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## *Rebuilding Health Care in Iraq*

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## **Rebuilding Health Care In Iraq**

Decades of war and violence have had tragic consequences for Iraq; in particular, the country's health care system has suffered greatly, leading to a low quality of care in the country. Limited health care reconstruction following the 2003 U.S.-led invasion of the country has further left the public health sector in a fragile state. In contrast, a strong health care system is a tool that governments can use to protect their populations while bolstering internal stability. The development of a sustainable public health care network can be used the further promote social cohesion, trust and strong infrastructure. Despite the obstacles, a strong health care system is critical to the future growth and prosperity of Iraq. While years of instability represent one of the contributing factors to its vulnerable state, this paper will discuss other contextual events in Iraq's history that have contributed to the health system's devastating decline.

As well, it will explore the present-day obstacles that threaten further growth and development of health care in the country. This will include an analysis of the precarious nature of public financing and the challenges in attracting financial private sector support. As well, this paper will focus on the impact of Iraq's labour shortages and weaknesses in health care education. It will also address the regional conflict between Iraqi Kurdistan the federal government and look at how this limits the creation and implementation of a national health plan. Understanding the elements that have contributed to the current state of health care and analyzing the financial, educational and regional challenges facing future growth demonstrate the imperative for a more coordinated, transparent and regulated role for local, regional and international actors in the rebuilding of a sustainable health care system in Iraq.

## **Health Care in Iraq**

### *Where are we now?*

While countries like Egypt, Yemen and Libya have seen life expectancy jump by nearly 15 percent since 1980, Iraq has witnessed a 3 percent decline.<sup>1</sup> This disturbing degradation in quality of life can be observed in current health statistics from across the country. Infant mortality in Iraq has reached a peak above the averages in the Middle East and North Africa (MENA) region.<sup>2</sup> The country's Ministry of Health says that nearly one fifth of Iraqi families are deprived of basic health needs; rural areas being the most affected.<sup>3</sup> To understand the diminishing quality of health in Iraq, it is critical to examine certain historical events and their remaining impact on Iraq's current health care system. Health conditions after the 2003 invasion mark a drastic change from the 1970-80s, when Iraq boasted one of the most advanced medical sectors of all the MENA countries. At the time, Iraqi medical graduates would regularly receive training in Germany or in Britain and would often return to practice in Iraq.<sup>4</sup> The rise of Saddam Hussein saw the health sector submitted to large number of cuts. Health care funding was in large majority redirected towards military goals. The 1980-88 Iran-Iraq war further diverted resources and staff from medical facilities and the conflict resulted in the overall weakening of the health sector and the large accumulation of public debt.<sup>5</sup>

The health system was dealt another difficult blow after the financial and trade sanctions that followed Iraq's 1990 invasion of Kuwait. The UN Security Council resolution essentially cut Iraq off from all outside medical information. The resulting intellectual embargo isolated Iraq from the medical community. Doctors were barred from entering or leaving the country and the breakdown of physical

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<sup>1</sup> World Bank. (2011) *Confronting Poverty in Iraq : Main Findings*. World Bank: Iraq Poverty Reduction Strategy High Committee.

<sup>2</sup> Ibid

<sup>3</sup> The Republic of Iraq. (2013) E-Iraq Building. *Health Sector Challenges*. Accessed Oct. 2013. <http://www.egov.gov.iq/egov-iraq/index.jsp?sid=1&id=389&pid=121&lid=5>

<sup>4</sup> Al Hilfi, T. Burnham, G. Lafta, R. (2013) *Health services in Iraq*. Lancet. Vol. 381, Iss. 9870

<sup>5</sup> Ibid

resources meant that medical education and research was nearly impossible.<sup>6</sup> The embargo affected every level of the medical system and “left the country’s next generation of doctors ill-equipped to inherit the country’s health crisis.”<sup>7</sup> Iraq’s health care system was in a fragile and depleted state at the time of the 2003 U.S.-lead invasion of the country. The invasion further harmed health resources particularly in terms of a significant loss of equipment and pharmaceutical stock.<sup>8</sup> The collapse of the sanitation system in the wake of the invasion permitted communicable diseases to ravage the population. This was, in part, because of weak infrastructure that had never fully recovered from damage of the first Gulf war.<sup>9</sup>

Throughout the 2003-2011 occupation of the country, coalition forces assisted in efforts to try aid the crumbling health situation with over 50 billion dollars in assistance. However, the federal Ministry of Health went through a period of turmoil under the control of various sectarian groups. At the same time, the northern parts of the country developed its own budget and management process through the Kurdish Regional Government’s (KRG) Health Ministry in Erbil. Although the management process was similar to that of Baghdad, the Kurdish facilities have benefitted from the immigration of doctors and nurses fleeing elsewhere in Iraq.<sup>10</sup> A 2013 report estimates that there have been over half a million deaths in Iraq since the invasion due to war-related causes. A weak, overtaxed health system is identified as a significant contributing factor, particularly the impact of the diversion of the health care to focus on crisis care, the interruption of supply distribution and the collapse of infrastructure that protects clean water.<sup>11</sup> The last U.S. troops left Iraq in 2011, but violence in the region largely between the

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<sup>6</sup> Richards, L., Wall, S. (2000) *Iraqi medical education under the intellectual embargo*. The Lancet. Vol. 355, Iss. 9202

<sup>7</sup> Ibid

<sup>8</sup> World Bank 2011

<sup>9</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

<sup>10</sup> Burnham G, Lafta R, Doocy S. (2009) *Doctors leaving 12 tertiary hospitals in Iraq, 2004–2007*. Social Science & Medicine. Vol. 69, Pg.172–77

<sup>11</sup> Hagopian A, Flaxman AD, Takaro TK, Esa Al Shatari SA, Rajaratnam J, et al. (2013) *Mortality in Iraq Associated with the 2003–2011 War and Occupation: Findings from a National Cluster Sample Survey by the University Collaborative Iraq Mortality Study*. PLoS Med . Vol. 10, Iss.10

Sunni minority, long dominant under Saddam Hussein, and majority Shi'ites who have gained power through elections, has led to the perpetuation of instability. These tensions have been growing recently under the influence of neighbouring Syria's civil war. These recent developments are the latest challenge facing the vulnerable health care system, which, as demonstrated, has struggled to provide efficient and effective care for its population over the last thirty years. The impact of Saddam Hussein's leadership, including multiple wars, sanctions and the subsequent invasion of the country explain, in part, the reasons behind why Iraq's health care system remains in such a desperate state. Moving forward, this paper will discuss the main obstacles that pose a threat to further health care development and stability within the framework of this historical context.

### **Challenges in Health Care**

#### *Public sector financial sustainability*

Funding remains a primary challenge for the development of Iraq's health system, both in the public and private sector. Typically government expenditure in the health care remains low across the MENA region, where about 8 percent of government budget are dedicated to health compared with the average of 17 percent in OECD countries.<sup>12</sup> The World Bank and other international organization are calling on the region, Iraq included, to focus on increasing spending and accountability. Yet, in Iraq there are many obstacles limiting public sector health spending including the country's oil revenue dependency, inter-ministerial mismanagement and limited aid flows.

The IMF estimates Iraq to have the world's second-largest oil reserves, with about 143 billion barrels. About 60 percent of the reserves are concentrated in the south and about 17 percent in the south, with the majority being run by

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<sup>12</sup> The World Bank (2013) Fairness and Accountability : Engaging in Health Systems in the Middle East and North Africa. Retried from <http://web.worldbank.org>

international companies.<sup>13</sup> The government receives nearly 100 per cent of the oil revenues and the significant sums are used, in part, to finance the health sector. It is worth noting the Kurdish Regional Government (KRG) has also begun to award contracts to foreign oil companies, however the conflicts arising from this development will be discussed further along in this paper. Overall, the economy in Iraq continues to grow with the revival of the oil sector, however the reliance on oil revenues makes Iraq's finances susceptible to external shocks. The latest international assessments of Iraq's public finances demonstrates that there are not enough fiscal buffers in place to withstand any large market changes.<sup>14</sup> While the substantial revenue increases has resulted in more health care expenditures, the risks posed by oil dependency puts the future of Iraq's health care financing on trepid grounds.

Government spending in the health sector amounted to about 4.9 percent of total government expenditure from 2002-2006.<sup>15</sup> By 2011, this number has increased to 9 percent.<sup>16</sup> The increase in spending is regarded as a step in the right direction, but there growing concerns regarding the management of funds and accountability. The federal Ministry of Health is the government branch responsible in majority for health development and management and each of the 18 Iraqi governates has a directorate of health. The KRG has its own Ministry of Health, established in 1992, which operated along a similar format.<sup>17</sup> The federal Ministry of Health does not have its own specific policy document; its guiding vision is provided as part of the five-year National Development Plan (NDP), prepared by the Ministry of Planning. This plan represents a collage of interests, as it is not only created in partnership with other ministries, but also international groups like the UN and USAID. The NDP calls for decentralization and some privatization, but fails to outline detailed plans

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<sup>13</sup> International Monetary Fund. (2013, April 8) *Program Note: Iraq*. Retrieved from <http://www.imf.org/external/np/country/notes/iraq.htm>

<sup>14</sup> Ibid

<sup>15</sup> Ministry of Health 2013

<sup>16</sup> The World Health Organization. (2012) *Key Health-related Statistics: Iraq*. Regional Office for the Eastern Mediterranean. Retrieved from <http://www.emro.who.int/countries/irq/index.html>

<sup>17</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

for accomplishing these goals and the funding goals remains to be explained. At this time, the majority of public spending goes to pharmacies, about 26.6 percent of total health care expenditures; followed by primary health care centers, administrative costs, salaries and about 14 percent on general hospitals. In majority, the health care expenditure is focused on curative care.<sup>18</sup> Budgets and procurement procedures for hospitals are handles centrally, which limits the flexibility of hospital staff to manage their services effectively. Poor communication between the finance and planning branches of the Ministry of Health are often sited as the source of the majority of these challenges.<sup>19</sup> Overall, a lack of internal coordination and clear policy direction poses a threat to the sustained and accountable spending public funds.

Also supplementing domestic health sector financing is the substantial external financial aid flowing into Iraq. Since the 2003 invasion, the U.S. government has been one of the primary aid suppliers through USAID and in partnership with the UN. In 2010, an American investment of 80 million dollars was announced in primary health care for the country.<sup>20</sup> Pledges in health care funding represents only a portion of U.S. foreign aid to the country, which totaled 470 million in 2013.<sup>21</sup> The United Nations has also assumed a major role in humanitarian aid development, with a good portion of aid entering Iraq through the Iraq Mutli Donor Trust Fund (IFT). The European Commission remains the WHO's key donor to the fun, with over 80 percent of the WHO's Iraq voluntary contributions coming from the region. Other notable bilateral aid donors include the governments of Canada, the UK, Sweden and Australia.<sup>22</sup> However, despite being extended to 2014, the fund remains closed for new projects and the flow of aid is

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<sup>18</sup> The World Health Organization. (2012) *Country Cooperation Strategy for WHO and Iraq 2012-2017*. Regional Office for the Eastern Mediterranean. WHO-EM/PME/004/E.

Retrieved from [http://applications.emro.who.int/docs/CCS\\_Iraq\\_2012\\_EN\\_14959.pdf](http://applications.emro.who.int/docs/CCS_Iraq_2012_EN_14959.pdf)

<sup>19</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

<sup>20</sup> The World Health Organization 2012

<sup>21</sup> Wong, K. (2013, November 18) *Awash in Oil Revenue, Iraq Stays on U.S. dole for reconstruction*. The Washington Times.

<sup>22</sup> The World Health Organization 2012

uncertain after the closure of the support mechanism.<sup>23</sup> This comes as Iraq's growing oil revenue has led to a political push in the U.S. for the country to limit its aid to the Iraq. While Iraq's own self-sustaining funding for its health system is desirable, much work will need to be done to strengthen the Ministry of Health's interactions with its sources of external aid in terms of harmonization and coordination before independent, domestic funding can be achieved.<sup>24</sup>

### *The Role of the Private Sector*

The role of the private sector in Iraq's health care sector is poised to grow substantially. Iraq's authorities are looking to boost non-oil investment as much as possible. The country's 2013 budget authorizes capital spending of 40 percent of non-oil GDP.<sup>25</sup> To achieve investments of this magnitude, the country is working with the OECD to create a favourable investment environment and infrastructure partnered with ethical government procedures.<sup>26</sup> However, there is much work to be done by the Ministry of Health in terms of creating national regulatory capacities to help maintain quality of health service. In particular, the regulation of the private pharmacy sector poses a challenge as it lacks any national policy and often companies operating in this sector dispense proprietary drugs rather than cheaper generic brands.<sup>27</sup> The 2010-2014 National Development planned called for private health care as a 'major force', but policies have yet to develop themselves substantially. The Ministry of Health continues to site private sector development and investment as the main challenges to developing the health system.<sup>28</sup> So far, there has been little or no development in terms of tax policy changes or focused investment policy that would enhance access to foreign investments in the economic

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<sup>23</sup> Ibid

<sup>24</sup> The World Health Organization 2012

<sup>25</sup> The International Monetary Fund. (2013) *Iraq: Selected Issues*. Country Report No. 13/218

<sup>26</sup> OECD (2013) *Investment and Infrastructure financing in Iraq*. Middle East and North Africa : Initiative on Governance and Investment for Development. Retrieved from <http://www.oecd.org/mena/investment/iraq.htm>

<sup>27</sup> The World Health Organization (2013) *Iraq Public Sector Modernization (I-PSM)*. Regional Office for the Eastern Mediterranean. Retrieved from <http://www.emro.who.int/irq/programmes/iraq-public-sector-modernization-i-psm.html>

<sup>28</sup> The Republic of Iraq 2013



arena.<sup>29</sup> Well-organized private-public partnerships have the potential play a role in providing affordable, quality health care to the country. However, there is an imperative for the Ministry of Health to match this growth with an increased regulatory capacity and transparency in its policy.

One of the main barriers towards increased private sector investment partnerships remains the high level of public sector corruption. In 2012, Iraq was ranked 169 out of 176 on the Corruption Perceptions Index, making it one of the top 10 countries perceived to be the most corrupt in the world.<sup>30</sup> While systems of political patronage have certainly influenced the current conditions, the Coalition Provisional Authority, (CPA) has left a serious impact in the wake of the invasion. The CPA was created in the immediate aftermath of the invasion to establish a clear and transparent course for the country's reconstruction, however its lack of oversight and accountability led to accusations of corruption. The CPA was headed and funded, as a division of the U.S. department of defense and it was responsible for awarding reconstruction contracts to private firms. It is argued, however, than rather than focus on efficiency and transparency, companies were often granted contracts based on political connections and U.S. campaign contributions.<sup>31</sup> In 2005, after the provisional government had taken over, it was reported that U.S. federal auditors discovered 8.8 billion dollars had gone missing after passing through the new Iraqi government ministries in Baghdad with little prospect of finding out where it went.<sup>32</sup> The CPA and the Iraqi government that preceded it did little to establish a strong foundation on which the post-war government could evolve and led to mistrust in the private sector. The 2013 National Development Plan looks for nearly a quarter of its investments to come from the private sector, thanks to developments in public-private cooperation.<sup>33</sup> There is some evidence of initiatives

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<sup>29</sup> The Republic of Iraq. (2010) *National Development Plan 2010-2014*. Ministry of Planning.

<sup>30</sup> Transparency International. (2012) *Corruption Perceptions Index 2012*. Retrieved from <http://www.transparency.org/cpi2012/results>

<sup>31</sup> Hogan, J., Long, A., Stretesky, B., & Lynch, J. (2006). Campaign contributions, post-war reconstruction contracts, and state crime. *Deviant Behavior*. Vol. 27, Iss. 3, 269-297.

<sup>32</sup> Ibid

<sup>33</sup> The Republic of Iraq (2013) *National Development Plan 2013-2017*. Ministry of Planning

already underway with General Electric opening its Iraq Health Care Centre to help provide clinical education, training and development in hopes to support knowledge transfer.<sup>34</sup>

## **Challenges in Health Care**

### *The limits of labour*

One of the most obvious impacts of the violence and upheaval in the country has been a direct and significant impact on the labour capacities of Iraq's health system. A shortage of health and medical staff, and of organizations that provide health services remains a concern. Estimates show that in 2009, as many as two-thirds of Iraq's senior physicians had fled the country.<sup>35</sup> A majority of Iraq's health professionals are working in Baghdad, where 20 percent of the population lives, which leaves poorer governates woefully understaffed. A lack of comprehensive educational opportunities, universal standards and regional insecurity contribute to the insufficient labour capacities in the country.

Attracting professionals to the public health care system remains a struggle. Health care in Iraq has been focused on a centralized, curative and hospital-oriented model, which means that fewer funds have been directed towards health care education. WHO statistics for 2012 highlight show there are 229 hospitals (general and specialized), of which only 61 are teaching hospitals.<sup>36</sup> Convincing qualified teachers and doctors to work in Iraq is in part difficult because many senior physicians can earn outside the country. In medical colleges, the Ministry of Higher Education controls the curriculum. While efforts with the WHO have helped to expand the opportunities for nurses and doctors to get hands-on learning, it has been noted that the curriculum remains more focused on theory than more practical

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<sup>34</sup> General Electric (2013) Far Away, So Close: New GE Healthcare Service Center in Iraq. Retrieved from <http://www.gereports.com/far-away-so-close/>

<sup>35</sup> Tarantino, D., Morton, M., Kosaraju, A., Jawad, S., Casscells, S. (2009) Health System Reconstruction in Iraq – The Way Ahead: A report from the Iraq Health Care Symposium, May 2008. World Medical & Health Policy. Vol. 1, Iss. 1

<sup>36</sup> The World Health Organization 2013

applications.<sup>37</sup> There have been some improvements of technical skills through workshops by various organizations and online courses set-up by the Ministry of Health, which provide access to key medical journals in-service education.<sup>38</sup> Yet there is no mandatory continued education for practitioners and limited access to organizations that could help strengthen standards.

The Iraq Ministry of Health has set targets and strategies for rebuilding physician capacity, which includes more focus on research and certification.<sup>39</sup> Due to the isolating sanctions of the 1990s, few books or journals from the last decade are in Iraq and post-invasion, college buildings have been perpetually poorly equipped and out-of-date.<sup>40</sup> Systems for licensure and accreditation of health professionals are still not in place, despite efforts to follow the goals laid out in the 2010 National Development Plan. In the 1960s, there were exam centers in different parts of the county to assess and train Iraqi doctors. The U.S. Medical Licensing Examination (USMLE) was in use at that time and it has been suggested that better standards of care could be achieved with the reintegration of a similar examination format.<sup>41</sup> National accreditation standards for centres were prepared in June 2010 with help from the International Medical Corps, yet the system remains in a pilot stage.<sup>42</sup>

Assuring security remains is also a factor limiting physician recruitment. Guaranteeing public safety to doctors and clinics remains a challenge what with persistent violence. "Those dealing with the public in often stressed environments- and particularly those in rural areas- lack the protection by the state."<sup>43</sup> So far, some increases in security has materially helped reconstruction of the health infrastructure and has even contribution to growing rates of returning physicians to Iraq from abroad. However, there remains a significant brain drain of Iraqi medical

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<sup>37</sup> Garfield, R., McCarthy, C.F. (2005) *Nursing and nursing education in Iraq: challenges and opportunities*. International Nursing Review. Vol 52

<sup>38</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

<sup>39</sup> The Republic of Iraq 2010

<sup>40</sup> Garfield, R., McCarthy, C.F. 2005

<sup>41</sup> ibid

<sup>42</sup> The World Health Organization 2010

<sup>43</sup> Naji, Lubna. (2012, August 8) Iraq Struggles to Revive Health Sector. The Financial Times

graduates to countries like the UK, U.S. and Australia.<sup>44</sup> While in part a security issue, it also reflects the tenuous relationship between the Ministry of Higher Education, which is responsible for the development of health professionals, and the Ministry of Health, which benefits from the trained staff. At this time, there remains no developed vision of health care shared jointly between both ministries, which result in a lack of direction in terms of physician education capacity building.<sup>45</sup> It's been suggested that the creation of a monitoring body could help assure greater integration of on-the-ground needs in education.<sup>46</sup>

### *Public health education*

Health education is not limited to doctors and nurses but extends more generally to public health workers. The WHO says the hospital-based system "lacks the capacity to deliver services that address the major health problems faced by the majority of the population in an equitable and sustainable manner."<sup>47</sup> The country's 2013 National Development Plan calls for a realignment of the health system with primary health care as the basis.<sup>48</sup> It remains, however, that the hospital-oriented model is an expensive one that has limited the development of a qualified public health workforce. The number of workers specialized in health policy, finances and social sciences is not substantial, this disparity plays a crucial role in managing and permitting the expansion of health systems in the country.<sup>49</sup> As the health system looks to expand, these skills will be in high demand, particularly as the federal Ministry of Health looks to increase health system accountability and trust.

Many of the issues facing the Iraqi public will also not be solved with a hospital-focused model. Recent WHO data demonstrates that non-communicable diseases pose a huge threat to the population with 42 percent of adult men smoking and 67 percent having a body mass index above 25.<sup>50</sup> "Building of public awareness and

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<sup>44</sup> Tarantino, D. et al. 2009

<sup>45</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

<sup>46</sup> Tarantino, D. et al. 2009

<sup>47</sup> The World Health Organization 2012

<sup>48</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

<sup>49</sup> *ibid*

<sup>50</sup> The World Health Organization. (2006) *Chronic non-communicable diseases risk factors survey in Iraq*.

momentum for behaviour change in areas such as smoking, exercise, and diet must be national priorities.”<sup>51</sup> Iraq needs an educated workforce and strong public health capacity to deal with these priorities and engage the public in health education initiatives. A 2012 World Bank report notes that “despite the low health status of Iraqis, public health services remain accessible and usually free.”<sup>52</sup> Nearly all of urban households, regardless of economic status, live within 10 kilometers of a free (or nearly free) government health center. Yet, so far, there is not an optimal use of health facilities, which marks the population’s lack of trust in the services provided by the public system.<sup>53</sup> The Ministry of Health has acknowledged that weak citizen participation is a result from general dissatisfaction.<sup>54</sup> An education policy that enhances health care professionals’ capacities and creates a public health workforce expanding past the hospitals and clinics will be critical in the coming years to help engage the population the building of a strong health sector.

## **Challenges in Health Care**

### *Regional conflict*

While wars, sanctions and a turbulent leadership have contributed to the poor state of the health system in Iraq, regional and ethnic divisions have hindered the development of a focused and universal health policy. In particular, the relationship between the federal government in Baghdad and the KRG has had a significant impact on the health system. To understand the current tensions, it is important to examine the historical context, economic factors and inter-government initiatives that continue to influence the future of health care.

There is a long history of conflict between the federal government and the autonomous Kurdish region. For context, after the First World War, Iraq became a

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STEPSReport. Retrieved from <http://www.who.int/chp/steps/IraqSTEPSReport2006.pdf>

<sup>51</sup> Al Hilfi, T. Burnham, G. Lafta, R. 2013

<sup>52</sup> The World Bank 2012

<sup>53</sup> Ibid

<sup>54</sup> The Republic of Iraq 2012

British mandate that united three provinces from the Hijaz region of Arabia. This meant the new Iraq was a complex mix of ethnic and religious groups. Kurds in the north had little wish to be ruled by Baghdad and ultimately, the Kurdish region was divided between Iraq, Syria and Turkey. Iraqi Kurds currently make up about 20 per cent of the entire Iraqi population.<sup>55</sup> In 1983, the Kurdish province's only medical university was moved to Erbil and after Saddam Hussein took power, extra-judicial killings extended to academic and health care professionals. Ba'ath party doctrine was added to the curriculum and ultimately the reputation of medical education in the region suffered.<sup>56</sup>

Following the Gulf war, Iraqi Kurdistan became the target of Saddam's forces due to burgeoning rebellions and health care further struggled under the impact of a double embargo. This occurred as the Iraqi regime imposed its own economic sanctions against the region at the same time the United Nations imposed its embargo on the whole of the country.<sup>57</sup> In October 1991, Saddam's forces retreated, leaving Iraqi Kurdistan to become an autonomous region, yet one with limited governing capacities. The UN oil-for food programme in 1997 played a key role in resource sharing. "Despite external interference and internal infighting, (the region) has blossomed economically, especially since the start of the UN oil-for-food programme in 1997."<sup>58</sup> This UN resolution allocated a sum of Iraqi oil export money for buying medicine and necessary humanitarian needs to the Kurdish administration. Currently, the federal government largely funds health care in Iraqi Kurdistan, however the KRG is responsible for its distribution and local services are readily available in all major cities and towns.<sup>59</sup> There are even some reports of

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<sup>55</sup> Husni, M., Taylor, F., Koye, N. (2006) *Medical education and health care in Iraqi Kurdistan in the last four decades*. *Medicine, Conflict and Survival*. Vol 22, Iss. 4

<sup>56</sup> *Ibid*

<sup>57</sup> *Ibid*

<sup>58</sup> Leezenberg, M. (2005) *Iraqi Kurdistan: contours of a post-civil war society*. *Iraqi Kurdistan: contours of a post-civil war society*. *Third World Quarterly*. Vol. 26, Iss. 4-5

<sup>59</sup> Kurdistan Regional Government. (2013) *Health Care*. Retrieved from <http://dfr.krg.org/p/p.aspx?p=63&l=12&s=040100&r=374> Nov. 2013

Kurds coming from neighbouring Turkey to Iraqi Kurdistan for medical treatment because of its superior facilities.<sup>60</sup>

While there has been a noted improvement in health facilities, tensions still exist between the KRG and the federal government, particularly over general funding. At this time, government support to Iraqi Kurdistan is based on a transfer of oil revenue funds. Under an agreement that was concluded between the two governments in 2004, 17 percent of the federal budget would be allocated to Kurdistan.<sup>61</sup> Kurdish officials have often said that authorities in Baghdad only sends about 10-11 percent of these revenues and allegations of mismanaged money and failed financial policy discussions have plagued both governments.<sup>62</sup> The 2014 Iraqi budget is projected at 150 billion dollars and could increase as oil exports grow in the region. This boost in revenue could change the calculation for Kurdistan's budget allocation, which could grow accordingly.<sup>63</sup> However, the Kurdish government is also looking to expand oil production within its jurisdiction, which could ease its dependence on the Iraqi federal government. The KRG has awarded production-sharing contracts with international companies, but these have been hotly contested by the central government on the grounds that the federal government is the only legal authority entitled to enter in agreements with foreign oil companies. A hydrocarbon law was intended to help clear up any issues of jurisdiction, but it has remained in development since 2006, largely because of the differences between the KRG and the federal government in Baghdad.<sup>64</sup>

### *Future collaborations*

There has, however, been a push by both the KRG and Bagdad to work past their differences towards greater unification on health policy to address the delivery of

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<sup>60</sup> Leezenberg 2005

<sup>61</sup> Husni 2006

<sup>62</sup> Francis, Bassam. (2012, June 16) *KRG Claims Baghdad is Shorting Its Budget Share, Halts Oil Flow*. Al-Monitor. Retrieved from <http://www.al-monitor.com/pulse/business/2012/06/krg-accuses-baghdad-of-reducing.html>

<sup>63</sup> Reuters. (2012, October 17) Oil Pipeline boosts Kurds in standoff with Baghdad. Retrieved from <http://www.reuters.com/article/2013/10/17/iraq-kurds-pipeline-idUSL6N0I73KD20131017>

<sup>64</sup> The International Monetary Fund 2013

cost-effective, integrated health services. In 2011, the federal Ministry of Health adopted the implementation of a WHO initiative, the Basic Health Service Package, which is a plan to help ensure the delivery of health services through multiples health facilities from community health houses to district hospitals. The idea is that it would be rolled out to all health districts in all Iraqi governates, with a pilot project that would include Iraqi Kurdistan. The initiative is expect to help identify the financial and human resource needs across the country.<sup>65</sup>

However, the nature of the relationship between Iraqi Kurdistan and the federal government contributes to the difficulty in implementing a national health plan and subsequently funding it. The long-standing conflict highlights the political challenges to health-care development in a increasingly decentralized government environment. There is a need for supra-ministerial and inter-ministerial political will and collaboration to help achieve health system reconstruction and sustainability. There is some precedent for success, for example coordination between KRG and Baghdad was possible with the planning committee for avian flu, which comprised a number of Iraqi ministries (agriculture, finance, health and planning) and these situation could serve as examples for collaboration moving forward.

## **Conclusion**

Iraq's health care system remains in a devastating state and in need of immediate reform and investment. The sustainability of an efficient and effective health care sector is critical moving forward as the Iraqi government looks to build security and trust with its citizens. Achieving this requires, in many cases, the country to develop new skills and capacities. The precarious future of international aid and the limits of oil revenue dependency have led to a need for private sector involvement in health care, which must be created with adequate regulation and oversight. The

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<sup>65</sup> The World Health Organization 2011



degradation of the health care workforce calls for a closer coordination among policy makers, educators and ministries to rebuild Iraq's labour market abilities. The growing need for public health education will also play a role in determining future health priorities for the country, as will increased cooperation with the KRG. Overcoming the financial, labour market and regional issues in Iraq requires an evolution of the role of local, national and international actors involved. Even if ongoing sectarian violence continues to limit the scope of this evolution, there remain opportunities for the development of a strong health system in country.

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