total
0-4	0	0.578	0.283	1.228	1.548	1.384
5-19	2.046	0.641	1.359	0.585	0.516	0.552
20-59	37.178	15.16	26.415	16.581	4.369	10.412
60 ומעלה	1177.843	935.053	1043.513	601.39	521.62	557.279
Total	67.468	57.798	62.709	87.342	85.435	86.38

It is evident that in all age groups (excluding 0-4), the rate of mortality from heart diseases is higher in the West Bank than in Israel. However, due to the differences in population structure in the West Bank and in Israel (the population of Israel is older) and in particular, the large proportion of the over-60 age group in Israel (14.5% of the population) and the high rate of mortality in this age group as compared to the smaller proportion

⁴⁸ The figures for the Occupied Territories are from a report by the Palestinian Ministry of Health, 2011, page 55 <http://www.moh.ps/attach/440.pdf> The information about Israel was received by email from the CBS Health Department on 28 Nov. 2013.

of this age group in the West Bank (4.8% of the population), the crude rate of deaths from heart diseases⁴⁹ in Israel is higher than in the West Bank.

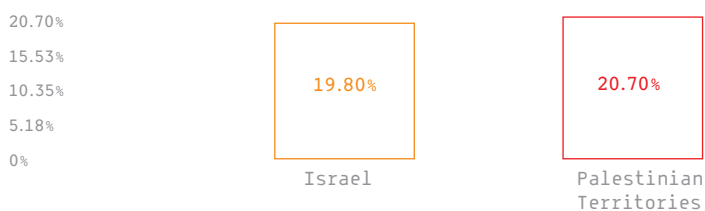
The higher mortality rates in the West Bank in the various age groups could indicate, among other things, lesser access to cardiology health services; this is in contrast with Israel, where a significant drop in mortality from heart diseases occurred as a result of lifestyle changes and improved access to medical technologies.

Cesarean Sections

This metric describes the percentage of C-sections of all deliveries.⁵⁰

RATE OF C-SECTIONS FROM ALL BIRTH (2011)

Israel ■
Palestinian Territories ■



⁴⁹ The crude death rate refers to the total number of deaths in all age groups.

⁵⁰ The figures for the Occupied Territories are from a report by the Palestinian Ministry of Health, 2011, page 169. <http://www.moh.ps/attach/440.pdf>
The figures for Israel are taken from: <http://www.oecd.org/health/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm>

In international comparison:⁵¹

RATE OF C-SECTIONS COMPARED TO OECD COUNTRIES (2011)



It is evident that the rate of C-sections in the Palestinian territories and in Israel is similar, as is their position relative to developed countries. According to the World Health Organization, the desired rate of C-sections is between 5% and 20%, which means that both Israel and the Occupied Territories are within the desired range.

Medical Personnel

The rate of people working in medical professions indicates the capacity of the health system to provide accessible services to patients, the extent of public investment in health infrastructure, and the capacity for long-term planning, due to the relatively long training required in these professions.

⁵¹ OECD data: <http://www.oecd.org/health/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm>;
http://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_PRO

The rate of doctors and specialists

This indicator considers the number of doctors and specialists per 1,000 people.⁵²

RATE OF DOCTORS AND SPECIALISTS PER 1,000 RESIDENTS (2011)

specialists ■
Non-specialist doctors ■



The graph shows that the rate of doctors is 1.6 times higher in Israel than in the Palestinian territories; this is a relatively small gap, and the rate of doctors in the Occupied Territories is not far from the OECD average. However, the rate of specialist doctors in the Occupied Territories is much smaller, about one eighth of the rate in Israel, which indicates an extensive shortage of specialist doctors.

⁵² The data for Israel is taken from: *Personnel in healthcare professions 2011*, page 5: <http://www.health.gov.il/NewsAndEvents/SpokemanMessegas/Documents/62614512.pdf>

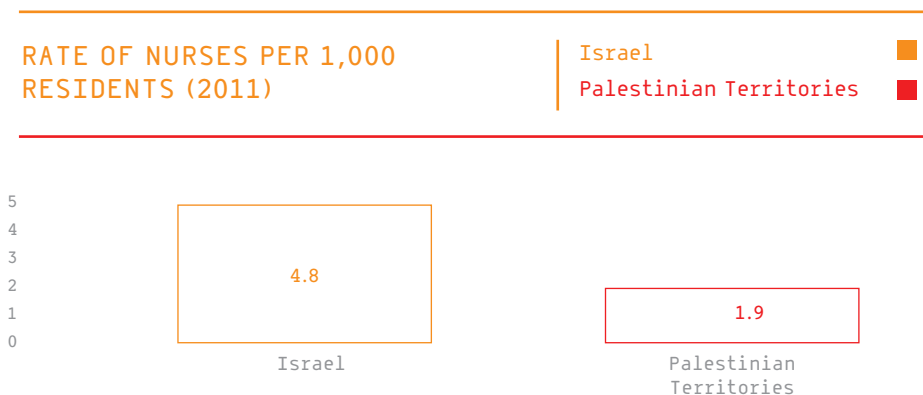
The figures for the Palestinian territories are taken from: *Palestinian Ministry of Health report, 2011*, page 22: <http://www.moh.ps/attach/440.pdf>.

The calculation of the rate of specialists was made based on absolute numbers of specialists as published in the annual report by the Palestinian Ministry of Health, 2011, page 42: <http://www.moh.ps/attach/440.pdf>.

Ministry of Health, Personnel in healthcare professions, 2011, page 5: <http://www.health.gov.il/NewsAndEvents/SpokemanMessegas/Documents/62614512.pdf>

Rate of nurses

The rate of nurses in the population is the number of nurses and midwives per 1,000 residents.⁵³



As the graph shows, the rate of nurses in the Occupied Territories is very low compared to the rate in Israel, which indicates a significant lack of personnel in this field.

Rate of dentists

This metric considers the rate of dentists per 1,000 people.⁵⁴



⁵³ The figures for the Occupied Territories are from a report by the Palestinian Ministry of Health, 2011, page 22: www.moh.ps/attach/440.pdf, and they are very similar to the figures from the World Health Organization, according to which the rate of nurses in the Occupied Territories stands at 1.8 nurses per 1,000 residents: Regional Health Observatory, World Health Organization, <http://rho.emro.who.int/rhodata/?vid=2624>

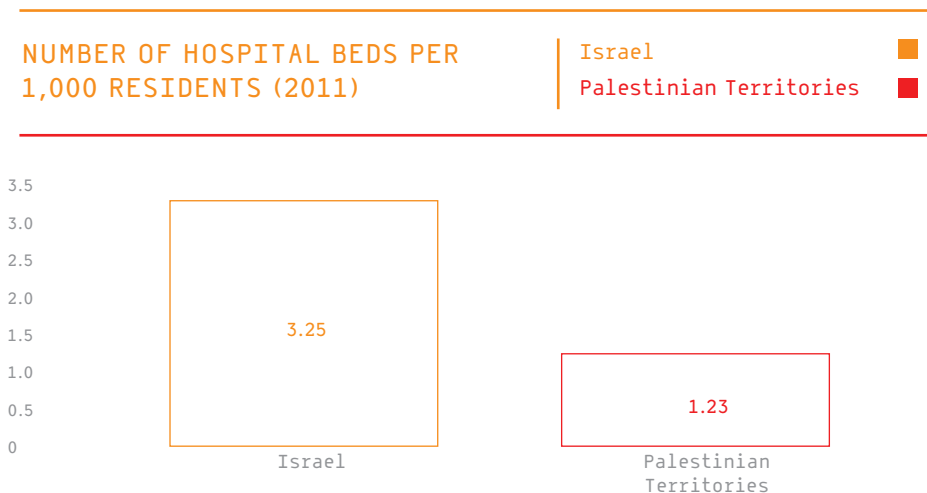
The figures for Israel are taken from: Personnel in healthcare professions 2011: <http://www.health.gov.il/NewsAndEvents/SpokemanMessegges/Documents/62614512.pdf> The figure refers to the rate of nurses up to age 65. The rate of unemployed nurses stands at 5.9 per 1000.

⁵⁴ The figures for the Occupied Territories are taken from a report by the Palestinian Ministry of Health, 2011, page 22: www.moh.ps/attach/440.pdf. The figures for Israel are taken from: Personnel in healthcare professions 2011: <http://www.health.gov.il/NewsAndEvents/SpokemanMessegges/Documents/62614512.pdf>

The rate of dentists in Israel is twice as high as in the Palestinian territories. The full array of data presented above shows that the rates of people working in the medical professions in the Occupied Territories is much lower than their rate inside Israel. The significant gaps between the rates of medical personnel reveal the gaps between the Israeli and Palestinian healthcare systems, and the ability of each system to provide accessible health care to the population it serves.

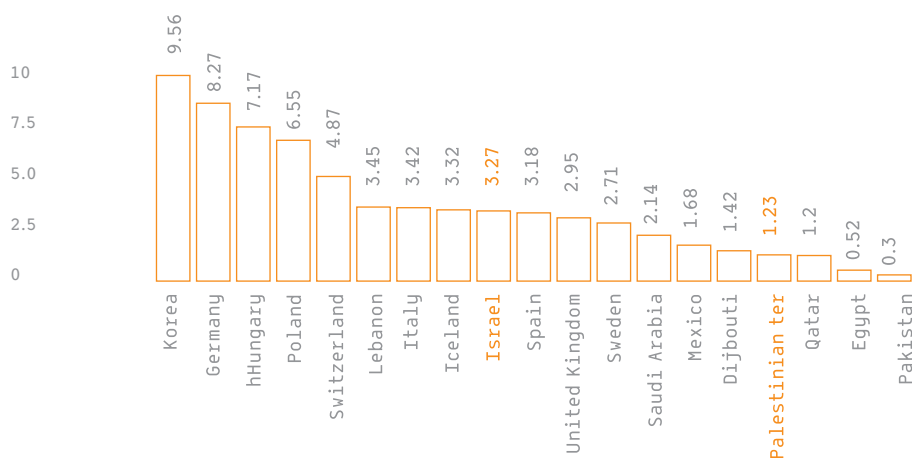
Hospital Beds

This indicator shows the number of hospital beds available per 1,000 people.⁵⁵



⁵⁵ The data for the Occupied Territories is taken from: Palestinian Ministry of Health report, 2011, page 21: <http://www.moh.ps/attach/440.pdf>. The data for Israel is taken from publications by the Israeli Ministry of Health: http://www.health.gov.il/PublicationsFiles/beds_2011.pdf and the Israeli Central Bureau of Statistics: http://www.cbs.gov.il/www/publications/isr_in_n12h.pdf. The calculation was performed in the following manner, based on consultation with the Ministry of Health: out of the total number of hospital beds (Ministry of Health publication, page 6) we subtracted (pp. 13–20, *ibid.*) the total number of beds in nursing institutions (institutions where all beds are for geriatric, nursing, and dementia patients) and divided the result by the size of the population (CBS, p. 5). The above figures aligns with the OECD figures: <http://www.oecd-ilibrary.org/docserver/download/190800051e1t006>.

NUMBER OF HOSPITAL BEDS PER 1,000 RESIDENTS (2011)



The number of hospital beds in Israel is low compared to the OECD average. The number of beds in the Palestinian territories is even lower: 2.7 times lower than in Israel.

Hospital bed occupancy

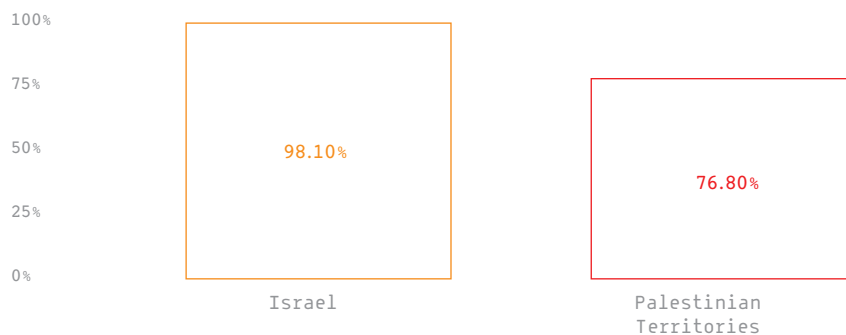
The occupancy rate for hospital beds is measured according to hospitalization days used in practice during a given period, as compared to the potential number of hospitalization days according to the registration certificate of each hospital.⁵⁶ According to the World Health Organization, when occupancy is higher than 85%, the risk of periodic crises involving a failures to provide treatment to all patients requiring it increases significantly.

⁵⁶ The figures for the Palestinian Territories are from a report by the Palestinian Ministry of Health, 2012, page 50: <http://www.moh.ps/attach/502.pdf>. The figures for Israel are taken from: *Israel Statistical Almanac, 2013*, CBS: http://www.cbs.gov.il/reader/shnaton/templ_shnaton.html?num_tab=st06_08&CYear=2013.

The International figures are taken from OECD publications: http://www.oecd-ilibrary.org/search?option1=titleAbstract&option2=&value2=&option3=&value3=&option4=&value4=&option5=&value5=&option6=&value6=&option7=&value7=&option8=&value8=&option9=&value9=&option10=&value10=&option11=&value11=&option12=&value12=&option13=&value13=&option14=&value14=&option15=&value15=&option16=&value16=&option17=&value17=&option21=discontinued&value21=true&option22=excludeKeyTableEditions&value22=true&option18=sort&value18=&form_name=quick&option19=content_type&value19=statistics&value1=BED+OCCUPANCY&x=16&y=13

HOSPITAL BED OCCUPANCY (2011)

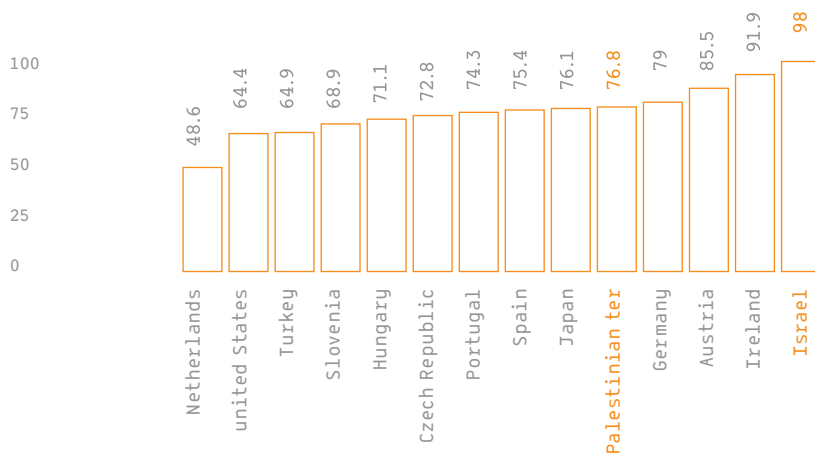
Israel ■
Palestinian Territories ■



The data shows that hospital bed occupancy is higher in Israel than in the Occupied Territories. It is important to note that in the Occupied Territories, many of the hospital beds belong to private, rather than public medical centers.

Hereunder follows an international comparison of occupancy rates:

HOSPITAL BED OCCUPANCY (2011)



The graph shows that hospital bed occupancy in Israel is the highest of all OECD countries and that hospital bed occupancy in the Palestinian territories is equal to the OECD average, which stands at 76.8%.

National Health Expenditure⁵⁷

	Palestinian Territories	Israel
National health expenditure per person (in USD)	248	2,046
National health expenditure as percentage of the GDP	16%	7.7%
Public spending as percentage of the national health expenditure	37%	61%
Rate of out of pocket payments from households for medications and health services of the national health expenditure	37%	27%

The national expenditure on healthcare per person in the Palestinian territories is about one eighth of the Israeli expenditure. The percentage of national health expenditure of the GDP, in contrast, is one of the highest in the world,⁵⁸ and stands at 16%. Several reasons can be suggested for this. First, health is an essential service for which the residents of the Occupied Territories have no choice but to pay, unlike other services that can be defined as less essential. Additionally, as described above (see page 7 in this report), in light of the limited ability of the Palestinian healthcare system to provide appropriate medical care, many patients are referred to healthcare providers outside of the public system, at a very high cost, which constitutes approximately 30% of the Palestinian Ministry of Health's expenditure for treatments every year.⁵⁹

Another prominent fact is that the public expenditure for health in the

⁵⁷ The figures are for 2011.

The figures for Israel are taken from: Central Bureau of Statistics, National Health Expenditure 2011, Press release http://www.cbs.gov.il/reader/newhodaot/hodaa_template.html?hodaa=201208211

The figures for the Palestinian territories are taken from: World Health Organization, Annual Report of the Regional Director, 2011, Country Statistical Profiles, p. 106: http://applications.emro.who.int/docs/RD_Annual_Report_2011_country_statistics_EN_14587.pdf

⁵⁸ <http://apps.who.int/nha/database/DataExplorer.aspx?ws=3&d=1>

⁵⁹ Palestinian Ministry of Health report, 2011.

Occupied Territories constitutes only a relatively small part of the total expenditure for health - 37% - which is low both as compared to Israel and to other countries in the world. This situation is common in developing countries. Over the years, this limited investment of the Palestinian Authority in public services has encouraged the development of a private healthcare system at the expense of the public system.

5.

Israeli Control of the Health of the Palestinian Population of the Occupied Territories

The Economic Dependence of the Palestinian Health System on Israel

The Palestinian Authority's budget relies on a number of sources:

1. Tax funds collected directly from the residents of the Palestinian territories.
2. Funds from donor countries.
3. Funds collected by Israel on products entering the Palestinian territories.

This third item requires a special explanation: under the 1994 Paris Agreements, customs duties and Value Added Tax (V.A.T.) on products entering the Palestinian Authority, and which go through border crossings controlled by Israel, are collected by Israel and conveyed to the Palestinian Authority at predetermined dates. Both Israeli publications and United Nations estimates show that the scope of customs funds Israel transfers to the Palestinian Authority is extensive: According to data from the Coordinator of Government Activities in the Territories (COGAT), funds from customs duties constitute 44% of the budget of the Palestinian Authority⁶⁰ whereas according to United Nations estimates, these funds constitute between 60 and 70%⁶¹ of the Palestinian Authority budget. In either case, this is a significant part of the budget of the Palestinian Authority, which is therefore effectively under Israeli control.

Israel has used this control of tax funds several times in the past, when

⁶⁰ Coordination of Government Activities in the Territories, *The West Bank Economy*: http://www.cogat.idf.il/Sip_Storage/FILES/3/4203.pdf

⁶¹ Report on UNCTAD assistance to the Palestinian people: *Developments in the Economy of the Occupied Palestinian Territory*, United Nations Conference on Trade and Development, September 2011.

it decided to delay transferring the funds in order to put pressure on the Palestinians. Thus, for example, after the Palestinian Authority addressed the United Nations General Assembly in November 2012 with a request to be granted the status of an observer state (which was granted), Israel delayed the transfer of the customs funds to the Palestinian Authority as a punitive measure.⁶² These cases demonstrate that Israel's ability to decide when to transfer and when to hold back such a critical part of the budget of the Palestinian Authority constitutes an enormous source of power, which allows it to control resources invested in many fields, including the healthcare system. Furthermore, the inability to foresee if and when funds will arrive makes it difficult for the Ministry of Health to plan its annual budget appropriately.

The financial dependence of the Palestinian health system on Israel is also expressed by the number of referrals for treatment in Israel. In the absence of advanced equipment, and particularly, of knowledge and expertise that will provide a solution for complex medical problems in fields such as oncology, cardiology, and orthopedics, the Palestinian Authority must refer many patients to external clinics and hospitals, especially in the private Palestinian medical system, as well as to clinics in Egypt, Jordan, and in Israel. In 2010, the cost of referrals to medical care outside the public system amounted to about 30% of the budget of the Palestinian Ministry of Health.⁶³ In 2012, for example, 5,113 patients were referred to Israel at a total cost of over one million shekel.⁶⁴ This means that a significant part of the health budget is routed out of the Palestinian public health system. This situation increases the dependency on Israel, and mostly makes it impossible to develop and establish an independent Palestinian health system that will provide appropriate responses to the needs of the patients. Concurrently, the dwindling of resources in the public system encourages the development of private health services, which fill the vacuum thus formed.

62 "The United Nations approved with a huge majority: Palestine – Observer State", <http://www.ynet.co.il/articles/0,7340,L-4313607,00.html>

63 Palestinian Ministry of Health Annual Report, 2012: <http://www.moh.ps/attach/502.pdf>.

64 The exact amount is NIS 104,243,716. See: Palestinian Ministry of Health Annual Report, 2012: <http://www.moh.ps/attach/502.pdf>.

The Palestinian Pharmaceutical Market as a Captive Market

The pharmaceutical market in the West Bank and in the Gaza Strip is bound by economic agreements with Israel, which allow Israel to control and run it in furtherance of its own interests, at the expense of those of the Palestinians.⁶⁵ This control is expressed in several primary fields:

Blocking import of less expensive pharmaceuticals from Arab countries: Under instructions by the Israeli Ministry of Health, import of pharmaceuticals to the Palestinian territories is limited to medications registered in Israel. Thus, the Ministry of Health has blocked the Palestinian Authority's access to the neighboring Arab markets, which could have provided medications to the Occupied Territories at lower prices. Moreover, a differential pricing system is used by the pharmaceutical industry worldwide, taking into account the socio-economic status of the target population, but the combined customs system of Israel and the Occupied Territories prevents the international pharmaceutical industry from implementing such differential pricing for the Occupied Territories, and thus the Palestinians must purchase medications at "first world" prices.

Limitations on raw material import: Importing raw materials is an almost impossible task for Palestinian manufacturers in light of the serious obstacles put in the way of the transfer of goods and raw materials to the Palestinian territories. Importing raw materials to the Occupied Territories requires authorization from the Israeli Ministry of Health. Israeli manufacturers, in contrast, are not generally required to obtain such an authorization. Furthermore, while the manufacturers in Israel are given such authorizations on an annual basis, Palestinian manufacturers are required to apply for a new authorization for every single shipment. In many cases, Israel declares a raw material as being one that might be used for military operations against it, and places significant limitations on its importation into the Occupied Territories by pharmaceutical companies, even when it is a material regularly used by Israeli companies.

Limitations on the exportation of pharmaceuticals: Export of finished pharmaceuticals is also subject to limitations imposed by Israel. Palestinian exporters are not allowed to export pharmaceuticals in large batches, but only in boxes, which significantly increases the costs of

⁶⁵ The information presented here is based on: *Captive Economy, The Pharmaceutical Industry and the Israeli Occupation, Who Profits*, March 2012.

the export process. Furthermore, Israeli security forces open the boxes for inspection, which may cause damage, since many medications must be refrigerated and must be packaged accordingly. The risk of damage to the pharmaceuticals, along with the high costs, leads to the fact that Palestinian businessmen only export medications via Jordan.

Environmental Damage: In the Gaza Strip, which is under a tight closure, the total Israeli control on the entry and exit of medications from and into the Gaza Strip has created an absurd situation in which medications can enter the Gaza Strip, but not leave it. As a result of this, the responsibility for sequestering all the expired medications in the Gaza Strip is placed with the Gaza authorities, instead of with the Israeli and international pharmaceutical companies. This is a heavy burden, which requires professional solutions, such as toxic waste processing sites. Excessive sequestration causes various forms of damage, such as the pollution of the water resources of the Gaza Strip.

Limitations on Developing the Future Palestinian Medical Professionals

The Training of Medical Students: Two universities in the West Bank have medical schools: Al-Quds University in Abu Dis (Jerusalem) and An-Najah University in Nablus. The clinical trainings for Al-Quds University, where each class numbers about 70 students, take place primarily at hospitals in East Jerusalem, where there are six established hospitals that are considered to be the largest and most advanced of all Palestinian medical institutions. Thus, in order to complete the clinical training, the students must apply for an entry permit to Israel. Every year, about ten percent of the students studying at Al-Quds University are denied entry to Jerusalem by the Civil Administration, and as a result are prevented from completing their studies and joining the ranks of physicians.

Failure to Recognize Medical Degrees: In order to work in East Jerusalem, medical school graduates must undergo Israeli licensing tests. Since 2006, the Israeli Ministry of Health has refused to recognize medical degrees granted by Al-Quds University in Abu Dis for bureaucratic-political reasons: the university is not recognized as an Israeli institution as it falls under the Palestinian Authority rather than the Israel Ministry of Education; on the other hand, the Israeli Ministry of Health refuses to recognize it as a foreign university, because some of its buildings are

located in East Jerusalem. In 2009, the Israeli Ministry of Health allowed some of the graduates to sit the test, but in 2011 it went back to a policy of sweeping refusal to recognize the degrees of Al-Quds graduates. To date, this lack of recognition has prevented some 300 graduates of the university, all of whom are residents of East Jerusalem, from sitting for the medical certification tests in Israel and working in the city, which hurts both the doctors themselves and the effectiveness of the East Jerusalem healthcare system, which suffers from a grave shortage of doctors. The graduates are engaged in a legal and public opinion struggle, in which PHR-IL has taken part as well,⁶⁶ for their right to sit for the qualification tests. Thus far, there have been no results.

Training and Continued Professional Education for Medical Teams: Against the background of the constant innovations and development in the medical world, periodic training and continued education for medical professionals are a vital tool to improve and even maintain the professional level of the healthcare system. As the healthcare system in Israel is much more advanced and varied than the Palestinian one, Palestinian doctors wish to attend trainings and professional education in Israel, just as Israeli doctors do around the world. However, Israel limits the number of Palestinian medical personnel permitted to enter it for training and work purposes to 200 individuals only.⁶⁷ Thus, Israel blocks the flow of the most readily available conduit of medical knowledge available to the residents of the Occupied Territories.

The situation is even more serious in the Gaza Strip, as Israel mostly does not permit medical teams to leave Gaza for training, not only to Israel, but even to the West Bank. These limitations make it harder for the healthcare system in the Gaza Strip to support a new generation of skilled and trained medical personnel. Moreover, they also make it impossible for the Palestinian healthcare system to develop as a single unit that operates both in Gaza and in the West Bank and provides training and studies for its employees.

Limitations on the Medical Employment Market: Quotas for

⁶⁶ <http://www.phr.org.il/default.asp?PageID=60&ItemID=1793>

⁶⁷ "Permission Status in Closures" as of 27 March 2013, COGAT, Ministry of Defense. From the "Gisha" website: <http://www.gisha.org/UserFiles/File/LegalDocuments/FOIA-travelcriteria/status/2013/27.03.13.pdf>

Teams Permitted to Work in East Jerusalem

The six Palestinian hospitals in East Jerusalem constitute a highly important medical center for the Palestinian healthcare system. The Al-Makassed hospital, for example, is considered to be one of the best Palestinian hospitals and a leader in the field of tertiary care. Traditionally, most of the medical professionals employed in Al-Makassed and in the other hospitals in East Jerusalem – some two thirds of them – come from the West Bank. In the past, several of them have also come from the Gaza Strip.⁶⁸ In recent years, however, the Civil Administration limits the number of Palestinian medical professionals from the West Bank who are permitted to work in East Jerusalem to about 2,000, and entirely prohibits the entry of medical professionals from the Gaza Strip.⁶⁹ Permits are granted individually, so when one particular employee leaves, the hospital is required to obtain a new permit for the employee who will replace them. Moreover, permits are always granted for a limited duration, usually of 3 to 6 months, after which Israel decides whether or not to renew the permit. The consideration of the applications by the Civil Administration is delayed for many days and even weeks, and the hospitals remain without essential staff while the medical professionals wait for an answer about their entry permit. By setting quotas for Palestinian medical personnel permitted entry into East Jerusalem, Israel makes the full and normal conduct of healthcare at the Palestinian hospitals in Jerusalem impossible. Moreover, the temporary nature of the permits and the staffing gaps when they are denied or postponed negatively impact the stability of the Palestinian healthcare system and its ability to provide appropriate medical services.

Limitations on Patient Mobility

The Palestinian territories are divided into three primary regions: the Gaza Strip, the West Bank, and East Jerusalem. Israel has the power to allow or deny transit of Palestinian residents between those three regions, as well as between the various villages and towns inside those regions, at its whim. The Palestinian healthcare system is therefore divided between these three regions as well. In other words, there are hospitals, clinics, and

⁶⁸ Ibid.

⁶⁹ Ibid.

medical teams in each of these regions, but there is no freedom of movement from region to region and from one medical institution to another. Israeli control of the travel between the regions and Israel's annexation of East Jerusalem create a situation in which the Palestinian Ministry of health cannot administrate all three regions as a single unit.

Every year, an average of 200,000 women, men, and children are required to apply to Israel for a permit to travel between Gaza, the West Bank, and East Jerusalem, so they can receive medical treatment, accompany a relative to treatment, or make sickbed visits.⁷⁰ Filing the application at one of the District Coordination and Liaison (DCL) offices⁷¹ in the West Bank or at the Erez DCL in the Gaza Strip involves a slow and convoluted administrative process which is governed by considerations that are not transparent to the applicants.

Eventually, some 80% of the applications filed are approved and some 20% are denied, or not approved in time.⁷² In other words, every year there are some 40,000 cases where patients, accompanying persons, and visitors from the West Bank or from the Gaza strip are prevented from leaving their region in order to obtain medical care or support ill relatives in another part of Palestine.

Limitations on Ambulance Movement

The limitations Israel imposes on freedom of movement also apply to Palestinian ambulances traveling between the West Bank and East Jerusalem. Every ambulance trip must be coordinated with the Israeli authorities in advance, a process that can take ninety minutes or more and cause a delay that puts patients in danger.⁷³ Furthermore, since Palestinian ambulances

70 Right to Health: Barriers to health access in the Occupied Palestinian Territory, 2011 and 2012, World Health Organization: http://www.emro.who.int/images/stories/palestine/documents/WHO_Access_Report-March_5_2013.pdf

71 DCL: The District Coordination and Liaison administration is a department in the Ministry of Defense's COGAT, is in charge of the liaison between the Israeli government and military and the residents of the Occupied Territories and of the Palestinian Authority.

72 Right to Health: Barriers to health access in the Occupied Palestinian Territory, 2011 and 2012, World Health Organization: http://www.emro.who.int/images/stories/palestine/documents/WHO_Access_Report-March_5_2013.pdf

73 For details see: Miri Weingarten, "Emergency in Waiting: Palestinian Ambulance Drivers' Entry into East Jerusalem," August 2007, PHR-IL; and also: Hadas Ziv,

are not permitted to travel inside Israel, they must work according to a "back to back" procedure, where the patient is transferred from the Palestinian ambulance to an Israeli ambulance, which continues the trip inside Jerusalem. This practice also puts the patient at medical risk, especially in critical conditions such as head or spinal injuries.

Ambulances are also frequently delayed at checkpoints inside the West Bank, where soldiers manning the checkpoints demand special permits, at their own discretion, for transit between different parts of the West Bank. Checkpoint congestion and irregular conduct sometimes lead to unreasonable delays at checkpoints, which have critical healthcare implications. An example of such a case that was handled by Physicians for Human Rights-Israel was the death of Nour Affana, a 14 year old girl from Abu Dis who died in an ambulance that was trying to bring her to a hospital near Bethlehem. The ambulance driver had to go through an Israeli military checkpoint known as "Container", and due to traffic jams formed because of ongoing inspections performed at the checkpoint which made it impossible to get through, he had to wait for about half an hour at the checkpoint entrance. He finally gave up and started to make his way to a hospital in Ramallah, but by the time he arrived there, Nour had died. The physician attending Nour, who had been suffering from a rare blood disorder that causes muscular dystrophy, estimated that although she had been in a critical condition, she could have been saved if she had arrived at the hospital on time.⁷⁴

The Conditioning of Exiting Gaza on a Secret Service (Shin Bet) Interrogation

Every year, several hundred patients applying for a permit to leave the Gaza Strip are summoned for questioning by the Israeli secret service (Shin Bet, or Shabak) as a condition for having their applications for leaving the Gaza Strip to the West Bank or to Israel for medical treatment or for accompanying a patient examined.⁷⁵ According to the World Health

"Evacuating patients in and to Jerusalem by the Palestinian Red Crescent in light of the memorandum of understanding between MDA and the Palestinian Red Crescent," November 2010, PHR-IL.

74 The death of 14 year old Nour Affana in an ambulance, while waiting at a traffic jam in the "Container" checkpoint:
<http://www.phr.org.il/default.asp?PageID=60&ItemID=1890>

75 Ibid.

Organization, 206 Palestinian residents of Gaza were summoned in 2012 for questioning by the Secret Service, of whom 65 were women and 141 were men. Some of them refused to attend the questioning due to fear of the military forces, some due to fear that Hamas authorities would accuse them of collaboration with Israel. Some of the people thus summoned testified that they had been asked to give information that was not relevant to the subject of their application, such as information about their neighbors, friends, and acquaintances. It should be noted that participating in this investigation does not guarantee an entry permit, but the permit will not be granted without attending the investigation and will instead be denied summarily.

Violence and Imprisonment

When analyzing Israel's influence on the health of Palestinians, one cannot ignore the great number of residents of the Occupied Territories who were wounded, injured, or killed by Israeli security forces.

According to data from the Israeli human rights organization B'tselem, since the beginning of the first Intifada (9 December 1987) and until the end of August 2013, 8,386 Palestinians were killed in the Occupied Territories by Israeli security forces.⁷⁶ The number of Israelis killed in that period stands at 1,433.⁷⁷ In addition, between the beginning of the first Intifada and 18 February 2013, 17,354 Palestinians were injured in the Occupied Territories by Israeli forces. The number of Israelis wounded in that period stands at 1,834.⁷⁸ To these figures one should add the victims of "Operation Protective Edge" in the Gaza Strip in the summer of 2014, during which 2,145 Palestinians and 72 Israelis were killed.

Beyond the numbers of the dead and wounded, it is also important to note the number of Palestinians imprisoned by Israel. As of October 2014, 6,500 Palestinian residents of the Occupied Territories are imprisoned in the Israeli prisons.⁷⁹ It is known that some of them are exposed to torture while

⁷⁶ B'tselem figures: http://www.btselem.org/hebrew/statistics/first_intifada_tables.

⁷⁷ Ibid.

⁷⁸ According to data from the United Nations Office of Coordination of Humanitarian Affairs (OCHA) in the Occupied Palestinian Territories.

⁷⁹ Addameer Association, October 2013: <http://www.addameer.org/>.

being imprisoned.⁸⁰ The Palestinians imprisoned in Israel are a population that is not small, and that is particularly vulnerable, and which relies on healthcare services whose quality and availability entirely depend on the Israeli imprisoning authority and on the extent of awareness and willingness of the medical team to act in accordance with the rules of medical ethics and human rights. Imprisonment also has political, social, and economic implications on the condition of Palestinian society in general, due to the importance of the political prisoners and to their social structure: they are mostly men of working age who function as providers for their families and as leaders within their communities.⁸¹ Imprisonment therefore contributes twice to Israel's control of the Palestinians: once by physically holding thousands of people, and again in the manner in which this affects the population as a whole, and the Palestinian resistance to the occupation as well.

80 See: Hadas Ziv, "Torture in Israel and the Involvement of Doctors in Performing It," July 2009, PHR-IL.

81 Excepted from: Maher Telhami, "Breaking the spirit and the body: Palestinian prisoners and detainees in Israel, PHR-IL, 2004.

6.

Summary

The data presented in the report indicate significant gaps between health indicators in Israel and the Palestinian territories. Infant mortality stands at 18.8 per 1000 births in the Palestinian territories, as compared to 3.7 in Israel; maternal deaths stand at 28 per 100,000 births in the Palestinian territories, as compared to 7 in Israel. The rates of infectious diseases such as hepatitis B are also higher in the Occupied Territories than in Israel. Moreover, not only is the life expectancy of the Palestinian residents of the Occupied Territories about ten years lower than in Israel, it is also evident that over the last few years the gap between Israel and the Occupied Territories has not only not shrunk, but actually grown. The Israeli control mechanisms discussed above effectively prevent the Palestinian Ministry of Health from providing full health services to the residents of the Occupied Territories.

The gaps between the Occupied Territories and Israel continue to grow and in contrast to the illusion created by the Oslo Accords, the Israeli mechanisms of control grow only deeper. For years, Physicians for Human Rights-Israel has demanded that Israel bear the responsibility for the health of the Palestinians due its being the occupying force, and by force of the laws of occupation. However, the occupation has long since transitioned from a temporary situation to an ongoing reality - a reality characterized by the colonialist settlement of Israeli citizens in the Occupied Territories, by the creation of facts on the ground involving the use of natural resources and lands, and in recent years, also by way of proposals by government ministers to annex Area C in such a way that will make permanent the Palestinian enclaves that have been formed, and that will prevent any contiguous territory and independent governance. Against this background, the nature and depth of the Israeli responsibility toward the residents of the Occupied Territories must be re-examined. In practice,

two populations live in a single territory under Israeli rule, one of which enjoys excessive privileges. For this reason, we can no longer suffice with merely calling on Israel to assume a certain responsibility; rather, full equality between the two populations must be demanded, without violating the rights of the Palestinians to continue developing a separate health system, which will serve them upon the end of the occupation.

Israel denies its responsibility for the health of the Palestinians and claims that the responsibility lies only with the Palestinian Authority in the West Bank and/or with Hamas in Gaza. Israel's responsibility toward the Palestinian residents is currently limited to its willingness to permit them access to certain medical treatments in Israel, financed by the Palestinian Authority and subject to stringent restrictions in terms of types of treatment and of the granting of entry permits to patients in need of treatment. This minimal responsibility is obviously insufficient, in light of the political reality. Our argument is that as long as Israeli control over the Occupied Territories continues in the manner described above, Israel must assume full responsibility for the health of the Palestinians, and provide them with health services equal to those provided to the citizens of Israel – even if Israel should choose to provide them via the Palestinian Authority. It is the duty of the Palestinian Ministry of Health to provide health services to the population to the best of its ability, but it is Israel's obligation to provide all the services that exceed the ability of the Palestinian Ministry of Health, so that a Palestinian child and an Israeli child, who may sometimes live only a few hundred yards apart, may receive equitable medical care.

Reality today is that Israeli citizens currently live in the West Bank and enjoy civil rights, Israeli infrastructure, and services provided by the Israeli healthcare system, alongside Palestinians who must make due with the limited services provided to them by the Palestinian Authority. This is the reality of separation based on national-ethnic affiliation, where the over-privileged group uses legislation and mechanisms of separation and oppression to retain its privileges.

The comparison between Israel and the Occupied Territories based on socio-economic indicators cannot be perceived as a comparison between two separate countries. The Palestinian territories do not have the status of a state but rather, merely the status of a "non-member observer state" of the U.N., which is recognized by part of the international community.

More importantly, the Palestinian Authority and Hamas, the two political entities that control the West Bank and the Gaza Strip, have only limited power and limited sovereignty, while Israel holds decisive influence and control over their economy and society.

There are those who will object to our demand for equality in health services, as they will consider it a call for the annexation of the Occupied Territories to Israel. We will therefore stress that our position entirely rejects the idea of annexation, through the understanding that such an action would only deepen Israeli control over the Palestinians. The demand for equality does not express an aspiration to make permanent Israel's control of the Occupied Territories and it also does not constitute support of any solution - be it of two states, one state, or any other solution. This is a demand that derives from the understanding that as long as Israeli control continues - as it has been ongoing for nearly half a century - Israel must provide equitable services to all persons living under its control, including the Palestinian residents of the Occupied Territories.