CHAPTER I

INTRODUCTION

1.1Country Background

Iraq is one of the Middle East Arabic countries. Iraq has borders with Turkey from the north, Iran from the east, Syria and Jordan from the east west and borders with Saudi Arabia and Kuwait in the south. The surface area of Iraq is about 435 000 km^2. The population of Iraq is 28,807,000 of whom 6 million who live in Baghdad the capital. Administrative divisions in 1988 eighteen governorates or provinces each divided into districts (110) and sub districts. Limited self-rule was granted to Kurds in three northern governorates officially known as Autonomous Region and popularly known as Kurdistan (land of the Kurds).

Iraq economy is dominated by the oil sector, which has traditionally provided about 95 percent of foreign exchange earnings. In the 1980s financial problems caused by massive expenditures in the eight-year war with Iran and damage to oil export facilities by Iran led the government to implement austerity measures, borrow heavily, and later reschedule foreign debt payments. Iraq suffered economic losses from the war of at least US$100 billion. After hostilities ended in 1988, oil exports gradually increased with the construction of new pipelines and restoration of damaged facilities. A combination of low oil prices, repayment of war debts (estimated at around US$3 billion a year) and the costs of reconstruction resulted in a serious financial crisis .After that Iraq's invasion of Kuwait in August 1990 and subsequent Gulf war 1991 followed by 13 years of economic sanctions and finally the last war at 2003 .All these have caused serious damage and suffering to the country and drastically reduced Iraq economy .

The challenges facing Iraq now and in the future due to past economic policies adopted by the previous regime, Three wars and international sanctions. In the light of this reality rebuilding programs and economic reform face major challenges. Lack of progress in executing these programs will create social frustration among the population. Therefore, fast steps are needed for development of economic and social sector including health sector.

The regime, which ruled Iraq between 1979 and 2003; established priorities for government programmes and budgetary allocations that did

not reflect population needs and priorities. Health policy choices were inappropriate especially in relation to health care financing Patterns of resource distribution tended to favour specific political, ethnic and geographic groups. As a result serious gaps developed in the provision of health services. The overall capacity and performance of the health system started to deteriorate during the 1980s .The decline was exacerbated as a result of both wars and of political and economic sanctions.

Within the last decade per capita spending on health fell dramatically indeed, current analysis by the Ministry of Health suggests that during the 1990s the funds available for health were reduced by 90%. The health care system became increasingly politicized, centrally controlled and poorly suited to respond to changing population health needs. At the same time, many health professionals left the country.
The health care system is inefficient; the system is based on a hospital-oriented, capital-intensive model that requires large-scale imports of medicines, medical equipment and even health workers. Although, the system ran fairly effectively, little health service data was collected. This led to a lack of cost-effective public health.

The Ministry of Health (MOH) is the main body responsible for the provision of health care (curative and preventive) to the people and controls all public health facilities at the central and provincial levels through 19 Directorates of health (DOHs), the private also provide curative service.

For public services; there are (1717) primary health care centers and sub-centers in Iraq. About 47% (805) are staffed with at least one medical doctor. The rest have trained health workers(medical assistants and nurses) on average, each center is responsible for providing primary care to population of about 20000- 30000. The secondary and tertiary care is provided by (172) governmental hospitals with 36900 beds .The number of private hospitals is 55 with 2033 beds of which about two thirds are in Baghdad.

Ministry of Health adopted the policy of central financing system & free medical services in all health facilities (PHC, hospital, preventive & curative activities). The source of funds for the MOH has become the ministry of finance transfers which covered the salaries, operating expenditures and pharmaceuticals for all MOH facilities in Iraq.

MOH currently provides services at its facilities at a free of charge, this means that people regardless of their socio-economic status are receiving health care includes drugs. The most important problems are the shortage of drugs and low quality of services at public sectors; spending ability to pay for publicly financing the health care by Iraqi government in the future .The needs to mechanism in place that ensure that the increase in spending is accompanied by the "right incentives" to improve quality and utilization and some effort need to be placed on the importance of measuring the impact of increased spending.

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.

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 labour 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. The MoH has partial control over the health facilities in the private sectors.

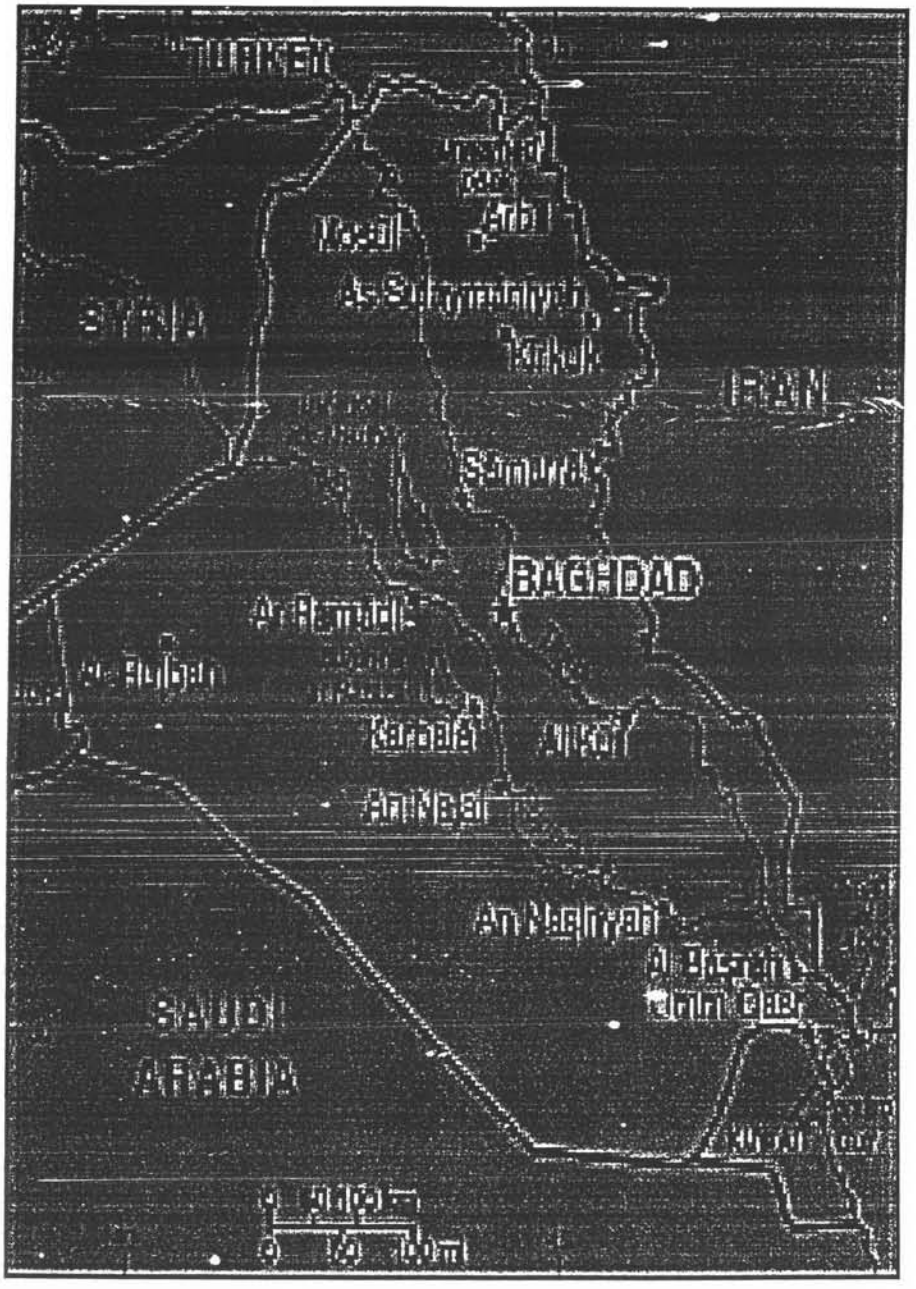
Iraq does not have any social health insurance system. There are isolated very small health insurance programs for employees of specific companies. Salaries in Iraq were too low to sustain an insurance based system.

Health outcomes are now among the poorest in the region. Maternal and infant mortality and malnutrition are high; certain communicable diseases have re-emerged to join non-communicable. The people of Iraq face a mixture of health hazards associated with poverty, inadequate and

dilapidated infrastructure. Children, adolescents, women, the elderly, disabled people and those who are chronically ill are at particular risk.

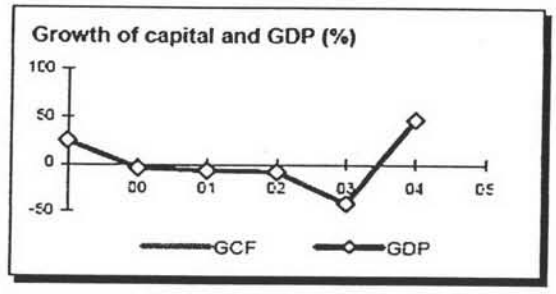
Life expectancy declining over the last 15 years .Iraq has a high child mortality and high adult mortality .Death certification by cause is incomplete and inaccurate. The leading causes of death in adults are non communicable diseases.

Figure 1.1Map of Iraq



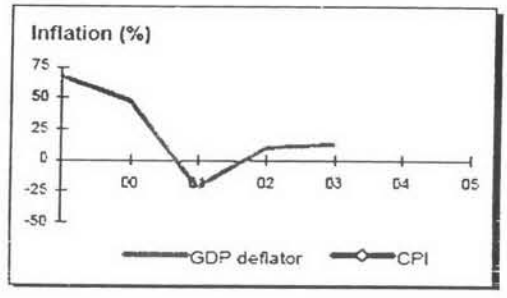
Source from Wikipedia, the free encyclopedia .available at "http://en.wikipedia.org/wiki/Iraq

Figure 1.2Growth of GDP for the years 2000-2005



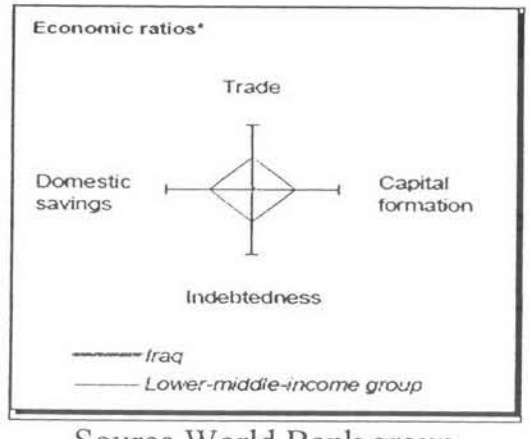
Source World Bank group

Figure 1.3 GDP deflator for 2000-2005



Source World Bank group

Figure 1.4 Iraq and lower income group



Source World Bank group

1.2Rationale

Economic development is a sustainable increase in living standards that implies increased per capita income, better education and health as well as environmental protection. Public policy generally aims at continuous and sustained economic growth and expansion of national economies so that 'developing countries' become 'developed countries'.

This development process supposes that legal and institutional adjustments are made to give incentives for innovation and for investments so as to develop an efficient production and distribution system for goods and services.it has evolved into a professional industry of highly specialized practitioners normally working in public-private partnerships that are sanctioned and many times at least partially funded by local, regional and state/provincial tax dollars.

It is corporations function as individual entities and in some cases as departments of local governments. Their role is to seek out new economic opportunities and retain their existing business wealth. There is intense competition between communities, states and nations for new economic projects. The creation and retention struggle is further intensified by the use of many variations of economic incentives to the potential business. These incentives vary greatly and can be highly controversial. The measurement of success within this industry is normally job creation, economic growth and increased or retained tax base.

This process in its simplest form is the creation of economic wealth for all citizens within the diverse layers of society so that all people have access to potential increased quality of life. Job creation, economic output and increase in taxable basis are the most common measurement tools traditionally economists have made little if any distinction between economic growth and economic development using the terms almost synonymously.

It can be seen as a complex multi-dimensional concept involving improvements in human well-being . However defined critics point out that GDP is a narrow measure of economic welfare that does not take account important non-economic aspects such as more leisure time, access to health & education, the environment, freedom, or social justice.

Professor Seers argues that development is about outcomes, that is, development occurs with the reduction and elimination of poverty, inequality, and unemployment within a growing economy.

Professor Todaro sees three objectives of development.Producing more 'life sustaining' necessities such as food, shelter, and health care and broadening their distribution .Raising standards of living and individual self esteem .Expanding economic and social choice and reducing fear .

Health Is a state of complete physical, mental, social well being and not the absence of disease. It is one of the components of an adequate standard of living. Historically, the protection of public health has been accompanied by legal regulation - health law is as old as law itself. Its development demonstrates that the state of an individual's health is often determined by factors beyond a person's medical condition.

The minimum requirement of health.

Availability – public health care facilities must exist in sufficient quantity. At a minimum, this includes safe drinking water, adequate sanitation, hospitals and clinics, trained medical personnel receiving domestically competitive salaries, and essential drugs

Accessibility – health care must be physically and economically affordable. It must be provided to all on a non-discriminatory basis. Information on how to obtain services must be freely available.

Acceptability – all health facilities must be respectful of medical ethics, and they must be culturally appropriate.

Quality – health facilities, goods, and services must be scientifically and medically appropriate and of good quality. At a minimum, this requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe water and adequate nutrition (within the facility).

As with every human right, the right to health entails the following obligations:

- Respect – the obligation to respect requires governments to refrain from interfering directly or indirectly with the enjoyment of the right to education
- Protect – the obligation to protect requires governments to prevent third parties, such as corporations, from interfering in any way with the enjoyment of the right to education

- Fulfill – the obligation to fulfill requires governments to adopt the necessary measures to achieve the full realization of the right to education.

Health development is the process of continuous, progressive improvement of the health status of individuals and groups in a population.

Good health is an important part of well being, health improvement at least contributes to economic growth and hence to poverty reduction, first it will reduce production losses due to illness of workers. Second it increase the school enrollment of children and help them study efficiently. Third it reduces illness treatment spending that would otherwise be spending on other alternative production.

Healthy People 2010 are a comprehensive, nationwide health promotion and disease prevention agenda. The overarching purpose of healthy people 2010 is promoting health and preventing illness, disability, and premature death. Several areas can be used in developing community health programs, developing community capacity, and increasing health status.

Healthy people objectives that can be used with economic development and health include access to health care, occupational safety and public health infrastructure.

Healthy People 2010 offer information on the relationship between income and health, health disparities, and achieving equity in access to health care.

Health performance and economic performance are interlinked. Wealthier countries have healthier populations for a start. And it is a basic truth that poverty, mainly through infant malnourishment and mortality, adversely affects life expectancy. National income has a direct effect on the development of health systems, through insurance coverage and public spending.

The effects of health on development are clear. Countries with weak health and education conditions find it harder to achieve sustained growth. Indeed, economic evidence confirms that a 10% improvement in life expectancy at birth is associated with a rise in economic growth of some 0.3-0.4 percentage points a year.

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Disease hinders institutional performance too. Lower life expectancy discourages adult training and damages productivity. Similarly, the emergence of deadly communicable diseases has become an obstacle for the development of sectors like the tourism industry, on which so many countries rely.

Policy choices cannot be taken lightly. Health financing, through out-of-pocket expenditures, is inequitable and can expose whole populations to huge cost burdens that block development and simply perpetuate the disease/poverty trap. On the other hand, health systems need financing and investment to improve their performance, yet this need cannot in turn impose an unfair burden on national spending or competitiveness.

The challenge is to harmonies health and economic policies to improve health outcomes. But how macroeconomic performance in term of what socioeconomic factors impact on human health? What is the interaction between them? What is appropriate way to improve population health status?

This study will answer these questions (implications for Iraq). How do economic indicators in terms of income, health expenditure, and governmental health expenditure, geographical and demographical factors effect on health? What is the interaction between these indicators? What is the effect of improved health status on productivity and economic development. When understanding these questions can determine further policy formulation. No studies exist in Iraq or Middle East country which took at these questions?

1.3 Research questions and objectives

1.3.1-. Research questions

1.3.3-Specific objectives

By using Middle east and Arabic countries indicators as implications for iraq to:

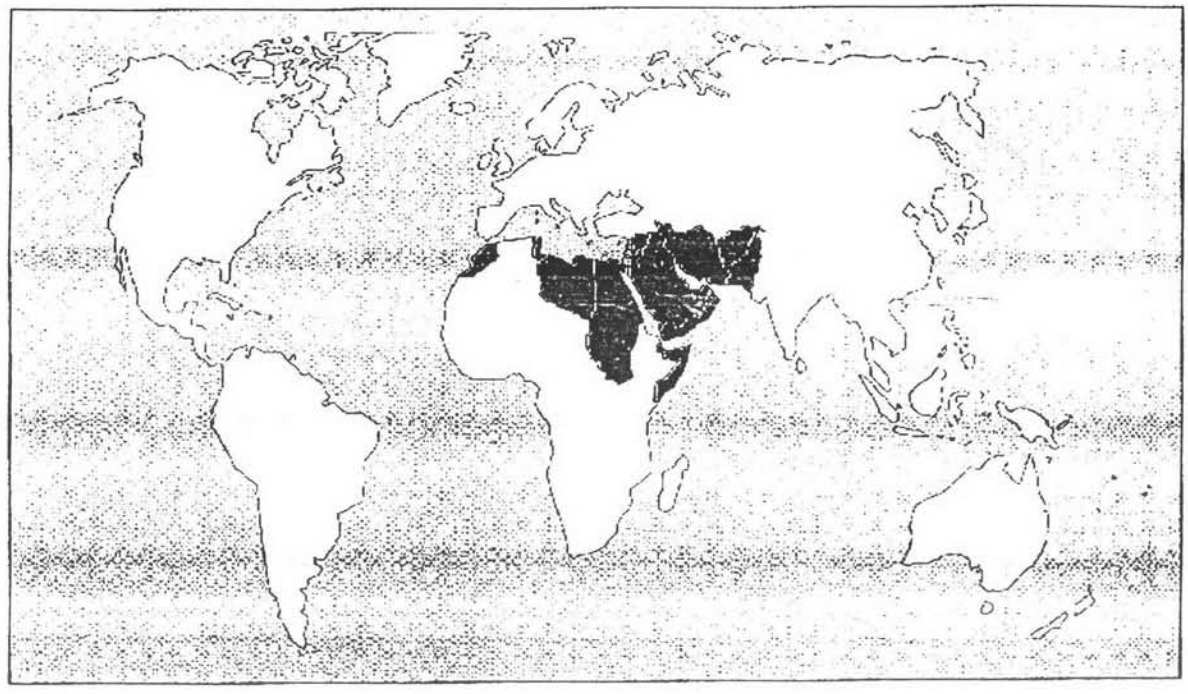
1-Explore the interaction between the health indicators and socioeconomic indicator.

2- Analyze the socio economic factors which have greatest impact on health status.

3- Examine the health status in response to socio economic factors determine in the study.

1.4 Scope of study

Figure1.5 Map of Middle East region.



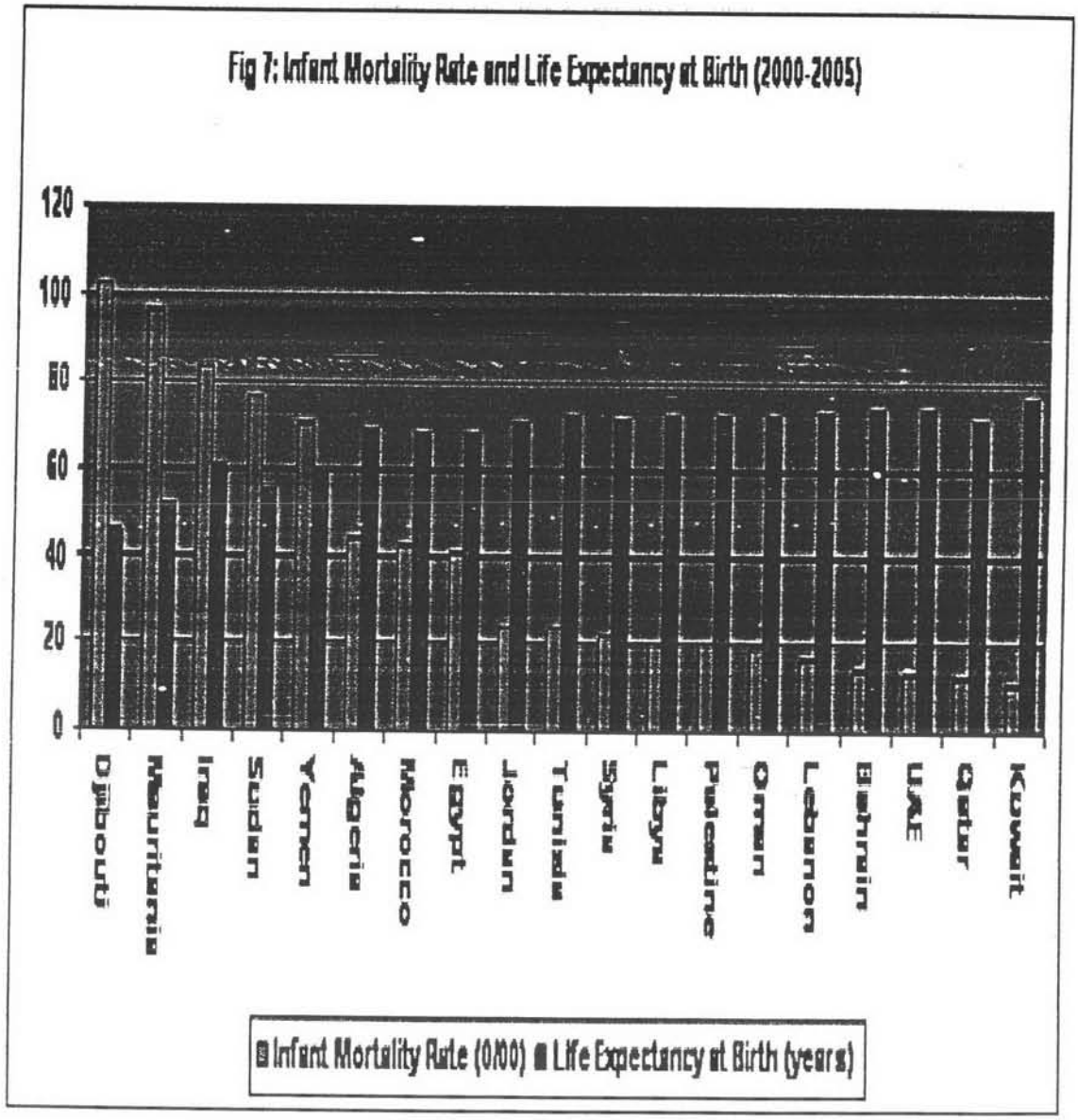
Source: World Health Organization Eastern Mediterranean Regional Office (EMRO) available www who \int .emro.

This study used data of 24 (Middle East and Arabic countries) for the period 1997-2004.It had barrowed the health and economic status indicators from these countries, also had Studied the interrelation between economic development and health development at these countries as implication for Iraq. The data that had been collected is a secondary data.

The reason for using and barrowing these indicators from these countries are. First non availability of data of Iraq for along period of time. Second non stability of health and economic status of Iraq because of three conflicts, 13 years of sanctions.

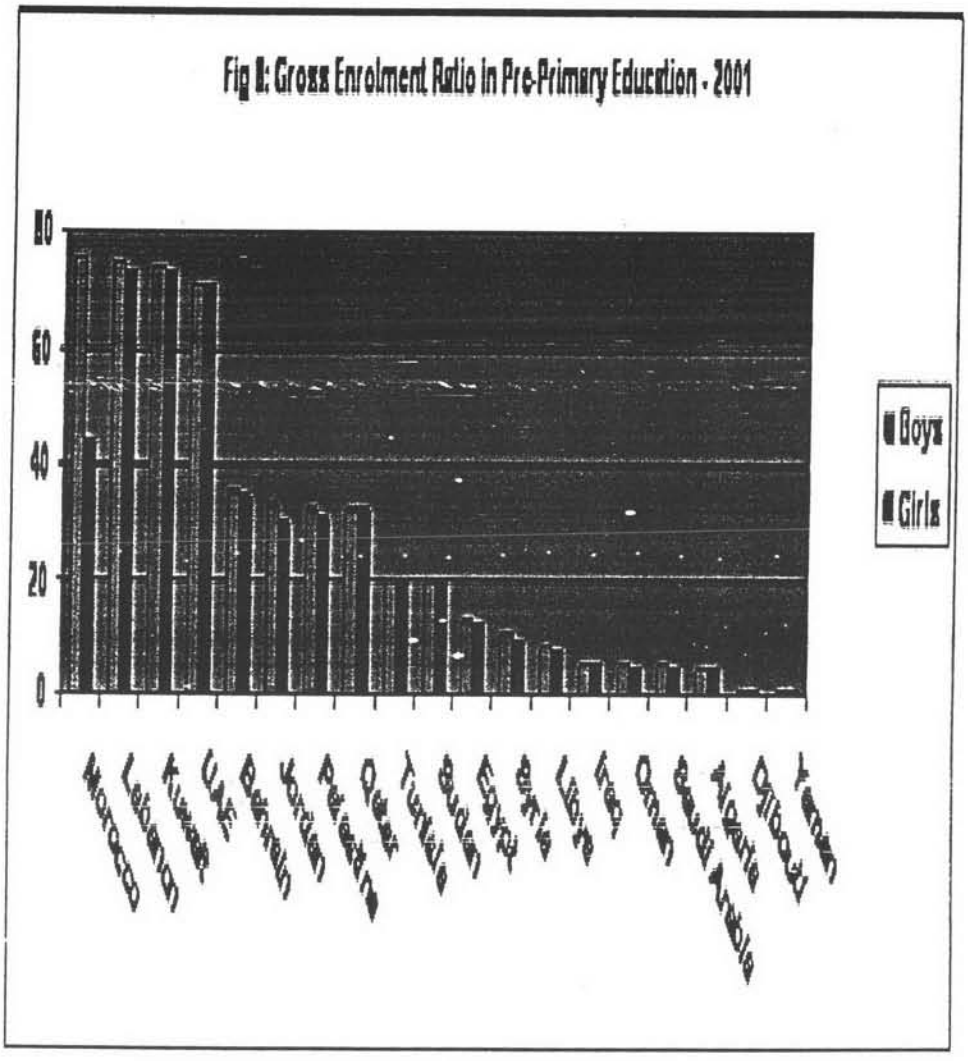
These countries that had same culture of Iraq are Middle East and Arabic countries : Bahrain, Syrian Arab Republic ,Jordan, Lebanon, Kuwait, Islamic Republic of Iran, Iraq, Egypt, Qatar ,Oman, Saudi Arabia, Pakistan, , Morocco, Libyan- Arab Jamahiriya , Sudan ,

Figure 1.6 infant mortality and life expectancy at birth (2000-2005)



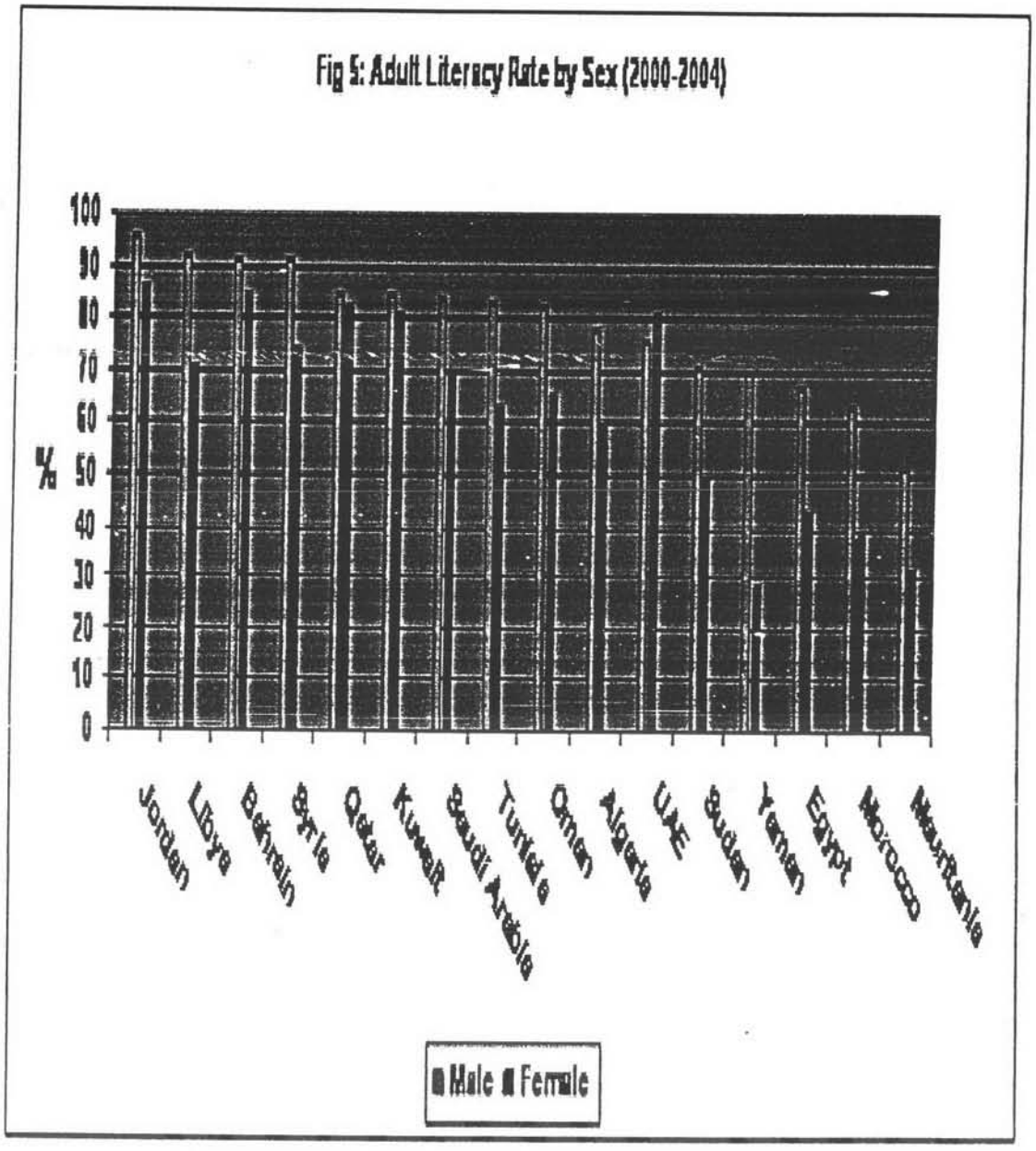
Source Unesco.organization available at www.iraq.unesco.org

Figure 1. 7 Gross Enrolment Ratios in Pre-Primary Education-2001 at Middle East countries



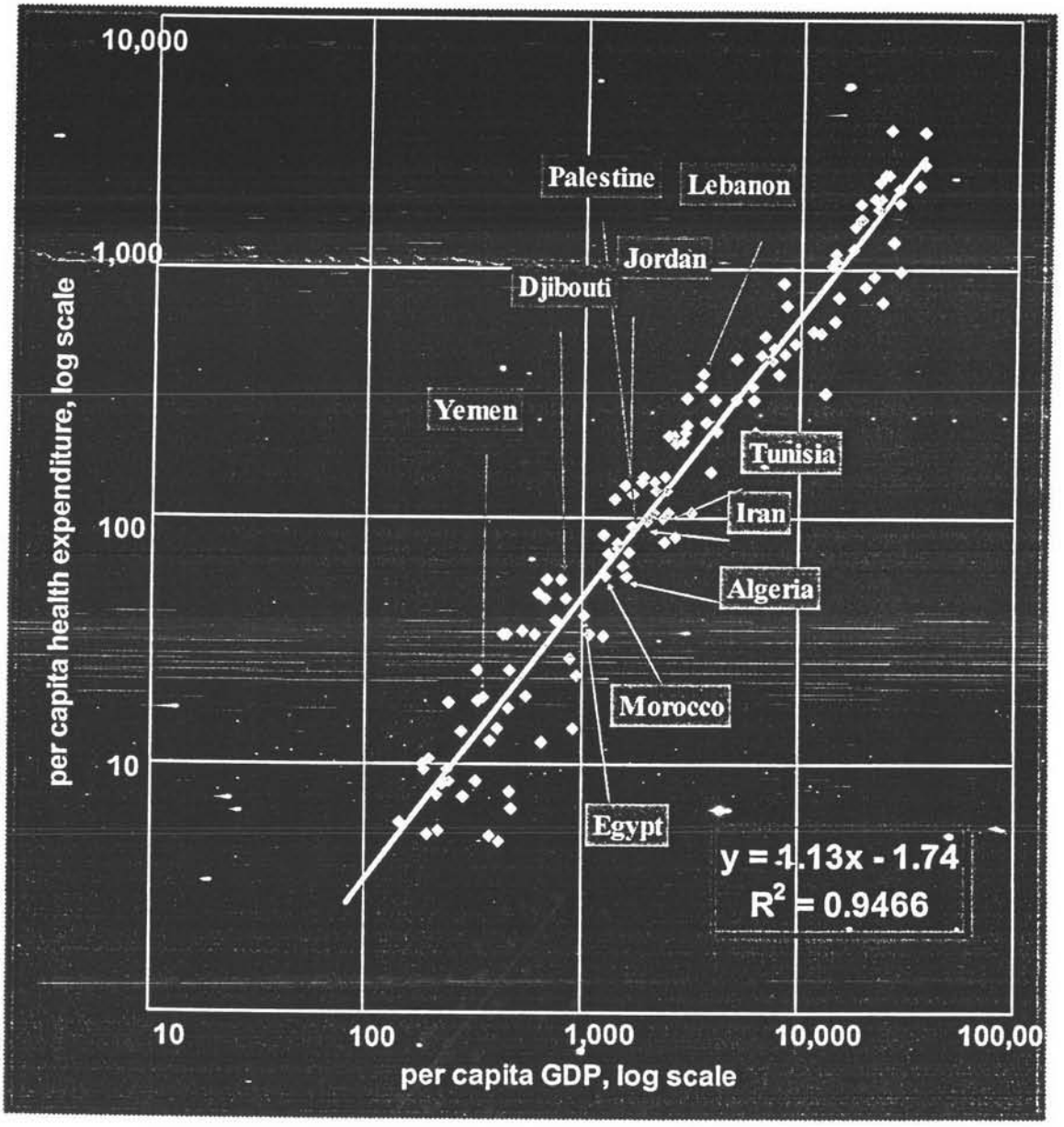
Source Unesco.organization available at www.iraq.unesco.org

Figure 1.8 Adult literacy rates by sex middle east countries



Source Unesco.organization available at www.iraq.unesco.org

Figure 1.7Per Capita GDP vs. Per Capita Health Expenditure, Global, and late 1990s



SOURC Maeda (2004) Seminar on Options for Iraq's Health Sector, World Bank of Middle East & North Africa Region

1.5 Expected outcome (possible benefit).

After complete this study and analysis of information can help policy makers to improve the health and economic status of population. And see as implications of Iraq which socioeconomic factors which have greater affect on health status especially for policy variable that can government change it policy and allocate resources to improve health status of population and establish an appropriate development policy and device health system reform.

1.6 Organization of the Report

There are six chapters in this study. Chapter one is the introduction presenting the country background, Rational, Research questions scope and of study. Chapter two presenting the economic development and health development in Iraq. Chapter three presented review of related literatures. Chapter four presented the conceptual framework and methodology employed for data collection. Chapter five presented empirical results, analysis. Chapter six presented implications for Iraq, conclusion and limitation of study.