Suggested Issues for Adoption of List of Issues Prior to Reporting, ahead of Israel's Review at the 66th Session of the Committee on Economic Social and Cultural Rights

Submitted by: Physicians for Human Rights Israel
http://www.phr.org.il/en

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About Physicians for Human Rights Israel (PHRI):
PHRI stands at the forefront of the struggle for human rights—the right to health in particular—in Israel and the Occupied Palestinian Territory. Founded in 1988 by a group of Israeli physicians led by Dr. Ruchama Marton, PHRI works to promote a just society where the right to health is granted equally to all people under Israel's responsibility.

1. Issues Covered in this Report under Article 12:

Unsafe Clinical Trials
Medical Permit Denials and their Impact on Female Patients
Lack of Consideration of Gender Implications of Medical Permit Denials
Denial of Treatment and Inadequate Provision of Medical Care to Asylum Seekers and Torture Victims
Discriminatory Application of Regulations Impacting Palestinian Residents who Hold Stay Permits
Inadequate Provision of Medical Care to Prisoners
Insufficient investment in medical system impacting medical care
Disadvantaged Communities Impacted by Unequal Investment in Health Services
Lack of Transparency in Budgetary Allocation to Peripheral Areas
Unclear Mandate for Ministry of Health in Addressing Racism

Unsafe Clinical Trials

1. A legal loophole exists regarding human trials that are not conducted in hospitals, a definition which excludes soldiers, prisons, private corporations and others.[1] Moreover, clinical trials are not regulated in primary legislation but by the outdated Public Health Ordinance 1940 and the 1980 Public Health Regulations. As a result, trials take place despite a lack of monitoring and control mechanisms. This situation enabled the unethical trial (1998-2006) on hundreds of soldiers for a vaccination for anthrax.[2]

2. Different legislation proposals to rectify this dangerous situation have been discussed in the Knesset since 2007.[3] Although the government notified it wants to turn one proposal by a Member of Knesset into government-initiated legislation, the Ministry of Health (MOH) is yet to

[1] Under customary international law everyone has the right to health and integrity of their body, placing a severe prohibition of medical experiments, except in cases of informed consent.
[2] Sfard, Michael, 2016. Anthrax Experiment - Omer 2 - Failures in Legal Regulation. https://goo.gl/uNA9iR
[3] This issue was raised in various Committees since 2007 and legislation was proposed in June 2016.

provided its input, thereby blocking any development. This footdragging has received intense criticism in Knesset discussions.

3. List of Issues Prior to Reporting:

- *Steps taken by the MOH to give input on proposed legislation and support regulation of all human trials in primary legislation.*
- *Steps taken by the Israeli authorities to temporarily ban unregulated human trials.*

Medical Permit Denials and their Impact on Female Cancer Patients

4. When the healthcare needs of Palestinian patients in the West Bank and Gaza extend beyond that which local institutions can provide, they must leave their local areas to receive treatment elsewhere. In order to cross or enter Israel, they must receive a permit from the Coordinator of Government Activities in the Territories (COGAT) and Israeli Security Agency (ISA). The majority of patients those seeking PHRI intervention with permit refusals or delays come from Gaza. PHRI also collects data on trends regarding these requests for assistance.

5. PHRI observations from recent years reflect troubling trends regarding denials of exit permits, confirmed by statistics collected by the World Health Organization (WHO). In 2012, 92% of patients from Gaza received a permit in time for their hospital appointment,[4] a figure that went down to 54% in 2017, the lowest since 2006[5]. 2018 has seen only a small rise in permits given.[6]

6. Permit denials denials come against a background of Gaza's deteriorating healthcare system, leaving in 2017 nearly 16,000 patients needing to exit the Strip for treatment.

7. In Gaza, cancer accounts for 1 in 4 patient referrals outside the Strip[7]. Radiotherapy treatment, including radioiodine treatments for thyroid cancer, is unavailable and there is a lack of chemotherapy drugs. PET CT and other diagnostic tests are also lacking. Shortage of medical equipment, combined with electricity cuts, have reduced the number of tumor removals.

8. Since 2017, PHRI has assisted over 100 female cancer patients who were denied permits. The need to acquire a new permit for every appointment means that care is not systematic, and chances of recovery are reduced compared to regular access to healthcare. In 2017, the WHO reported that 54 patients died while waiting to receive security permits.[8]

9. Only after media exposure and outreach to COGAT from organizations such as "1 out of 9" and the "Israel Cancer Association" were their permits reversed, with a 100% success rate in

[4] World Health Organization, Right to Health: Barriers to health access in the occupied Palestinian territory, 2011 and 2012, p. 13.
[5] World Health Organization, Right to Health: Crossing barriers to access health in the occupied Palestinian territory 2017, p. 21. https://goo.gl/SqdB6T
[6] See WHO monthly reports on referral of patients from the Gaza Strip. https://goo.gl/Sm9mmN
[7] WHO Report 2017, Ibid,
[8] WHO Monthly Report, December 2017. https://goo.gl/GmdFbn

reversing permit decisions between the months of February to June 2018. This indicates arbitrary reasons for the initial response of the Israeli authorities.

10. This success was short lived. From May 2017 onwards, 13 patients reached out to PHRI and al Mezan, a Gaza based Palestinian human rights organization, after they were denied permits on the basis of a new criterion, “family proximity to Hamas”. According to statistics provided by the Israeli Ministry of Defense in response to a Freedom of Information Act request by Gisha, the Legal Center for Freedom of Movement, in the first three months of 2018 over 800 permit requests from Gaza residents were denied on the grounds “first-degree relative is a Hamas operative”, compared to 21 in all of 2017.[9] After repeated appeals to COGAT that had little impact, PHRI, together with other human rights organizations, contested the permit refusals for 5 female cancer patients in the High Court of Justice. In August 2018 the HCJ ruled that Israel cannot apply the Cabinet’s collective punishment to this patient grouping.

11. From PHRI’s caseload, the ruling has not affected the ability of female cancer patients to access treatment. Since the ruling, several women with cancer have reached out to PHRI and other human rights organizations after their permit was denied for different reasons, including one patient who had previously been denied on the basis of “family proximity to Hamas”.

Lack of Consideration of Gender Implications of Medical Permit Denials

12. According to a response to a Freedom of Information request by PHRI received in October 2018 relating to “family proximity to Hamas”, in 2017 most of the requests refused were those of women. As of October 2018 the number of women refused according to this criterion doubled the number of men, namely 608, compared to 361 men.[10]

13. Another criterion, whose use increased in 2018, also demonstrates the impact on women. In 2018, five Gazan patients reached out to PHRI after their permits were refused and conditioned on their ability to return family members “illegally” residing in the West Bank back to Gaza. COGAT further claimed that, if these patients receive exit permits - they would use access to medical care to move their residence to the West Bank. This aforementioned claim of “illegality” is based on a stipulation in the Oslo Accords that gives Israel the power to approve or reject any changes the Palestinian Authority makes in its population registry.

14. By October 2018, 464 exit permits were denied on the basis of this claim, compared to 367 in the whole of 2017, according to figures provided by the Israeli Ministry of Defense in response to a freedom of information requested by PHRI - an 8% increase. A significant proportion of these denials impact women, 55% in 2017 and 43% in 2018. Palestinians who move to the West Bank from Gaza do so primarily for economic reasons to earn money for their families, primarily men, and thereby this policy punishes women for the actions of men.

[9] Letter from COGAT to Gisha, on file with Gisha.
[10] Letter from COGAT to PHRI (5 November 2018), on file with PHRI.

15. Although there is no specific policy to harm women, the Israeli authorities do not take into account the gender implications of the policies implemented. Israel has signed Resolution 1325, which ensures protection of women in times of conflict and calls on States to adopt a gender perspective and assess the unique needs of women.

16. List of Issues Prior to Reporting:

- *Steps taken to abolish the current/existing exit permit mechanism and allow all Palestinian inhabitants in need of medical treatment and their escorts access and free passage to the best medical treatment available to them, without any delay.*
- *Steps taken to protect the civilian population in the Gaza strip from being subjected to collective punishment*[11]
- *Steps taken implement UN resolution 1325, which Israel has signed, including mapping the impact of permit policies on women specifically.*

Denial of Treatment and Inadequate Provision of Medical Care to Asylum Seekers and Torture Victims

17. An estimated 35,000 African asylum seekers, mostly Eritreans and Sudanese, currently live in Israel. The GOI considers this group as “infiltrators” and denies them civil status or the right to a fair asylum procedure that would grant them refugee status.[12] In so doing it also deprives them of access to public healthcare services, except in medical emergencies.[13] They are thus forced to rely on civil society organizations for primary medical treatment as well as on the very few and limited services that are funded by the MOH.[14]

18. Severe medical conditions, including oncology and cardiology patients, as well as those needing surgery, do not receive the appropriate response. These medical needs do not fall under the definition of medical emergencies, even though denial of treatment may result in irreversible damage to their health. In the absence of health insurance, these patients must await a deterioration in their condition to be eligible for emergency treatment.

19. An agreement between the MoH and the Meuhedet MOH in 2001, allowed all status less minors, regardless of their parents' visa status, to access medical treatment. In September 2018 the MoH limited the existing insurance agreement to children of asylum seekers and migrant workers with valid visas. As a result, several thousand children remain without proper access to medical treatment, even if they were born and raised in Israel.[15] To receive medical treatment, these children will have to wait until their condition deteriorates to become eligible for life-saving treatment in hospitals.

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[11] A similar recommendation was made by the Special Rapporteurs on Health, Torture, in August 2018.

[12] Israel grants Eritrean and Sudanese asylum seekers “group protection” and does not deport them to their country of origin.Israel has ratified the Refugee Convention but thus far it has accorded refugee status to only 9 Eritreans and 2 Sudanese.

[13] Patient's Rights Law (1996). https://www.nevo.co.il/law_html/Law01/133_001.htm (Hebrew).

[14] Zoe Gutzeit. Painful Exclusion. November 2017. https://goo.gl/PraRnb

[15] PHRI has, since September 2018, received over 20 requests from parents who were denied enrollment to this insurance, including parents of newborns.

20. Approximately 4,000 of these asylum seekers are survivors of Sinai torture camps. Israel recognized approximately 500 of them as human trafficking victims, granting limited treatment.[16]

21. The majority of Sinai victims remain unrecognized and thus receive no specialized medical, physical, or mental health support. Their trauma is left unattended for, even when severe levels of depression, anxiety, and PTSD symptoms are clearly present.[17]

22. In the past year the Ministry of Justice has launched a mapping project to identify the needs of those among the Sinai victims who were not recognized as trafficking victims and who are particularly vulnerable. PHRI was recently informed that despite previous declarations, this project will not lead to the establishment of a mechanism to identify and provide adequate medical and rehabilitation services to Sinai torture victims. Rather, pending an official government decision, it may only provide a humanitarian response to very few, in order to relieve the Government's burden of fully carrying out its responsibilities.

23. The Gesher Clinic, the only clinic funded by the MOH that provides mental healthcare for asylum seekers, is under budgeted. With a waitlist of over 200 patients, it is unable to accept patients who suffer from PTSD symptoms and limits itself only to the very acute cases, e.g., cases of psychosis. The MOH has publicly affirmed that it is working to expand mental healthcare services to this community, but the exact nature of such expansion remains unclear.

24. The GOI recognized its obligation to safeguard torture survivors by its 1991 ratification of the UN Convention Against Torture and other Cruel, Inhuman, or Degrading Treatment or Punishment (UNCAT). Article 14 states that State parties must ensure aid and rehabilitation to victims of acts of torture. Paragraph 15 of General Comment No. 3 highlights the duty of State parties to asylum seekers and refugees.[18] The GOI does not abide by these obligations.[19]

25. List of Issues Prior to Reporting:

- *Steps taken to apply the National Health Insurance Act or an equally comprehensive mechanism to all asylum seekers so that they receive access to healthcare services.*
- *Steps taken to ensure that all status-less minors receive access to medical treatment.*

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[16] Recognized trafficking victims in Israel are eligible for a year-long stay at a designated shelter, where they receive medical, psychological, and psychosocial support. Israel also grants them a B/1 Visa (a work permit) for that entire year. Once they have completed the year in the shelter, they are either sent back to their country of origin for further after-care, or, in case they cannot be deported, they remain in Israel but without a B/1 visa and no access to further medical care. Some receive further support in a designated day-center operated by MESILA, the Tel Aviv municipality welfare center for the foreign community.

[17] Zoe Gutzeit 2016. Not Passive Victims: Towards the Rehabilitation of the Sinai Torture Survivors in Israel. https://goo.gl/eEC4x2

[18] Specifically, it details the obligations of State Parties to torture survivors, including providing a means for redress and rehabilitation services. These include providing access to rehabilitation programs as soon as possible following an assessment by qualified independent medical professionals and adopting a long-term, integrated approach and ensuring that specialist services for victims of torture or ill-treatment are available, appropriate and readily accessible.

[19] The recent List of Issues published by the UN Committee Against Torture prior to Israel's sixth report also raised the lack of services provided to torture victims. https://goo.gl/9YAGtJ

- *Steps taken to expand psycho-social, psychological, psychiatric and medical assistance to refugees and those exposed to torture, including those living outside of Tel Aviv-Yafo.*
- *Steps taken to ensure that procedures are in place to identify as early as possible all victims of torture among asylum seekers and that, when signs of torture or traumatization have been detected, victims have immediate access to specialized medical and psychosocial services.*
- *Steps taken to expand and adapt the services provided to recognized victims of trafficking and slavery so that they suit the needs and living conditions of those victims who cannot be transferred to their country of origin following the year-long stay at the rehabilitation-shelter.*

Discriminatory Application of Regulations for Palestinian Residents who Hold Stay Permits[20]

26. Palestinians married to Israeli citizens and residents are systematically discriminated against by regulations published in 2016 governing the application of the National Health Insurance Act to this grouping.

27. The 2003 "temporary directive" to the Citizenship Law prevented the roughly 8,000 Palestinians who are married to Israeli citizens and residents from becoming Israeli residents through the regular family reunification procedures, consequently also denying them access to health and welfare services in Israel. A petition by PHRI and others in 2009 resulted, after years of discussions, in the application of the National Health Insurance Act to this group.

28. Initially seen as a huge achievement, these regulations impose on those who are eligible financial obligations without providing exemptions and discounts to those in need. As per these regulations, Palestinians married to citizens must submit a payment of 6 months in arrears to health funds, while those married to residents must submit a payment of 27 months in arrears, on top of the monthly 285 NIS fee. These retrospective payments amount to 1,710 NIS and 7,695 NIS respectively, indicating discriminatory political considerations in the differential treatment of citizens and residents. Moreover, failing to meet these demands results in postponement of eligibility to medical treatment and leaves many of them with no access to public healthcare. PHRI and the Jerusalem-based St. Yves Society have appealed to the High Court of Justice in 2017. Recently, the court has issued an order nisi demanding that Israeli authorities explain why there are no financial discounts for these families and the reasoning behind the differential demands from those married to citizens and those married to residents.

29. *List of Issues Prior to reporting:*

- *Steps taken to revise the regulations governing the application of the National Health Insurance Act to those that fall under the Citizenship Law, enabling this group access to*

[20] In its Fourth Periodic Report to the Committee, Israel addresses this issue claiming that Israel has "extended health coverage" to this grouping. Critically, it notes that only "2,716 permit holders joined an HMO health insurance plan" (p.40), i.e. approximately over 5,000 permit holders have not been able to join such a plan due to the financial obstacles we outline.

public health services by cutting waiting periods and through the implementation of discounts and exemptions mechanisms for families unable to pay the full price.

Inadequate Provision of Medical Care to Prisoners

30. The 1994 National Health Law does not apply to those entitled to receive health services under another law. Yet Prison Law 5732-1971, which the Israeli Prison Service (IPS) uses as the legal basis for its' sole provision of health services, does not address critical healthcare issues for prisoners, such as the treatments available or possible sources of supervision over this health system. This legal loophole impacts the health services in various ways.

31. The placement of health system under the IPS means that there is no supervision from medical bodies such as the MOH and the Israel Medical Association - organizations that have the power to supervise and demand certain professional standards. This leads to problems in availability, access to and quality of treatment, as well as the entry of non-medical factors, including economic ones, on the provision of health, as well as ethical conflicts as a result of dual loyalty. The reduced quality of care provided is especially critical as the prison population in general suffers from greater ill-health than the general population.

32. Primary care is provided to prisoners by prison doctors and emergency medical technicians (EMTs) in clinics inside each prison. Emergency care and specialized treatment is provided primarily through hospital*s or* through various visits of external specialists.[21]Committees established by both the MOH and the Ministry of Public Security to review prison healthcare have repeatedly pointed out the need for further training of existing prison medical personnel. A significant proportion of IPS doctors are General Practitioners who have undergone no specializations and have no prior training vis a vis prison populations. Meanwhile, no nurses are available and prison authorities rely on EMTs. The latter, who effectively manage the prison clinic, act as clinic assistants, do patient-screening, order medications and undertake responsibility for the prisoner's health during the doctors' out of office hours and responding to emergency medical situations, do not have the necessary training for their position.[22]

33. IPS doctors, being directly employed by the prison services, are often in a state of conflict between the interests of their employers and their professional and ethical obligations toward their patients. This finds expression in various situations, including, for example, the role of prison doctors in "rubber stamping" solitary confinement.[23]

34. The above impedes proper treatment of prisoners. As an illustration, the IPS has only identified 450 carriers of Hepatitis C among the general prisoner population that is around 16,500, and only treated 30 of these this far.[24] This despite guidelines - of local medical bodies

[21] This includes, e.g. the visits of external specialists to the IPS Medical Center (known as Marash)
[22] Their training lasts up to 3 months, as compared to a paramedic, whose training in various academic frameworks is more than a year.
[23] Ola Shtiwi 2016. Politics of Punishment: Solitary confinement of prisoners & detainees in Israeli prisons. https://goo.gl/rfZwKa
[24] Michaeli, Niv, IPS Failures in Diagnosis and Treatment of Inmates with Hepatitis C, July 2017 https://goo.gl/hhtnAe

such as the Family Physicians Association and international bodies such as the WHO - for a national early-detection test for at risk populations and despite high percentage of at-risk groupings within the prisoner population.[25] In addition, improper treatment can be seen in: waiting times for medical examinations in public hospitals that are, according to one official source, 7 - 20 times the waiting time in the public health system[26] and improper medical follow up, including non-performance or partial performance of vital examinations.

35. These failings are enabled and compounded by a lack of external oversight mechanisms with the necessary tools to identify and address shortcomings of the medical services provided by the IPS, a criticism repeated in various committees reviewing these issues. The only channel of complaint with medical authority available to prisoners is the Commissioner for Public Complaints at the MOH, yet prisoners are largely unaware of this option and lengthy processing time renders it unsuitable for the immediate health needs of prisoners. The Commissioner does not carry out in-depth examinations and structural (as opposed to case by case) analysis. Indeed, a Freedom of Information request by PHRI revealed that between December 2016 - July 2018, only 24 complaints by prisoners were received, of which 18 were sent by PHRI. In recent years, the lack of appropriate supervision by health authorities has led the Israeli Medical Association to argue that "the IPS must be subject to the supervision mechanisms of the Ministry of Health" as the current mechanism is insufficient and cannot protect the health rights of prisoners, while various committees also noted the need for additional expert supervision. Supervision mechanisms under the Ministry of Public Security, which is directly responsible for the IPS are similarly inadequate. The Ministry has no expertise in medical care and the treatment of individual complaints is carried out by only one officer with no background in health.

36. Since 2002, various ministerial committees, as well as the public defender's office, suggested changes to the current prison health system. From their suggestions, only 1 suggestion was implemented fully by the IPS.[27]

37. List of Issues Prior to Reporting:

- *Steps taken to apply the standards of the public medical system applied to the IPS, such as adequate training, waiting times and lack of dual loyalty, including through transferring the responsibility of prisoner health care from the IPS a national civil authority.*
- *Steps taken by the Ministry of Public Security, under whom the IPS operates, as well as the Ministry of Health, to ensure develop adequate supervision mechanisms of the health system within Israeli prisons.*
- *Steps taken by the MOH to implement the National Health Insurance Law, bearing in mind existing legal loopholes, to ensure greater integration of the prison system within*

[25] Ibid.

[26] In 2010, the IPS Chief Superintendent noted this in an interview with the IPS magazine "Seeing the Prisons Service" in 2010. On file with PHRI.

[27] The computerisation of medical records, suggested by the 2003 Israeli Committee was fully implemented. The recommendation of bringing in specialist doctors by the same Committee was only somewhat implemented due geographical divergences between prisons.

the civilian healthcare system, including in terms of manpower and supervision for standard of care.

Insufficient investment in medical system impacting medical care

38. Over the past decades, a lack of government investment in Israel's health system has resulted in a deterioration in critical indicators of medical care and increased inequalities in the provision of care. Between 2000 and 2017, the percentage of current national expenditure on health out of Israel's GDP increased only 0.4%, compared with an OECD average of 1.7%.[28] This stagnation in the healthcare budget is seen, for example, in the amount and use of critical medical equipment, such as MRI's, which is one of the lowest in the OECD, with 4.9 per million in Israel, compared to a 15.8 average in the OECD. A lack of medical personnel is reflected in waiting times, with, for example, a median waiting time of 31 days for an endocrinologist in 2010 and 90 days in 2018.[29] The lack of medical personnel and overload on the medical system has a direct impact on the well-being of patients, with hospital-acquired infections becoming the third most common cause of death in 2015, resulting in a mortality rate of over 40 per 100,000.[30]

39. The lack of sufficient public expenditure on health has been supplemented by growing private expenditure, with the burden placed on the citizen. There has been a significant growth in supplementary insurance policies,[31] funded by the private citizen, from an expenditure of 1.6 billion shekels in 2005 to 4.6 billion in 2017.[32] According to the 2017 data of the Israel Central Bureau of Statistics, there was an increase of 7% in expenses for private health insurance and 2% in expenses for supplementary insurance. This enables quality medical care to those who can afford it, in contradiction to the intention of the 1994 National health Insurance Law, which determined that health services will be based on principle of equality. In 2016, 77% of the population had supplementary insurance coverage, yet only 58% of the population in the periphery.[33]

Disadvantaged communities impacted by unequal investment in health services

40. The impact of the lack of government investment is seen most strongly in peripheral areas, namely the North and South where most of the Bedouin and Palestinian-Israeli populations live. Steps taken to address the issue are mainly on the level of public declarations, with little transparency as to the actual investment of resources.

41. Historically, investment in the health system in the center of Israel has been prioritized over the periphery. For example, the South of Israel, with 1.24 million residents, has 1,938 hospital

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[28] Central Bureau of Statistics, August 2018 (Hebrew).https://goo.gl/R27HwP, p.5
[29] Some, therefore, wait significantly longer times. https://www.ynet.co.il/articles/0,7340,L-5254370,00.htm/
[30] In comparison, Greece, which has the second highest hospital-acquired infection rate in the OECD, has 24 deaths per 100,000, as per 2017 data of the Central Bureau of Statistics, (Hebrew) https://goo.gl/R27HwP, p.8.
[31] These are private insurance arrangement operated by the Health Maintenance Organizations (HMO).
[32] Central Bureau of Statistics, p. 2.
[33] MOH Committee for Examination of the Supplementary Health Service Plans of the HMOs, Steering Committee No. 1 - Background on the activities of the Supplementary Health Service Plans, page 19. https://goo.gl/SwxxHV

beds, while the Tel Aviv district, with 1.39 million inhabitants, has 3,373 hospital beds.[34] According to MOH figures, the South has 52 rehabilitation beds, compared to 267 in Tel Aviv.[35][36] Lack of infrastructure causes delays in treatments and requires traveling significant distances for hospital admission, with concomitant family separation, impeding the recovery process.

Lack of transparency in budgetary allocation to peripheral areas

42. At the end of 2010, the MOH amended the formula that determines the budget that the HMO's receive so that it will include an additional budget for those live away from population centers in order to better cover the investment and expenses of the HMOs. However, in light of growing gaps between the center and the periphery, it is unclear whether these funds were actually spent in pursuit of their stated goal.

43. A request by PHRI and others in August 2017 for specific details on this budgetary expenditure has been ignored, with the MOH responding that they do not have these details and that we must appeal to the HMO's. In response to Freedom of Information requests by PHRI, these, however, were unwilling to provide the necessary info, with 2 out of the 4 not responding and 1 refusing to provide the information requested due to claims of "trade secrets".[37]

Unclear Mandate for Ministry of Health in Addressing Racism

44. In 2018, The MOH's Committee on the Elimination of Racism, DIscrimination and Exclusion officially acknowledged the presence of racism in the health system.[38] The Committee published a report with recommendations, including further investigation of areas where racism critically impacted health, such as the abduction of Yemenite children in the 1950's and the separation of women in maternity wards according to ethnic background. Although this is an important first step, no deadlines have been set and the mandate of the MOH in investigating and ensuring accountability is unclear.

45. List of Issues Prior to Reporting

- *Steps taken to prevent further deterioration of the health system through increasing budgetary allocation to the public healthcare sector*
- *Steps taken by the Ministry of Health to close gaps in healthcare provision in peripheral areas, including efforts to be transparent regarding these initiatives.*
- *Steps taken by the Israeli authorities to give MOH a mandate to investigate racism in health system, including providing access to information and a range of sanctions to ensure accountability*

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[34] MOH publication, Hospital Beds and Licencing, January 2018 (Hebrew). https://goo.gl/8WBNsY, p.8

[35] See MOH publication, Hospital Beds and Licencing, January 2018 (Hebrew). https://goo.gl/8WBNsY, p.15.

[36] Following a petition to the High Court of Justice by PHRI and other organizations in 2016, the MOH committed to increasing the overall number of beds across Israel, with priority for North and South. However, in their response, it was clear that these changes will still leave significant gaps between the periphery and the center.

[37] Letter from Maccabi to PHRI (13 May 2018), on file with PHRI.

[38] MOH report "Promoting Equality in Health through the Eradication of Racism, Discrimination and Exclusion in the Health Care System", August 2018.