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Original Article

Institutional Mechanisms Sustaining Fragmentation of Interdisciplinary Collaboration in Fragile Health Systems: Evidence From Palestine

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Abstract

Background: Although interdisciplinary collaboration (IDC) is widely promoted in health policy, little is known about the institutional mechanisms that may sustain fragmentation in fragile and conflict affected health systems. This study examines these mechanisms using Palestine as a case study.

Methods: Applying the Walt and Gilson Policy Triangle, this documentary health policy analysis systematically examined five Palestinian national policy and regulatory documents, along with six international frameworks and four comparator-country documents from 2004 to 2025 (search conducted January–March 2025). Stakeholder mapping of 11 actor groups assessed power, interests, and reform feasibility inferred from documentary evidence rather than direct stakeholder engagement. Comparative analysis of four comparator-country documents (Canada, the United Kingdom, Australia, and Jordan) identified transferable policy mechanisms for illustrative comparison rather than formal comparative evaluation.

Results: Analysis reveals patterns consistent with institutional fragmentation across all eight policy domains. Of the five Palestinian national documents, none explicitly mention IDC; across the full 15 document corpus, only 2 documents (13.3%) explicitly mention IDC, and 9 documents (60%) lack any relevant provisions. The findings suggest three institutional mechanisms that appear to sustain persistent policy fragmentation: (1) disciplinary path dependency, whereby historical governance arrangements reproduce siloed structures; (2) donor aligned institutionalisation, where vertical funding mechanisms reinforce professional divisions; and (3) fragmented sovereignty constraint, whereby political separation between West Bank and Gaza precludes unified policy implementation. These mechanisms are presented as the author's analytical interpretation of documentary patterns rather than established causal findings.

Conclusion: The findings suggest that fragmentation may represent a structurally embedded feature of the current policy architecture rather than an isolated implementation problem. The evidence supports further investigation of a phased reform strategy targeting accreditation standards, interprofessional education (IPE), and governance mechanisms as a potentially realistic pathway. The mechanisms identified warrant further testing for transferability to other fragile health systems.

Keywords: Interdisciplinary Collaboration, Health Policy Analysis, Institutional Fragmentation, Conflict-Affected Settings, Palestine, Policy Mechanisms

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Background

Although interdisciplinary collaboration (IDC) is widely recognised as essential for safe, effective, and efficient healthcare delivery, its implementation in fragile health systems remains poorly understood. Fragile health systems, characterised by weak governance, limited institutional capacity, resource constraints, and vulnerability to shocks, are particularly susceptible to fragmentation mechanisms that undermine coherent policy implementation and service delivery.[1,2] In such settings, the absence of strong integrative governance structures allows disciplinary, institutional, and political divisions to persist, often with serious consequences for patient safety and health outcomes.[3,4]

Healthcare fragmentation produces care discontinuities that harm patients and waste resources. Evidence from high-income settings suggests that preventable errors attributable to poor coordination consume a substantial proportion of health expenditure, a burden that resource-constrained settings can still less afford.[5] IDC is consistently associated with improved patient safety, reduced hospital length of stay, better chronic disease management, and enhanced professional satisfaction.[6,7] Recent systematic reviews confirm that interdisciplinary team-based care significantly improves outcomes for chronically ill patients, including better glycemic control, reduced blood pressure, and improved quality of life.[8]

The Palestinian health system operates under prolonged political fragmentation, recurrent conflict, and chronic fiscal constraints, all hallmarks of a fragile health system.[9] Laboratory medicine, nursing, and rehabilitation services are clinically interdependent, yet they function within separate regulatory,

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Key Messages

Implications for policy makers

- Fragmentation appears to be structurally sustained through three mechanisms: disciplinary path dependency, donor aligned institutionalisation, and fragmented sovereignty constraint. Policy interventions may need to address these mechanisms directly.
- Accreditation standards offer an administratively efficient lever for embedding interdisciplinary collaboration (IDC) without requiring primary legislation.
- Financing reform could transition from project specific vertical funding toward models that incentivise integrative governance infrastructure.
- Governance structures may need to move beyond discipline specific regulatory bodies toward mechanisms creating shared accountability for integrated outcomes.
- International partners should consider aligning funding conditions with national IDC frameworks, avoiding the creation of parallel systems that reinforce fragmentation.

Implications for the public

When doctors, nurses, laboratory staff, and rehabilitation therapists work together effectively, patients receive safer, more coordinated care. In West Bank and Gaza, however, these professionals often work in isolation. Test results are not shared effectively, care plans are not coordinated, and rehabilitation needs are missed. This can lead to medical errors, longer hospital stays, and worse management of chronic diseases like diabetes and heart conditions. Our study examined why this fragmentation persists. We found that it is not simply a workforce problem but is structurally embedded in how health policy, regulation, financing, and education are organized. We recommend practical steps, such as changing accreditation standards and training requirements, to improve collaboration and benefit all patients.

educational, financing, and governance arrangements. Although national strategies acknowledge the importance of integrated care, no policy architecture systematically enables or incentivises IDC across these professions. This disconnect between clinical interdependence and institutional fragmentation constitutes the policy problem addressed in this study.

Although integrated care and IDC have received increasing attention within health policy research, most studies focus on workforce barriers, professional roles, communication failures, or implementation challenges. Far less attention has been given to the institutional policy mechanisms through which fragmentation becomes embedded and reproduced, particularly in fragile and conflict-affected health systems. This omission limits understanding of why reforms promoting IDC frequently achieve only modest or short-lived improvements.

Palestine provides a critical case for examining fragmentation mechanisms that operate across fragile health systems globally. While the empirical evidence derives from the Palestinian context, the three mechanisms identified, disciplinary path dependency, donor-aligned institutionalisation, and fragmented sovereignty constraint, are relevant to other settings experiencing political instability, donor dependence, and institutional fragility.[10,11]

Addressing this gap, the present study moves beyond describing policy deficiencies to offer an explanation of how fragmentation may be institutionally sustained. Using Palestine as an empirical case, the analysis identifies three interconnected mechanisms, disciplinary path dependency, donor-aligned institutionalisation, and fragmented sovereignty constraint, that together may reproduce professional silos across governance, education, regulation, and financing. By integrating documentary policy analysis with institutional theory, the study proposes an illustrative conceptual framework that warrants further testing in fragile settings.

The three mechanisms examined in this study, disciplinary path dependency, donor-aligned institutionalisation, and fragmented sovereignty constraint, are derived inductively from the documentary analysis presented in the Results section below, where they are synthesised into a conceptual model (Figure).

The analysis addresses four research questions: (1) What is the current policy, regulatory, and institutional landscape governing laboratory, nursing, and rehabilitation services with respect to IDC? (2) What mechanisms are consistent with persistent fragmentation? (3) What transferable lessons emerge from international comparators? (4) What policy options are plausible and supported by comparative evidence for strengthening interdisciplinary integration? Question 4 is presented as a subsidiary question; the primary focus of the study is questions 1 and 2, which are supported by the systematically screened documentary corpus. Questions 3 and 4 draw on supplementary literature beyond the core corpus and are addressed in the Discussion section.

Methods

Analytical Framework

The Walt and Gilson Policy Triangle[12] provided the primary analytical framework, organising analysis across four dimensions: Context (political, economic, epidemiological factors), Content (policy substance, goals, mechanisms), Actors (individuals, organisations, interests), and Process (pathways of policy emergence and implementation). This framework was selected for its demonstrated utility in health policy analysis in low- and middle-income countries and its capacity to capture both structural and agency-based determinants of policy change.[13,14]

The Policy Triangle's four dimensions directly informed document coding as follows: Contextual factors (political fragmentation, resource constraints, conflict) guided coding of structural conditions; Content dimensions informed assessment of policy goals, mechanisms, and provisions; Actor considerations guided stakeholder identification and documentary inference of positions; and Process dimensions

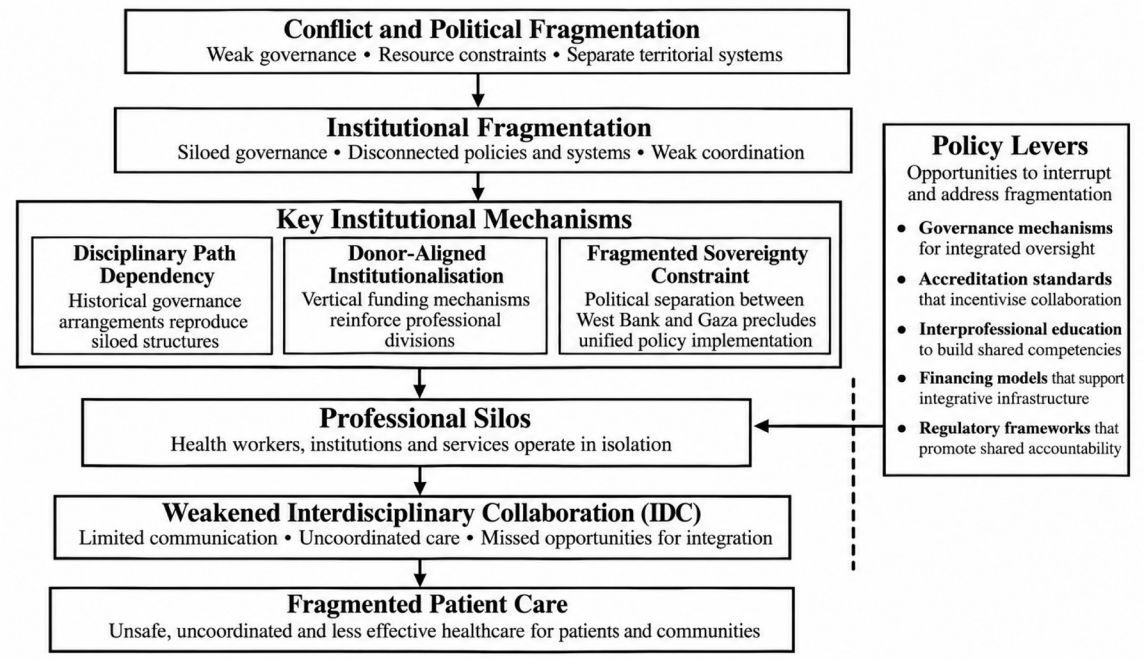


Figure. Conceptual Model: Mechanisms and Policy Levers for Interdisciplinary Collaboration in Fragile Health Systems. (The figure is built inductively from the three mechanisms derived from documentary analysis above, rather than being presented as an a priori framework. It synthesises the patterns identified in this Results section into a conceptual model and represents a theoretical interpretation warranting further empirical testing).

informed analysis of policy implementation mechanisms and accountability structures. These dimensions were applied systematically across all documents, with codes allocated to the relevant Policy Triangle dimension during thematic analysis.

The analytical approach was supplemented by institutional theory, particularly the concept of path dependency, to explain how historical governance arrangements may reproduce siloed structures.[15] This theoretical lens is essential for understanding why fragmentation may persist despite rhetorical commitments to integration. The three explanatory mechanisms, disciplinary path dependency, donor-aligned institutionalisation, and fragmented sovereignty constraint, were analytically distinguished from pre-existing theoretical concepts through careful coding and thematic synthesis. While path dependency and institutional theory provided sensitising concepts, the specific mechanisms emerged from patterns observed in the documentary data and were subsequently interpreted using these theoretical frameworks. The combination of the Policy Triangle and institutional theory enables analysis of both the formal policy architecture and the informal institutional dynamics that sustain it.

Search Strategy and Document Identification

Policy documents were identified between January and March 2025 through structured searches of: Palestinian Ministry of Health (MoH) official portal, Palestinian Legislative Council legal database, World Health Organization (WHO) Regional Office for the Eastern Mediterranean digital library, UNRWA (United Nations Relief and Works Agency for Palestine Refugees in the Near East) operational documents archive, and comparator-country government health ministry websites. PubMed and Google Scholar were searched for peer-reviewed evidence on IDC, integrated care policy, and implementation science in fragile and conflict-affected settings.

Search terms included "interprofessional collaboration," "interdisciplinary collaboration," "integrated care," "team-based care," "laboratory services," "nursing," "rehabilitation," "health policy," "health systems," and "West Bank and Gaza," combined with Boolean operators. For comparator countries, terms were combined with country-specific identifiers for Canada, the United Kingdom, Australia, Jordan, and Lebanon.

Eligibility Criteria

Documents were included if they: (*a*) addressed health policy, regulation, education, financing, or governance relevant to laboratory, nursing, or rehabilitation services; (*b*) were issued by recognised governmental, intergovernmental, or professional bodies; (*c*) were available in English or Arabic; (*d*) were published between 2004 and 2025 (with the understanding that the 2004–2025 window is bounded by the actual search dates of January–March 2025). Excluded were documents addressing non-health sectors, unpublished institutional communications, documents without identifiable issuing bodies, and materials lacking policy relevance.

Document Analysis

Systematic document analysis constituted the primary empirical method, following a structured thematic content analysis protocol adapted from Ritchie and Spencer.[16] All document identification, screening, extraction, and coding was conducted by the primary analyst (IA), with quality assurance procedures described below. Documents were coded for: references to IDC, integrated care, or team-based practice; cross-disciplinary governance provisions; interprofessional competency requirements in education or licensure; explicit mentions of laboratory, nursing, or rehabilitation in shared governance contexts; and policy gaps,

contradictions, and unresolved tensions. A standardised coding framework was developed iteratively, with initial codes derived from the analytical framework and supplementary codes emerging inductively from document content. Arabic-language documents were translated into English by the primary analyst (IA), who is fluent in Arabic, with translation reviewed for accuracy against original texts. Translation decisions were documented and verified through comparison with available English versions where applicable.

Quality Assurance Procedures

To ensure coding consistency, the following procedures were implemented:

1. Pilot testing: The coding framework was piloted on three documents (one Palestinian policy, one international framework, one comparator document) to identify ambiguities, refine definitions, and ensure coverage of relevant concepts. Pilot results were reviewed and the framework was revised accordingly.
2. Intra-coder consistency: A random sample of documents (n = 3, representing 20% of the corpus) was re-coded by the same analyst (IA) after a four-week interval to assess consistency. Coding agreement was assessed qualitatively through consensus review of discrepancies. Given the interpretive nature of documentary analysis and the small corpus size, quantitative reliability statistics (eg, Cohen's κ) were not calculated; instead, all discrepancies were discussed and resolved through consensus between the primary analyst and two peer reviewers.
3. Peer review: Coded passages were reviewed by two independent researchers with expertise in health policy analysis (not authors of this study) to assess coding consistency and identify ambiguous decisions. Discrepancies were discussed and resolved through consensus.
4. Documentation: All coding decisions were documented with specific justifications. A complete audit trail of coding decisions, thematic synthesis, and analytical interpretations is maintained for transparency and replication. The audit trail includes coding logs, decision memos, and a record of all revisions to the coding framework.

Derivation of Explanatory Mechanisms

Following initial thematic coding, coded data were subjected to a second stage of interpretive analysis to identify recurring institutional patterns across documents. Codes relating to governance, professional regulation, financing, education, and implementation were iteratively compared using the constant comparative method. Rather than treating individual policy gaps as isolated findings, the analysis examined how recurrent patterns interacted across policy domains to reproduce fragmentation.

Three higher-order explanatory mechanisms emerged from this process. First, repeated references to profession-specific governance, education, licensing, and workforce planning were interpreted as disciplinary path dependency, reflecting institutional continuity that reinforces professional separation. Second, recurrent evidence that donor-supported programmes operated through vertical funding arrangements with limited investment in cross-sector governance was interpreted as donor-aligned institutionalisation. Third, consistent documentation of separate administrative authorities, regulatory systems, and implementation arrangements between the West Bank and Gaza was interpreted as fragmented sovereignty constraint. These mechanisms were therefore analytically derived from patterns observed across the documentary dataset and subsequently interpreted using institutional theory to explain how fragmentation may be reproduced within fragile health systems. An evidence matrix (Table S3, Supplementary file 1) linking documentary evidence, codes, policy domains, and the three higher-order mechanisms has been provided to make the derivation path visible.

Policy Gap Assessment

A policy gap scoring matrix was developed to systematically assess the strength of IDC provisions across eight policy domains. The framework was developed iteratively through: (*a*) review of WHO guidance on integrated care policy assessment[17,18]; (*b*) adaptation of established health policy analysis frameworks[12,19]; and (*c*) pilot testing on a subset of documents with subsequent refinement. Each domain was scored using a four-point ordinal scale (0 = absent, 1 = limited, 2 = partial, 3 = comprehensive). Scoring anchors for the 0–3 scale are as follows, with supporting examples: 0 = absent; no provisions in the policy domain addressing IDC or collaboration (eg, professional licensing regulations containing no reference to interprofessional competencies); 1 = limited; generic aspirational statements without operational mechanisms or measurable criteria (eg, National Health Strategy references to integration without indicators or accountability structures); 2 = partial; specific provisions addressing IDC with some operational criteria but incomplete implementation mechanisms (eg, accreditation standards referencing multidisciplinary care without specific coordination criteria); 3 = comprehensive; explicit, measurable IDC requirements with accountability mechanisms and implementation frameworks (eg, accreditation standards specifying interprofessional round requirements, shared documentation, and team functioning review). This scoring approach should be understood as a qualitative analytic heuristic for descriptive comparison rather than a validated measurement instrument. The purpose is to provide a structured comparative assessment of policy content across domains and to identify priority areas for reform, not to produce precise quantitative measures. The evidentiary basis for each domain score is provided in the evidence/justification column of the policy gap assessment table, with supporting documentary evidence described in the Results section and Supplementary file 1 (Table S4).

Stakeholder Analysis

Stakeholder analysis mapped 11 actor groups using the framework of Brugha and Varvasovszky,[20] examining interests

and policy positions, power and influence, capacity and resources, and existing relationships relevant to IDC reform. The stakeholder power and interest ratings presented in the Results are analytically inferred from documentary evidence rather than confirmed through stakeholder engagement. These ratings should be interpreted as the author's documentary-based assessment requiring future stakeholder validation. Stakeholders were identified through purposive sampling, beginning with governmental authorities and proceeding to professional bodies, educational institutions, healthcare facilities, and international actors. Power was assessed according to statutory authority, regulatory influence, control over financial resources, implementation capacity, and ability to influence national policy as documented in the reviewed materials. Interest reflected each stakeholder's mandate, expected benefits from IDC, and demonstrated engagement in health system reform as evidenced in policy documents and public records.

Transferable Policy Lessons from Comparator Health Systems

Five health systems (Canada, the United Kingdom, Australia, Jordan, and Lebanon) were originally identified for comparative analysis; however, the documentary corpus included documents from four comparator countries (Canada, United Kingdom, Australia, and Jordan). The Lebanon case is therefore presented as illustrative reference literature drawing on broader evidence cited in the Discussion, rather than as part of the systematically reviewed documentary corpus. Selection was purposive to maximise learning about transferable mechanisms: Canada, the United Kingdom, and Australia offer established policy models, while Jordan and Lebanon provide insights into implementation in Middle Eastern and crisis-affected contexts. Comparative analysis examined legislative frameworks, interprofessional education (IPE) mandates, financing structures, and governance mechanisms, with explicit attention to transferability to the Palestinian context. The comparative section is presented as illustrative policy learning from comparator experiences, drawing on additional literature beyond the core documentary corpus as referenced in the Discussion.

Scope of the Analysis

This study was designed to identify and describe institutional policy mechanisms consistent with interdisciplinary fragmentation rather than to evaluate policy implementation or measure clinical outcomes. The analysis therefore focuses on the formal policy architecture reflected in documentary evidence and should be interpreted as an examination of institutional arrangements rather than organisational performance or healthcare effectiveness. The study does not claim to establish causation, effectiveness of policy options, or transferability of mechanisms without further empirical testing.

Results

Document Characteristics

Thirty-five documents were identified through initial searches. Fifteen met inclusion criteria (42.9% of identified documents). A complete inventory of the 15 included documents is provided in Table S1 (Supplementary file 1), including source, jurisdiction, type, year, and analytical role. The 20 excluded documents are listed with reasons for exclusion in Table S2 (Supplementary file 1). A document-selection flow diagram is provided in Figure S1 (Supplementary file 1). The corpus encompassed West Bank and Gaza national policy and regulatory documents (n = 5), international organisational frameworks (n = 6), and comparator country documents (n = 4) (Table 1). Of the five Palestinian national documents, none explicitly mention IDC; across the full 15-document corpus, only 2 documents (13.3%) explicitly mention IDC, and 9 documents (60%) lack any relevant provisions.

Current Policy Landscape: Institutionalised Fragmentation

Analysis across eight policy domains revealed a consistent pattern of institutionalised fragmentation (Table 2). The National Health Strategy 2017–2022 emphasises integrated service delivery as a strategic objective but does not specify IDC indicators, measurable targets, or accountability mechanisms linking laboratory, nursing, and rehabilitation services.[21] Similarly, the Healthcare Facility Accreditation Standards refer to multidisciplinary care in general terms but do not define measurable requirements for routine interdisciplinary communication, shared care planning, or joint clinical decision-making.[22] Collectively, these documents indicate that policy support for integrated care remains largely

Table 1. Quantitative Summary of Included Policy Documents

Characteristic	Number	Percent
Documents identified	35	100
Documents included	15	42.9
Document type		
National policies/strategies	4	26.7
Laws/regulatory instruments	3	20.0
Accreditation standards	2	13.3
WHO/UNRWA reports	4	26.7
Comparator country documents	2	13.3
Geographic scope		
West Bank and Gaza	5	33.3
International	6	40.0
Comparator country	4	26.7
IDC provisions		
Explicitly mentioning IDC	2	13.3
Partially addressing collaboration	4	26.7
Lacking IDC provisions	9	60.0

Abbreviations: IDC, interdisciplinary collaboration; WHO, World Health Organization; UNRWA, United Nations Relief and Works Agency for Palestine Refugees in the Near East.

Note: The discrepancy between "Comparator country documents" (n = 2) under Document type and "Comparator country" (n = 4) under geographic scope is resolved as follows: two documents are comparator-country specific policy documents (Jordan accreditation standards, UK legislation), while two additional comparator-country references (Canada, Australia) are cited as comparative literature. The Lebanon case is discussed as illustrative reference literature rather than as a systematically reviewed comparator document. Raw counts are reported throughout; percentages are provided for descriptive comparison but should be interpreted with appropriate caution given the purposive sample.

Table 2. Policy Gap Assessment: Interdisciplinary Collaboration Provisions Across Policy Domains

Policy Domain	IDC Present	Score (0–3)	Evidence/Justification
National strategy	Partial	1	Integration goals stated without indicators, targets, or accountability
Professional licensing	None	0	Professional licensing regulations define profession-specific scopes of practice and competency requirements but contain no explicit requirements for interprofessional competencies, shared clinical decision-making, or collaborative practice across laboratory, nursing, and rehabilitation professions
Facility accreditation	Partial	2	MDT care referenced generically; no specific coordination criteria
Health profession education	None	0	No IPE mandate; parallel professional training
Financing/reimbursement	None	0	Line-item budgets; no bundled payments or team-based incentives
Governance structures	Partial	1	Directorate-based governance; no inter-directorate IDC steering body
Workforce development	None	0	No IDC training requirements; CPD lacks collaborative modules
Monitoring/evaluation	None	0	No IDC indicators; no measurement framework

Abbreviations: IDC, interdisciplinary collaboration; MDT, multidisciplinary team; IPE, interprofessional education; CPD, continuing professional development. Scores: 0 = absent (no provisions addressing IDC in the policy domain); 1 = limited (generic aspirational statements without operational mechanisms); 2 = partial (specific provisions with some operational criteria but incomplete implementation mechanisms); 3 = comprehensive (explicit, measurable IDC requirements with accountability frameworks). This scoring represents a qualitative analytic heuristic for descriptive comparison and priority identification, not a validated measurement instrument. Supporting documentary evidence for each domain score is detailed in the Results text below and in Tables S3 and S4 (Supplementary file 1).

aspirational rather than operational.

Table 2 summarises the comparative assessment of IDC policy content across eight policy domains using the qualitative policy gap scoring framework described in the Methods. The table provides a structured comparison of the extent to which current policies support interdisciplinary governance, education, regulation, financing, and accountability.

Professional regulation follows a discipline-specific model. The Palestinian Nursing and Midwifery Council Law (No. 4, 2008) establishes professional registration, licensing, disciplinary procedures, and competency requirements exclusively for nursing and midwifery, without reference to shared competencies or interprofessional practice.[23] Rehabilitation remains regulated through profession-specific arrangements with no common interprofessional competency framework. Laboratory medicine is regulated through the MoH's Department of Laboratories, whose operational guidelines address quality assurance without interprofessional communication protocols. Rehabilitation is the least uniformly regulated discipline: physiotherapy, occupational therapy, and speech-language pathology lack unified national regulatory frameworks, and none has an established interprofessional competency requirement.

Facility accreditation standards reference multidisciplinary care generically but without specific criteria for laboratory-nursing-rehabilitation coordination.[22] Health profession education proceeds along parallel disciplinary tracks at multiple universities under accreditation standards that include no IPE mandate. Financing follows disciplinary budget lines without bundled payment mechanisms or performance incentives for team-based care.

Mechanisms Consistent With Sustaining Fragmentation

Documentary analysis identified three cross-cutting mechanisms that are consistent with the persistence of fragmentation. These are described below as empirical findings; their theoretical interpretation is developed in the Discussion. These mechanisms represent the author's analytical interpretation of patterns observed across documents rather than established causal mechanisms. The three mechanisms identified through documentary analysis are synthesised in the conceptual model presented in Figure. Rather than representing independent barriers, these mechanisms interact to reproduce institutional fragmentation that ultimately weakens IDC and contributes to fragmented patient care. The figure also illustrates how governance, accreditation, professional education, financing, and regulation may act as strategic policy interventions capable of disrupting this pathway.

Mechanism 1: Disciplinary Path Dependency

Policy documents consistently described profession-specific education, licensing frameworks, organisational mandates, and workforce planning processes that had evolved independently across the laboratory, nursing, and rehabilitation professions. For example, the Palestinian Nursing and Midwifery Council Law (No. 4, 2008) establishes professional registration, licensing, disciplinary procedures, and competency requirements exclusively for nursing and midwifery without reference to shared competencies or interprofessional practice.[23] Similarly, MoH laboratory guidance focuses primarily on quality assurance, laboratory management, and technical standards while providing no formal provisions for routine interdisciplinary communication or shared clinical governance with nursing or rehabilitation services. These examples illustrate how profession-specific institutional arrangements remain embedded across multiple policy domains. Educational curricula, professional regulations, and administrative structures were developed and implemented within separate disciplinary systems, with limited policy

provisions for coordinated planning or shared professional responsibilities. Across the reviewed documents, few formal mechanisms were identified to support interdisciplinary governance, joint workforce development, or routine collaboration between professional groups, indicating that institutional arrangements continue to reinforce discipline-specific modes of organisation.

Mechanism 2: Donor-Aligned Institutionalisation

The reviewed policy documents indicated that bilateral and multilateral donor funding was predominantly directed towards disease-specific programmes, including maternal and child health, non-communicable diseases, cancer services, emergency preparedness, and humanitarian response. Across the reviewed WHO, UNRWA, and donor-supported policy documents, funding priorities were generally organised around programme-specific objectives and reporting requirements rather than cross-disciplinary governance structures. Although these investments strengthened individual programme areas, the documents provided limited evidence of dedicated investment in IPE, integrated governance mechanisms, or shared accountability structures supporting routine IDC.

Mechanism 3: Fragmented Sovereignty Constraint

Policy documents described the Palestinian health system as operating within multiple administrative and regulatory jurisdictions. National policy documents, WHO reports, and MoH publications consistently referred to separate governance arrangements for the West Bank and Gaza following the political division of 2007. These documents further described differences in administrative authority, regulatory oversight, financing arrangements, and implementation responsibilities while providing little evidence of a unified institutional mechanism capable of coordinating interdisciplinary policy across jurisdictions. Since 2007, the West Bank and Gaza have maintained separate governmental administrations with distinct MoH structures, budgetary arrangements, and service delivery systems, while health facilities in East Jerusalem function under different licensing and regulatory frameworks. The reviewed documents reported variation in policy implementation, accreditation processes, workforce regulation, and administrative oversight across these jurisdictions. They also identified the absence of a unified governance mechanism capable of coordinating interdisciplinary policy development and implementation across all parts of the Palestinian health system, resulting in inconsistent institutional arrangements for collaborative practice.

The conceptual framework illustrates the relationships between conflict-related political fragmentation, institutional fragmentation, the three institutional mechanisms (disciplinary path dependency, donor-aligned institutionalisation, and fragmented sovereignty constraint) described above, professional silos, IDC, patient care, and policy levers. The arrow from the Policy Levers box indicates that governance, accreditation, professional education, financing, and regulation function as interventions capable of interrupting the fragmentation pathway and promoting integrated care.

Stakeholder Configuration

Analysis of 11 stakeholder groups identified a configuration of interests and power with significant implications for

Table 3. Stakeholder Power-Interest Mapping

Stakeholder	Interest in IDC	Power/Influence	Likely Position (Documentary Inference)	Recommended Engagement
MoH (West Bank)	Moderate-high	Very high	Rhetorically supportive; operationally constrained	Engage as framework owner; champion role
MoH (Gaza)	Low-moderate	Moderate	Neutral; responsive to MoH signals	Coordinate via WHO/UNRWA
Ministry of Higher Education/AQAC	Moderate	Moderate	Supportive with incentives	Propose accreditation revision
Palestinian Nursing & Midwifery Council	High	Moderate-high	Potential strong champion	Involve in IPE competency design
Laboratory Professional Association	Moderate	Moderate	Cautiously supportive	Co-develop IPE modules
Rehabilitation Associations (PT, OT, SLP)	High	Low-moderate	Strong supporter	Empower as advocacy voice
Palestinian Universities	Moderate	Moderate	Supportive with incentives	Fund IPE pilots; faculty development
WHO OPT Country Office	High	High	Strong champion	Co-convene National Working Group
UNRWA Health Department	High	Moderate-high	Strong supporter; operational partner	Utilise NCD integration as demonstration
Bilateral Donors (EU, USAID)	Moderate	High	Supportive with conditions	Align funding with National IDC Framework
NGO Health Sector	High	Moderate	Strong supporter	Include as civil society voice
Private Health Sector	Low-moderate	Moderate	Neutral to resistant	Engage through accreditation

Abbreviations: MoH, Ministry of Health; IDC, interdisciplinary collaboration; AQAC, Accreditation and Quality Assurance Commission; IPE, interprofessional education; PT, physiotherapy; OT, occupational therapy; SLP, speech-language pathology; WHO, World Health Organization; OPT, occupied Palestinian territory; UNRWA, United Nations Relief and Works Agency for Palestine Refugees in the Near East; NCD, non-communicable disease; EU, European Union; USAID, United States Agency for International Development; NGO, non-governmental organisation.

Note: Stakeholder positions and power ratings are analytically inferred from documentary evidence rather than confirmed through stakeholder interviews. These assessments require validation through primary stakeholder engagement.

reform feasibility (Table 3). The MoH is structurally dominant, with rhetorical endorsement of integration but constrained operational commitment given bureaucratic compartmentalisation, fiscal pressure, and political fragility. The Palestinian Nursing and Midwifery Council is the most institutionally developed professional regulatory body and a strategic entry point for interprofessional competency reform. Rehabilitation professional associations, though organisationally weak, express strong support for collaborative frameworks. WHO, UNRWA, and the non-governmental organisation health sector constitute a latent advocacy coalition with technical expertise and operational motivation. The stakeholder power and interest ratings in this table are derived from documentary evidence and should be interpreted as analytically inferred propositions requiring stakeholder validation through primary data collection.

Comparative Policy Analysis

The comparative analysis draws on four comparator-country documents (Canada, United Kingdom, Australia, and Jordan) and additional illustrative literature (including Lebanon) cited in the Discussion. The Lebanon case is presented as reference literature rather than as part of the systematically reviewed comparator corpus. Comparative analysis identified four policy mechanisms with strong potential for adaptation to the Palestinian health system rather than direct replication (Table 4). First, professional accreditation standards are administratively efficient levers for embedding IPE without primary legislation. The Canadian Interprofessional Health Collaborative framework[24] demonstrates that mandatory embedding IPE without primary legislation requirements in professional accreditation can achieve durable attitudinal and behavioural transformation.[25] Jordan's accreditation standards include explicit multidisciplinary care planning requirements, demonstrating feasibility in a Middle Eastern context.[26]

Second, unified or coordinated regulatory frameworks create system-wide consistency. The UK's Integrated Care Systems were placed on a statutory footing by the Health and Care Act 2022 (not the Health and Social Care Act 2012), establishing statutory requirements for multidisciplinary team working for complex conditions.[27] Australia's Health Practitioner Regulation National Law created a unified regulatory agency designed to achieve cross-professional consistency.[28]

Third, statutory cross-disciplinary governance bodies, even at facility or district level, anchor collaborative accountability. The UK's Integrated Care Boards demonstrate that formal governance structures create mechanisms for shared accountability that transcend disciplinary boundaries.

Fourth, financing mechanisms, particularly bundled payments and performance-based financing, are among the most powerful drivers of behavioural change toward team-based care.[29,30] Illustrative evidence from Lebanon's crisis-driven interdisciplinary mobile health teams (described in Bhattacharyya et al) demonstrates that collaborative care models can be operationalised under severe resource constraints, though sustainability depends on institutional embedding.[31]

Synthesis of Comparative Lessons

Across the comparator countries, a consistent pattern emerges: accreditation reform is the most immediately feasible entry point, requiring only administrative revision, while financing reform and governance restructuring require greater political commitment and donor coordination. The Jordanian experience demonstrates that Middle Eastern health systems can successfully implement multidisciplinary team care criteria in accreditation, and illustrative evidence from Lebanon suggests that collaborative care models can function even under severe resource constraints, though sustainability depends on institutional embedding, which remains a challenge.

Discussion

Theoretical Contribution: Mechanisms of Fragmentation

The findings are consistent with the interpretation that weak IDC is not simply a consequence of conflict, resource scarcity, or workforce shortages. Rather, the documentary evidence indicates that fragmentation may be reproduced through institutional mechanisms embedded within governance arrangements, professional education systems, financing structures, and regulatory processes. Together, these institutional arrangements appear to reinforce professional separation even where national policy documents express support for integrated care. This institutional perspective extends existing literature by explaining why fragmented patterns of collaboration may persist despite repeated policy initiatives promoting multidisciplinary practice.

Table 4. Transferable Policy Mechanisms and Their Adaptation Potential

Policy Mechanism	Main Features	Transferability to Palestine	Adaptation Required
Accreditation standards (Canada, Jordan)	IPE requirements in professional accreditation; MDT criteria in facility standards	High	Administrative revision of existing standards; no new legislation
Unified regulatory frameworks (UK, Australia)	Statutory MDT working for complex conditions; cross-professional regulatory consistency	Moderate	Feasible through ministerial regulation; political will needed
Cross-disciplinary governance structures (UK)	Statutory Integrated Care Systems; cross-disciplinary accountability	Moderate	Feasible at facility/district level; pilot before national roll-out
Financing reform (Canada, UK, Australia)	Bundled payments; performance-based financing for team-based care	Moderate	Requires donor coordination; phased pilots with evaluation

Abbreviations: IPE, interprofessional education; MDT, multidisciplinary team; UK, United Kingdom.

This interpretation should be understood as an analytical contribution requiring further empirical testing rather than a definitive causal explanation. The conceptual model (Figure) integrates these empirical findings into a coherent explanatory framework. Rather than viewing IDC as solely a workforce or organisational challenge, the framework positions collaboration as the product of interacting institutional processes operating across governance, regulation, education, and financing. This systems perspective offers a potentially transferable analytical framework for examining interdisciplinary fragmentation in other fragile and conflict-affected health systems.

Extension of Path Dependency in Health Systems

The concept of path dependency has been applied extensively in comparative political economy and institutional theory,[32,33] but less systematically in health policy analysis. This study extends path dependency theory to health systems by demonstrating how governance structures designed along professional lines create self-reinforcing dynamics. The Palestinian case illustrates three reinforcing sub-mechanisms: (*a*) institutional inertia, whereby existing structures persist because they are administratively convenient and politically acceptable; (*b*) professional socialisation, whereby new professionals are trained within disciplinary silos; and (*c*) resource allocation following disciplinary lines. These sub-mechanisms collectively create a "lock-in" effect that resists policy redirection.[34]

This finding resonates with broader health policy scholarship on institutional barriers to health system reform in fragile settings. The mechanisms identified here extend existing work by specifying potential pathways through which institutional arrangements may perpetuate fragmentation.[35]

Governance Failure in Fragile Settings

The concept of governance failure, developed primarily in the context of fragile states,[10] helps explain the fragmented sovereignty constraint. In settings where political authority is divided or contested, efforts to mandate cross-territorial collaboration confront fundamental constitutional barriers. The Palestinian case demonstrates that governance failure operates not merely as the absence of governance but as the proliferation of competing governance authorities with overlapping but non-coordinated mandates. This insight has relevance for other conflict-affected settings with divided governance structures, including Yemen, Sudan, and Ukraine.[36,37]

Donor Dependence and Institutional Fragmentation

The donor-aligned institutionalisation mechanism contributes to a broader literature on aid effectiveness and health system strengthening.[38] While vertical programming approaches efficiently achieve discrete outcomes, they systematically undermine integrative governance infrastructure by creating parallel systems that fragment coordination. This study contributes to the "aid effectiveness" literature by demonstrating a specific mechanism—the misalignment between donor financing architectures and integrative governance needs—that may sustain fragmentation despite rhetorical commitments to health system strengthening. This finding is consistent with scholarship examining the unintended consequences of donor funding models on health system governance in low- and middle-income countries.[11,39] The Palestinian case provides a particularly clear illustration of how financing mechanisms designed to achieve specific health outcomes can inadvertently institutionalise fragmentation.

International Relevance and Transferability

The Palestinian case illuminates policy challenges common to fragile and conflict-affected health systems globally. Countries experiencing political instability, donor-dependent financing, and institutional fragility confront similar barriers to IDC implementation. Illustrative evidence from Lebanon's crisis-driven mobile health teams[31] and Syria's refugee Health Cluster model[40] demonstrates that collaborative care can be operationalised under conflict conditions, but sustainability requires institutional embedding absent in purely humanitarian responses.

The international policy literature increasingly emphasises integrated people-centred health services,[17,18] yet implementation in fragile settings remains undertheorised. This analysis contributes a framework for understanding why integration policies often fail in such contexts, highlighting governance fragmentation, financing misalignment, and institutional path dependency as mechanisms requiring explicit policy attention.

Future research should examine whether the conceptual mechanisms identified in this study operate similarly in other fragile and conflict-affected health systems. Comparative empirical studies across different national contexts would help refine the proposed framework, assess its transferability, and identify contextual factors influencing the implementation of interdisciplinary policy reforms.

Implications for Other Conflict-Affected Settings

The mechanisms identified in this analysis have implications for health systems in other conflict-affected settings. In Yemen, the division between Houthi-controlled and internationally recognised governance structures parallels the West Bank-Gaza division, creating similar constraints on unified policy implementation.[41] In Sudan, ongoing conflict has fragmented health governance across multiple jurisdictions.[42] In Ukraine, occupation of territories has created parallel health systems with divergent regulatory frameworks.[43] In each case, efforts to promote IDC confront institutional fragmentation sustained by path dependency, donor-aligned financing, and divided sovereignty. The Palestinian case offers a framework for analysing these mechanisms and identifying entry points for reform. However, the transferability of these mechanisms to other settings remains theoretical and requires comparative empirical testing.

Transferable Policy Lessons

Four transferable lessons emerge for health systems in fragile settings.

First, accreditation standards are a powerful administrative

lever. Without primary legislation, facility accreditation can be revised to include explicit IDC criteria. This approach is administratively efficient, builds on existing structures, and creates immediate accountability mechanisms at the facility level. The Jordanian experience demonstrates feasibility in a Middle Eastern context.[26]

Second, IPE must be mandated through accreditation. Pre-service education is the long-term driver of cultural change, and professional program accreditation is the most effective mechanism for embedding IPE requirements. The Canadian and Australian experience demonstrates durable attitudinal and behavioural transformation from IPE programs.[24,25,28]

Third, governance structures must be reformed to create cross-disciplinary accountability. This requires moving beyond disciplinary regulatory bodies toward mechanisms that create shared accountability for integrated outcomes. Even at facility or district level, statutory cross-disciplinary governance bodies anchor collaborative accountability.

Fourth, financing mechanisms must incentivise integration. Bundled payment mechanisms and performance-based financing are among the most powerful drivers of behavioural change toward team-based care.[29,30] Donors should transition from project-specific funding to models incentivising integrative infrastructure.[11,39]

Strategic Policy Priorities

The findings support consideration of a National Framework for IDC that strengthens governance, accreditation, professional education, and financing through phased implementation. The following roadmap is presented as an illustrative proposal requiring stakeholder and fiscal validation rather than a definitive study finding. The framework should be implemented through a phased strategic roadmap:

- Phase 1 (Years 1–2): Establish National IDC Working Group with multi-stakeholder representation; commission baseline assessment; pilot IPE in selected universities; revise facility accreditation standards to include explicit IDC criteria.
- Phase 2 (Years 3–4): Adopt revised health profession program accreditation standards requiring IPE; issue ministerial regulation on IDC governance requirements; revise licensing criteria; launch performance-based financing pilots.
- Phase 3 (Years 5–6): Achieve full framework adoption; conduct independent evaluation; integrate IDC provisions into successor National Health Strategy.

Implementation Barriers and Mitigation

Three implementation barriers require explicit mitigation:

1. Political will and institutional inertia: Addressed through visible MoH senior leadership championship, early demonstration of pilot benefits, and international normative pressure through WHO engagement.
2. Professional identity resistance: Mitigated by involving professional bodies as co-architects and framing IDC as enhancement rather than erosion of professional effectiveness.
3. Resource constraints: Managed through a phased financing model in which international donors fund Phase 1 investments while the Palestinian Authority progressively assumes recurrent costs. This recommendation is prescriptive and not supported by any reported fiscal or political-feasibility assessment; it requires further validation.

Methodological Contribution and Limitations

This study demonstrates the value of documentary policy analysis in conflict settings where primary data collection may be infeasible. Policy documents constitute a public record of institutional intentions, contradictions, and gaps that can be systematically analysed without the methodological and ethical complexities of field research in active conflict zones. The application of the Walt and Gilson Policy Triangle[12] provides a theoretically grounded approach suitable for settings with limited primary data availability.

Several limitations warrant acknowledgment. First, the review relied exclusively on documentary analysis without primary data collection from stakeholders. Interviews with health authorities, professional bodies, and health workers would have enriched understanding of implementation dynamics, political feasibility, and contextual constraints. The stakeholder classifications presented in Table 3 are documentary inferences requiring validation through primary engagement. Second, the predominance of grey literature and policy documents precluded formal quality appraisal using tools designed for peer-reviewed studies, though established qualitative reporting standards were applied. No specific reporting standard (eg, RAMESES [Realist And Meta-narrative Evidence Syntheses: Evolving Standards] or Consolidated Criteria for Reporting Qualitative Research [COREQ]-adapted documentary standards) is cited, reflecting the absence of established standards for this documentary design. Third, the policy gap assessment framework provides a systematic comparative approach but should not be interpreted as a validated measurement instrument. Fourth, the post-October 2023 conflict escalation in Gaza creates a moving analytical target; findings must be interpreted in light of this dynamic environment, and documentary evidence from Gaza is particularly constrained by the destruction of health infrastructure and institutional records. Fifth, the study focuses on laboratory, nursing, and rehabilitation services; findings may not be directly generalisable to other health professions or sectors. Sixth, the successor to the 2017–2022 National Health Strategy was not identified within the documentary corpus, representing a potential gap in the analysis; a successor strategy was sought but not identified within the available documentary sources. Seventh, the study's conclusions regarding mechanisms and transferability are based on documentary evidence and require further empirical testing before definitive claims can be made.

The following claims should be interpreted with appropriate caution: claims regarding effects on patient outcomes are not supported by patient-level or service-delivery data; stakeholder positions and reform feasibility are inferred from documents

rather than confirmed through engagement; the proposed transferability to Yemen, Sudan, Ukraine, and other fragile systems remains theoretical and requires comparative testing; and the six-year implementation roadmap is an illustrative proposal requiring stakeholder and fiscal validation.

Conclusion

This study suggests that weak IDC in fragile health systems may be primarily an institutional and policy challenge rather than solely a workforce problem. Through documentary policy analysis, the findings indicate that three interconnected mechanisms, disciplinary path dependency, donor-aligned institutionalisation, and fragmented sovereignty constraint, appear to sustain professional silos and contribute to fragmented patient care. By integrating these mechanisms into a single conceptual framework, the study extends existing health policy scholarship beyond descriptive accounts of fragmentation and offers a potentially transferable explanation of how institutional arrangements may shape interdisciplinary practice in conflict-affected settings. The conceptual framework presented in Figure provides a policy-oriented explanation of how institutional fragmentation may be reproduced and identifies strategic intervention points through which policy-makers may strengthen IDC across fragile health systems. These findings highlight the importance of coordinated governance, integrated professional education, financing reform, accreditation, and regulatory alignment as mutually reinforcing policy levers for strengthening IDC and advancing integrated, patient-centred care across fragile health systems. These conclusions should be understood as analytical interpretations requiring further empirical testing rather than established findings.

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Disclosure of artificial intelligence (AI) use

Section(s) of manuscript affected: Language and grammar editing.

Type of AI tool(s) used: Grammarly Premium and ChatGPT (version 4.0).

Purpose of use: Language and grammar editing; refinement of academic writing style and clarity. AI tools were used solely for language polishing and grammatical correction. All intellectual content, analysis, interpretation, and conclusions are the sole work of the author. No AI tools were used for content generation, data analysis, interpretation of findings, figure generation, or reference management.

Declaration: The author confirms full responsibility for the accuracy, integrity, and originality of the work, and that AI tools were not used to generate substantive content, interpret findings, or make scientific judgments.

Ethical issues

Ethical approval was not required for this study as it involved documentary analysis of publicly available policy documents and did not include human participants, human data, or human biological material. All documents analysed are in the public domain. No member checking or stakeholder consultations were conducted as primary data collection; all analyses are derived from documentary evidence only.

Conflicts of interest

Author declares that he has no conflicts of interest.

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Data availability statement

All policy documents and publicly available sources analysed during this study are cited in the manuscript with full bibliographic details. A complete inventory of the 15 included documents is provided in Table S1, and excluded documents are listed in Table S2. The coding framework is provided in Supplementary file 2, and the scoring criteria and evidence matrix are provided in Tables S4 and S3 (Supplementary file 1). The documents are accessible through the respective issuing bodies' official repositories.

Supplementary files

Supplementary file 1 contains Tables S1-S4 and Figure S1.

Supplementary file 2. Detailed Document Analysis Coding Framework.

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