4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

The history of the health system in Iraq began in the early twenties of the 20th century. The first government in Iraq at that time saw the establishment of the Ministry of Health which, after a couple of years was part of the Ministry of Interior until 1939 where it was merged with the Ministry of Social Affairs. This existed till 1952, when a new Ministry of Health was reestablished and continues today. Since the early decades of the last century, the MOH went through different organizational structures. The newest structure was adopted after the war and the fall of the last regime in 2003, which has recently seen other modifications.

During the 1970s and early 1980s, Iraq experienced improvements in several critical health outcomes. Infant mortality rates decreased from 80 per 1,000 live births in 1979 to 40 in 1989. In the same period, under-five mortality rates fell from 120 to 60. However, the capacity and performance started to deteriorate during the 1980s—the decline was exacerbated as a result both of wars and of political and economic sanctions. During this period, health policy choices were inappropriate, especially in relation to health care financing. The per capita spending on health was extremely low; indeed, current analysis by the Ministry of Health suggests that during the 1990s the funds available for health were reduced by 90 percent. One significant consequence of all these factors was a serious decline in indicators of population health outcome. At the same time, many health professionals left the country. The health care system became increasingly politicized, centrally controlled, and poorly suited to respond to changing population health needs. The result was that health indicators, at least in the center and south of Iraq, 18 fell to levels comparable to some of the least developed countries. From 1990 to 1996, infant, child, and maternal mortality rates more than doubled.

Burden of Disease: Health outcomes are now among the poorest in the region. Maternal and infant mortality and malnutrition are high; certain communicable diseases have reemerged to join non-communicable conditions in a double burden of disease. Malaria, cholera, and Leishmanisis are endemic in several parts of the country. The registered number of cases of HIV/AIDS is relatively low; however, all risk factors are present for increased rates of transmission. In the aftermath of conflict, general insecurity and gender violence have prevented women from seeking health care for themselves and their children. During the 1990s, there was a trend of increasing vulnerabilities for women and maternal mortality grew close to three-fold in that period. It is estimated that 30 percent of women gave birth without a qualified health worker in attendance.

Health System and Services: The health care system—a hospital-oriented, capital-intensive model that requires large-scale imports of medicines, medical equipment and even health workers—is inefficient and access is inequitable. Although the system ran fairly effectively, little health service data was collected. This led to a lack of cost-effective public health interventions, and services only partially matched population health needs. To this day, the levels and distribution, of available human resources for health is inadequate.

Health Infrastructure: The physical infrastructure has deteriorated as a result of over twenty years of under-investment, poor management, and conflict. Widespread looting

in April 2003, the subsequent unpredictability of electricity and water supply further weakened the functional capacity of health care services, and the general insecurity created an extremely inhospitable working environment for health personnel, particularly women. Although NGOs and UN agencies started rehabilitating some health facilities in the late 1990s, by early 2003, most of the health infrastructure continues to be in poor condition.

There is no reported history of existence of social health insurance system. There have been some limited opportunities in some industrial factories and state companies where health insurance funds were established to cover the cost of curative services of their workers; but these funds were not able to sustain after few years of their establishment. Since the early decades of the last century, Ministry of Health has witnessed many trials of reform in its structure mainly after its re-establishment in 1952. There were comprehensive reforms that have taken place in 1983 and 1990. The newest structure was adopted after the war and the fall of the last regime in 2003.

4.2 Public Health Care System

Organizational structure of public system

The structure and functions of the Ministry of Health are in a state of flux and organizational and structural changes are being conducted, therefore the precise structure and organization will only emerge after the process of reconstruction has been completed. The structure health system before the reform process (initiated in 2003) is given in annex 1.

The public health system is handled almost entirely by the MOH. There are many Directorate Generals at MOH/HQ, each with many Depts. and Sections that deal with different technical topics as seen in the above diagram. There are 16 Departments of Health (DoH) in 15 provinces in the center and south of Iraq (2 in Baghdad), each in the center of each province. The 3 DoHs in the Northern provinces are directly connected to the 2 MoHs in Erbil and Suleimaniyah. The Directorate Generals of the MOH are technically responsible for the following functions:

- The DG of Public Health and PHC is responsible for the preventive health and some promotive health programs; in addition to its responsibility in managing policies on PHCs
- The DG of Planning and human resources is responsible for the planning of budgetary needs of MOH and for planning the needs human resources including nursing programs.
- The DG of Admin, Finance And Legal Affairs is responsible for the issuance of all legislations, admin and financial instructions for the implementations by the DoHs of Health at governorates and specialist departments.
- The DG of Engineering is looking after the engineering projects of health facilities including constructions, rehabilitation and renovation.
- The DG of Technical Affairs is responsible for the management of curative care, Dental and oral care, Pharmacy and medical Labs.
- The DG of Operation And Specialist Services is the one, which looks after emergencies, ambulance care and Preparedness and response actions.
- Kimadia: Is the company that imports and distributes drugs and medical appliances to health facilities and to the private sector to less extent.

- The DG of Public Clinics: Is a semiofficial and Independent Dept. that deals with curative care in a wide network of clinics at subsidized prices. In addition it is responsible for delivering the drugs for chronic diseases to the patients on monthly basis.
- The DG of Medical City is the biggest body that provides secondary and tertiary medical care in all medical and surgical disciplines.
- The DGs of the Departments of Health in Baghdad (Two in Baghdad namely Kerkh and Rasafa) and one each of the other 17 governorates. They are responsible for the provision of Health care in the form of PHCs, hospitals and preventive health to the people.

In December 2003 a change in financing system took place from self-financing to a centralized one. This led to rejoining tertiary centers to health directorates instead of their independency. There was re-designing the organizational structure of Ministry of health Center directorates and the development of new directorates such as Medical Operations directorate. Military Health services (Military medical staff and military facilities) were transferred under the umbrella of MOH after the events of 2003.

Financing in general and since the fall of the last regime in 2003 is financed through Ministry of Finance except for some limited number of bed in nursing homes mainly in the Baghdad and some few governorates, where patients are being charged for admissions and medical interventions. The annual estimated budget is prepared by MoH (Directorate General of Planning and human resources) and presented to Mo Finance before the end of the fiscal year. Mo Finance discusses it with Mo Health and agrees on some figures that are necessary to run health care in the minimum status to cover all recurrent costs and staff salaries. The DG of Planning and human resources of MOH issues the necessary instructions to all DoHs on expenditures of allocated amounts. The legal dept. of MoH is responsible on issuance of the necessary legislations and regulates the legal instructions that are proposed by the technical depts. of MOH/HQ.

The public health system extends form the central level till the grass root level. PHC is provided everywhere. Secondary care is provided at central, provincial and district levels. Tertiary care mainly exists in the center and in some regions. There exists no national insurance system or a system based on sickness funds.

Key organizational changes over last 5 years in the public system, and consequences

About one year after the fall of the political regime in Baghdad, MoH is in the process of reforming the health systems and is adopting a new organizational structure

Planned organizational reforms in the public system

The health sector is undergoing modifications as part of the overall strategy of the government which includes, the liberalization of external trade aimed at integrating the Iraqi economy with the global economy, removing distortions in the local prices of commodities and services, increasing competitiveness, and enhancing performance efficiency of the Iraqi economy. This process was initiated immediately after the fall of the previous regime. Restrictions on trade were cancelled and imports were subjected to a uniform custom tax of 5%. Food and medicine were exempted. The liberalization of trade will help Iraq's current efforts to join the WTO.

The strategy is aimed at shrinking the size of government in comparison to the rest of the economy decreasing it over the next three years. Government, however, will

continue to play a dominant role in economic activity over this period, and will play a key role as provider of public goods thereafter. The structure of government will be reconsidered, with the intent to eliminate government departments that compete with the private sector in economic and service activities and to reduce the overall size of the government. The state will come to rely on the private sector for some purposes, rather than attempting to internalize these functions by enlarging its departments.

4.3 Private Health Care System

Modern, for-profit

The Private Health sector is strong powerful and has the capacity to supplement the weakness of the public sector especially in curative services. A high number of private clinics are distributed nationwide. In addition there are private hospitals run by specialists mostly located in Baghdad and to a lesser extent in the centers of provinces. Those clinics, in addition to its curative duties, handle a system of distribution of drugs to patients with a long list of chronic diseases through subsidized prices.

The organizational model of private hospitals is primarily individual or group practices owned primarily by physicians and entrepreneurs. This sector therefore caters mainly to surgical and/or Obstetrics and Gynecological beds, operative and labor theatres, support services as Medical labs and X-ray units.

The principal funding of the above private facilities are purely private. Almost all owners of private hospitals are medical specialists and the same is true to private clinics too.

Modern, not-for-profit

There is very limited experience in the provision of health care by NGOs. There is one hospital in Baghdad run by the Iraqi Red Crescent Society(IRCS) which is almost an entirely independent for-profit hospital but provide some medical and surgical care at a relatively low prices in comparison to private sector.

Traditional

No detailed data are available on traditional medicine due to the non-licensing of such types of health practices, but there are many traditional healers illegally providing their services on a for-profit basis, but not information is scarce. There are limited number of traditional healers that deal with the management of fractures and sciatica. In addition, there are big numbers of shops that provide a long list of herbs as part herbal medicine practices.

There are no legislations or formal accreditation of traditional practices in general, Moreover, there are no clear relation between one category of traditional healers and other. All of them are working for-profit objective, but can advise their clients to consult private or public facilities. There is no training program or schools for traditional healers and they learn the trade mostly from apprenticeship or inherit the family practice.

Key changes in private sector organization

There have not been any major changes in the organization and functioning of the private practice over the last 10 years; but generally speaking and due to the economic sanctions imposed on Iraq foe 13 years since 1990 and the limited financial resources available in the hands of the previous government, the private sector has seen an uncontrolled expansion in its activities that lead to a remarkable elevation in the cost of

services provided that has rendered millions of people financially unprotected health catastrophes

The role of the private sector in the near future will enhance as a result of government policies to encourage trade liberalization and the WTO. A national committee already has been established to design a rules-based, transparent and stable foreign trade regime, and domestic regulations and policies, which are WTO compatible. The process of joining the WTO and the international commitments arising from it will act as a "lock-in mechanism" and guide for domestic economic reforms. The committee will also assess the social and economic impact of Iraq's WTO accession and determine remedial measures.

A set of government policies have been issued removing all restrictions on foreign investing encouraging open economy or and attracting foreign investment. Iraq has a sound legal framework for the formation and registration of foreign-, Iraqi-, and jointly-owned companies under the investment law of 19 September 2003. Foreign, legal, and natural persons have the right to be an investor or partner in, or a founder of, companies in Iraq by virtue of company law number 21 of 1997, as amended. Further objectives in the area of foreign investment include:

a. Continue to remove all kinds of restrictions on foreign investors and to encourage the flow of direct or indirect foreign investment in all sectors (except strategic areas) in a manner that ensures the flow of foreign capital, modern technology and management expertise.
b. Encourage partnerships between foreign and Iraqi investors in the Iraqi private sector.
c. Simplify the procedures for foreign investors through a single-window approach for all proceedings related to foreign investors that would draw together all Iraqi government officials concerned in one place.
d. Create a specialized authority to provide facilities to investors and offer investment opportunities in the country.
e. Conclude foreign investment agreements with developed and developing countries, and to ratify investment guaranty agreements with groups such as the MIGA and the U.S. OPIC.

The regional development strategy aims at eliminating dual territorial development in Iraq reflected in the clear economic and social differences between the various Iraqi governorates on one hand, and between urban and rural areas on the other hand. The strategy also seeks to utilize the relative advantages in the various regions and to consolidate the development efforts. In addition, the strategy intends to promote development, as well as administrative and regulatory capabilities of the various governorates, local departments and municipalities, and to guarantee efficiency and equality in development throughout Iraq.

Public/private interactions (Institutional)

There are no official and formal mechanisms for public–private collaboration and partnership that refer to the presence of an officially accepted and clear policy or guidelines or system that governs the interaction between the public and private health institutions and/or any interactions between the NGOs and MoH. The only area of interaction is in the referral of patients from the private to the public sector where they are accepted for admissions and management, still the way of referral is not properly described and practiced. The Dept. of inspection of non governmental health facilities of

the Directorate general of Inspection at MoH is responsible on supervision and monitoring the health care provided at all types of private facilities; medical, dental pharmacies, drug houses and hospitals. Although there is no evidence that the system of checks and balances is working.

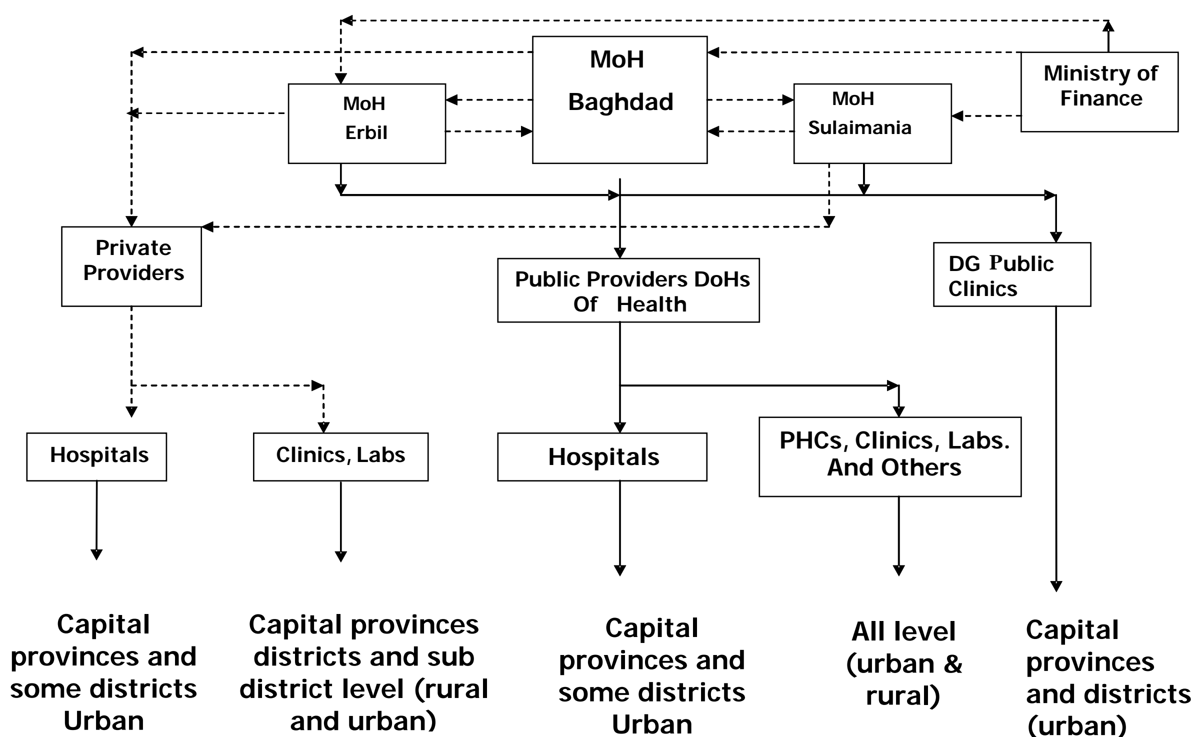
Public/private interactions (Individual)

Providers of health care at public sector are allowed by low to practice their profession in the private sector beyond the working hours at the public sector; but there exists no institutional private practice at public facilities by law. The physicians in the private sector can work in the "Public clinics" which operate in the PHC centers in the evenings and some are also engaged in private practice during the evening times.

Planned changes to private sector organization

Due to the recent restructuring of the ministry of health and the rethinking of the service provision model, the private sector may be asked to perform a larger role in health care provision, however the situation will only be clear after the remodeling of the health system is completed.

4.4 Overall Health Care System



MoH is the main body responsible for the provision of health care to the people everywhere in the country. Following the war in 2003 onwards, MoH started to receive its total funding from Ministry of Finance, but these funds are hardly enough to cover the salaries of their staff members with some minor funds to cover other recurrent expenses. This has lead MoH to rely more and more on UN agencies and International NGOs.

Soon after the war in 2003 and the destruction of the army, thousands of medical and health staff was transferred to MoH and most of military health facilities are being connected to MoH which started to provide health care services to the people and became fully integrated into the Public health system of MoH. There is nothing clear now and onwards on the future of military health care after the completion of the re establishment of the new Iraqi Army.

There are no other ministries, so far, that are involved in the provision of Health care. Ministry of Labor and social affairs are responsible for the provision of social care to Handicapped and elderly within a network of institutions in most of governorates. Doctors and health personnel providing health care to these categories are seconded from MoH.

There is a specialist directorate in MoH under the name of Public Clinics that provide curative care to the public at subsidized prices beyond the working official hours of public facilities for a period of 3 hours a day in the afternoon. For the provision of these services, the Directorate of Public Clinics is making use of the buildings of many PHCs to provide their services. These clinics play a great role in the delivery of drugs to patients with chronic diseases through a drug card carried by the patients on monthly basis. These clinics are completely independent facilities and cover all its expenses and payments through patients' capitation fees. Some of its profits might be forwarded to Mo Finance. The clinics recruit its staff independently either from MoH staff or retired or private practitioners.

Private hospitals are being licensed and monitored by MoH. Private clinics and Pharmacies are supposed to be licensed by Medical syndicates, but there are some kind of uncertainty and unclear guidelines on the issue of their monitoring by the syndicates. MoH lists these clinics under its supervision and mentoring activities. Financing of private facilities are entirely private one.

In 1992, where the three Kurdish northern governorates of Suleiamniyah, Erbil and Dohuk had been placed beyond the control of the central Government of Baghdad, two Ministries of Health were established; one placed in Erbil and the second in Suleimaniyah. These 2 ministries were relying on local financial resources to fund their activities, but following the war, it seems that the central MO Financing of Baghdad started to support them at least to cover the salaries of their staff members.

There are no insurance organizations working in Iraq. Voluntary bodies with responsibilities in the health system don't exist in Iraq.

The above structure of health don't differ that much from that existing few years ago, except, as mentioned above, that during the years of international embargo, the limited financial resources and through the interim system of self financing, resources were being generated from the direct payment by the clients of health facilities against providing health services to be used to run health care over there.