

# Flow Of Funds - Health Care Sector in Iraq

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# Table of Contents

<b>Introduction.....</b>	<b>3</b>
<b>1. Profile of the Health Care System .....</b>	<b>3</b>
1.1. Pre-conflict.....	3
1.2. Post-conflict.....	6
<b>2. Funds Flow Map .....</b>	<b>8</b>
2.1. Pre-conflict.....	8
2.2. Post-conflict.....	8
<b>3. Background about the situation in Iraq .....</b>	<b>9</b>
<b>4. Central Ministry Of Health (South and Center).....</b>	<b>10</b>
4.1 Pre-conflict.....	10
4.1.1. Sources and uses of funds .....	13
4.1.2. Process of requesting and transferring funds .....	16
4.1.3. Categorizing expenditures .....	17
4.1.4. Pharmaceuticals .....	18
4.2. Post-conflict .....	18
4.2.1 Sources and uses of funds .....	19
4.2.2. Process of requesting and transferring funds .....	21
4.2.3. Categorizing expenditures .....	22
4.2.4. Pharmaceuticals .....	22
4.2.5. 2004 Situation .....	22
<b>5. Sulimanyia Ministry Of Health .....</b>	<b>22</b>
5.1. Pre-conflict.....	22
5.1.2. Sources and Uses of Funds .....	22
5.2. Post conflict .....	23
<b>6. Erbil Ministry Of Health.....</b>	<b>23</b>
<b>7. Conclusions.....</b>	<b>24</b>
<b>4. References.....</b>	<b>26</b>

## Introduction

The Ministry of Health has initiated the process of conducting National Health Accounts (NHA) in Iraq. This report has been prepared as one of the first steps in this process. It provides a basic description of the health care financing system in the period pre- and post-conflict. A retrospective round of NHA would be considered to allow for comparisons, which could provide useful information for policy-making in Iraq.

Geographically, Iraq's budget was previously only for the Center and South of the country. The Northern/Kurdistan region (Erbil, Sulimanyia and Dehouk Governorates) had, and continues to have, two independent ministries of health based in Sulimanyia and Erbil. In the post-conflict period, the northern regions of Iraq are treated as regional governments, with revenues flowing into the central Treasury's consolidated revenue account and expenditures centrally funded by tied grants. (1)

## 1. Profile of the Health Care System

This section provides basic information about the main actors in the Iraqi Health Care System in the pre- and post-conflict period. The information contains the following<sup>1</sup>:

- Benefits offered by the entity/organization
- Coverage and eligibility criteria, special programmes for specific population groups
- Main sources of financing for the entity/organization
- Nature of the relationship between the financing and service delivery functions
- Size of operation as indicated by numbers of facilities, beds and staff

### 1.1. Pre-conflict

Benefits offered by entity	Coverage/special categories	Principal financing sources	Provider-payer relationship	Size of operation
<b>Central Ministry of Health (Center and South)</b>				
Comprehensive health care services: public health, preventive care, curative care and hospitalization.	The entire population center is eligible for receiving health care provided by the MOH. Services were actually provided for	<ul style="list-style-type: none"> <li>▪ Out-of-pocket payments by patients according to the auto-financing system.</li> <li>▪ Central Ministry of Finance</li> <li>▪ Oil For Food</li> </ul>	<ul style="list-style-type: none"> <li>▪ Services were provided in the Ministry of Health's own large network of facilities</li> <li>▪ The largest part of provider's income came in the form of "incentives"</li> </ul>	<ul style="list-style-type: none"> <li>▪ Primary Health Centers = 1,012</li> <li>▪ Specialized Centers = 58</li> <li>▪ Hospitals = 143</li> <li>▪ Number of beds = 27,512</li> <li>▪ Number of employees =</li> </ul>

<sup>1</sup> The analysis is conducted using a framework adapted from the "Guide to producing national health accounts"

	the population of the South and Center since they facilities were located in these regions	program (Pharmaceuticals)	generated from the auto-financing scheme	82,715
<b>▪ Sulimanyia Ministry of Health (Sulimanyia)</b>				
Comprehensive health care services: public health, preventive care, curative care and hospitalization	The population of Sulimanyia	<ul style="list-style-type: none"> <li>▪ Ministry of Finance in Sulimanyia</li> <li>▪ Nominal out of pocket contributions</li> <li>▪ Oil for Food program (Pharmaceuticals)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Services were provided in the Ministry of Health's own network of facilities</li> <li>▪ Health care providers and staff were paid salaries for which the original source of funds was the MOF.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Primary Health Care Centers = 387</li> <li>▪ Hospitals = 26</li> <li>▪ Number of beds = 2,360</li> <li>▪ Number of employees = 10,172</li> </ul>
<b>▪ Erbil Ministry of Health (Erbil and Dehouk)</b>				
Comprehensive health care services: public health, preventive care, curative care and hospitalization	The population of Erbil and Dehouk	<ul style="list-style-type: none"> <li>▪ Ministry of Finance in Erbil</li> <li>▪ Nominal out of pocket contributions</li> <li>▪ Oil for Food program (Pharmaceuticals)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Services were provided in the Ministry of Health's own network of facilities</li> <li>▪ Health care providers and staff were paid salaries for which the original source of funds was the MOF</li> </ul>	<ul style="list-style-type: none"> <li>▪ Primary Health Care Centers = 274</li> <li>▪ Hospitals = 19</li> <li>▪ Number of beds = 2,137</li> <li>▪ Number of employees = 12,417</li> </ul>
<b>▪ Presidential Divan</b>				
Curative care and hospitalization	Some of its facilities were open to the public and some such as Ibn Sina Hospital allowed only high-ranking Government	<ul style="list-style-type: none"> <li>▪ Ministry of Finance</li> <li>▪ Out-of-pocket household expenditures</li> </ul>	<ul style="list-style-type: none"> <li>▪ Facilities were owned by the Presidential Divan</li> </ul>	<ul style="list-style-type: none"> <li>▪ Hospitals = 2</li> <li>▪ Number of beds = 742</li> <li>▪ Number of employees = 1,583</li> </ul>

	officials to receive care.			
<b>Ministry of Defense</b>				
Primary health care, curative care and hospitalization	Those employed in the military and their families	Ministry of Finance	MOD had its own facilities and providers working in military facilities were salaried staff	<ul style="list-style-type: none"> <li>▪ Primary Health Centers = 24</li> <li>▪ Hospitals = 7</li> <li>▪ Number of beds = 1,421</li> <li>▪ Number of employees = 12,192</li> </ul>
<b>▪ Ministry of Military Industry</b>				
Outpatient curative health care	Those employed in military factories	Ministry of Finance	Ministry of Military Industry had its own facilities. Providers working in military facilities were salaried staff.	<ul style="list-style-type: none"> <li>▪ Outpatient clinics = 20</li> </ul>
<b>Ministry of Oil</b>				
Curative health care and hospitalization	Those employed in the Ministry of Oil	Ministry of Finance	Ministry of Oil had its own facilities	<ul style="list-style-type: none"> <li>▪ Hospitals = 1</li> <li>▪ Number of beds = 150</li> <li>▪ Number of employees = 221</li> </ul>
<b>▪ Private Sector</b>				
Curative outpatient care and hospitalization	All citizens who were willing to pay	Direct out-of-pocket payments	Private providers operated on a fee-for-service basis	<ul style="list-style-type: none"> <li>▪ Outpatient clinics = not available</li> <li>▪ Hospitals = 69</li> <li>▪ Number of Beds = 2,016</li> </ul>

## 1.2. Post-conflict

Benefits offered by actor	Coverage/special categories	Principal financing sources	Provider-payer relationship	Size of operation
<b>Central Ministry of Health (South and Center)</b>				
Comprehensive health care services: public health, preventive care, curative care and hospitalization	The entire population is eligible for receiving health care provided by the MOH	<ul style="list-style-type: none"> <li>▪ Majority of funds from the Ministry of Finance</li> <li>▪ Out-of-pocket payments for “tickets” which are visit fees</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ministry of Health’s own facilities. In addition, those facilities previously belonging to the Military.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Primary Health Centers = 987</li> <li>▪ Specialized Centers = 66</li> <li>▪ Hospitals = 152</li> <li>▪ Number of beds = 29,965</li> <li>▪ Number of employees = 105,437</li> </ul>
<b>Sulimanya Ministry of Health (Sulimanya)</b>				
Comprehensive health care services: public health, preventive care, curative care and hospitalization	The population of Sulimanya	<ul style="list-style-type: none"> <li>▪ Ministry of Finance in Sulimanya</li> <li>▪ Nominal out-of-pocket contributions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Services are provided in the Ministry of Health’s own network of facilities</li> <li>▪ Health care providers and staff were paid salaries for which the original source of funds was the MOF.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Primary Health Care Centers = 387</li> <li>▪ Hospitals = 26</li> <li>▪ Number of beds = 2,360</li> <li>▪ Number of employees = 10,172</li> </ul>
<b>Erbil Ministry of Health (Erbil and Dehouk)</b>				
Comprehensive health care services: public health, preventive care, curative care and hospitalization	The population of Erbil and Dehouk	<ul style="list-style-type: none"> <li>▪ Ministry of Finance in Erbil</li> <li>▪ Nominal out-of-pocket contributions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Services are provided in the Ministry of Health’s own network of facilities.</li> <li>Health care providers and staff were paid salaries for which the original source of funds was the MOF</li> </ul>	<ul style="list-style-type: none"> <li>▪ Primary Health Care Centers = 274</li> <li>▪ Hospitals = 19</li> <li>▪ Number of beds = 2,137</li> <li>▪ Number of employees = 12,417</li> </ul>

Ministry of Oil				
Curative health care and hospitalization	Those employed in the Ministry of Oil	Ministry of Finance	Ministry of Oil has its own facilities	<ul style="list-style-type: none"> <li>▪ Hospitals = 1</li> <li>▪ Number of beds = 150</li> <li>▪ Number of employees = 221</li> </ul>
▪ Private Sector				
Curative outpatient care and hospitalization	All citizens willing to pay	Direct out-of-pocket payments	Private providers operate on a fee-for-service basis	<ul style="list-style-type: none"> <li>▪ Outpatient clinics = not available</li> <li>▪ Hospitals = 65</li> <li>▪ Number of Beds = 1,890</li> </ul> <p><b>NGO &amp; Private sector in the North:</b></p> <ul style="list-style-type: none"> <li>▪ 16 NGO facilities</li> </ul> <p><b>Sulimanyia</b></p> <ul style="list-style-type: none"> <li>▪ Hospitals = 8</li> <li>▪ Specialist and GP clinics = 242</li> <li>▪ Pharmacies = 124</li> <li>▪ Laboratories and Radiology clinics = 19</li> </ul> <p><b>Erbil and Dehouk</b></p> <ul style="list-style-type: none"> <li>▪ Hospitals = 6</li> <li>▪ Specialist and GP clinics = 117</li> <li>▪ Pharmacies = 93</li> <li>▪ Laboratories and Radiology clinics = 13</li> </ul>

The main observations are: 1) Iraq does not have any social health insurance system (there are isolated, very small health insurance programs for employees of specific

companies), and 2) The Northern regions have two ministries of health operating independently of the central MOH. The main change, observed in the health care sector after the war, is the inclusion of the Ministry of Defense medical system, the Presidential System, and Ministry of Military Industry's system in the MOH system.

## 2. Funds Flow Map

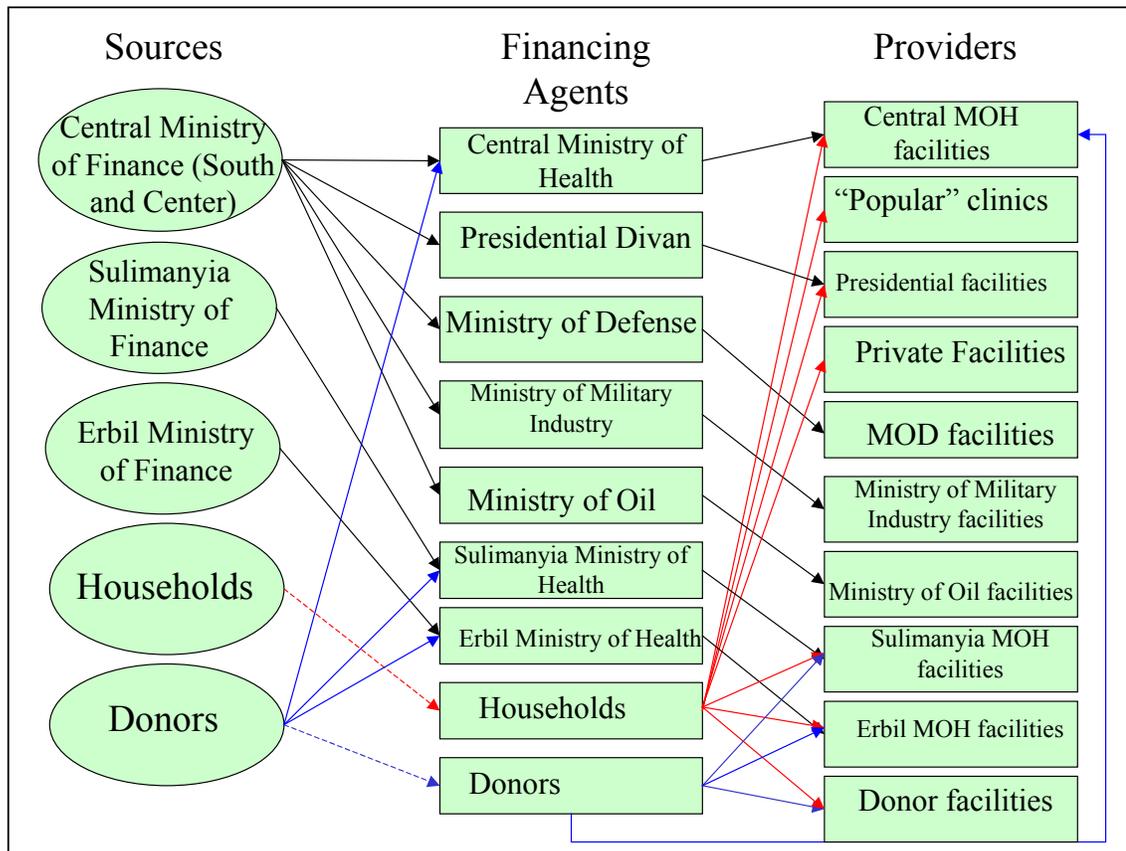
Funds flow maps are prepared using the standard NHA definitions as follows:

**Financing Sources** are institutions or entities that provide health funds used in the system -- "where does the money come from?"

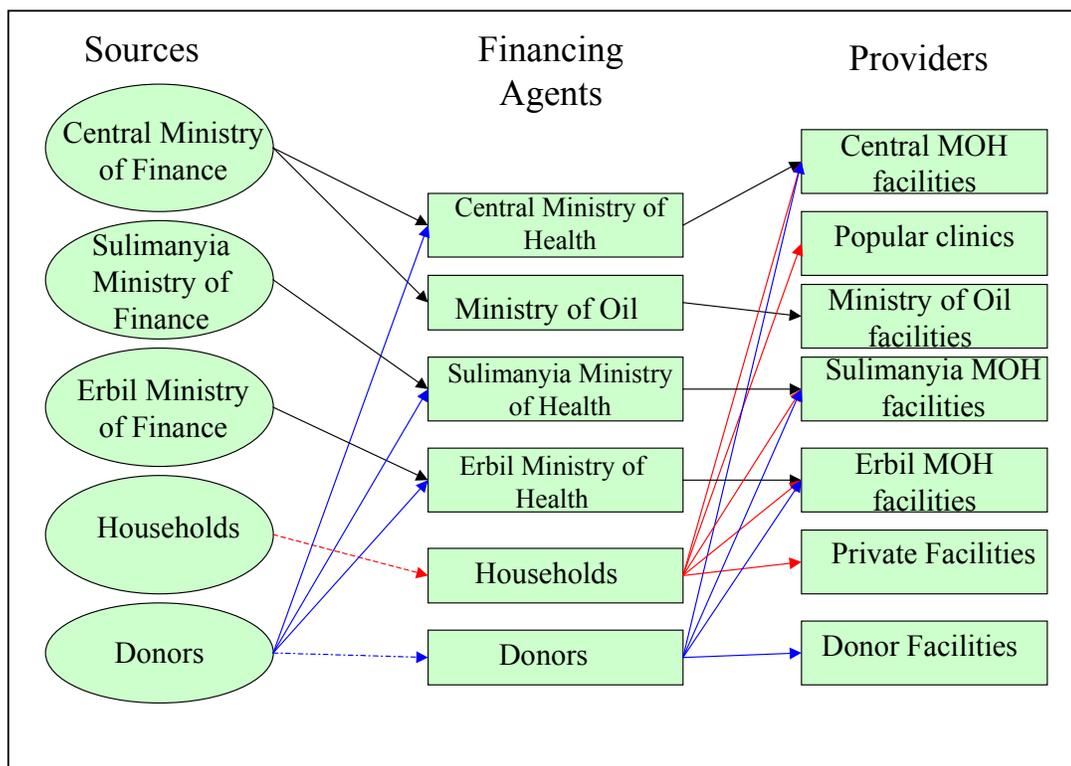
**Financing Agents** are institutions or entities that have power and control over how funds are used (i.e., programmatic responsibilities). They receive funds from sources and use them to pay for services or products or activities -- "who manages and organizes the funds?" (e.g., MOH, insurance companies)

**Providers** are end users of health care funds, entities that actually provide/deliver the health service -- "where did the money go?" (e.g., hospitals, clinics, health stations, pharmacies)

### 2.1. Pre-conflict



## 2.2. Post-conflict



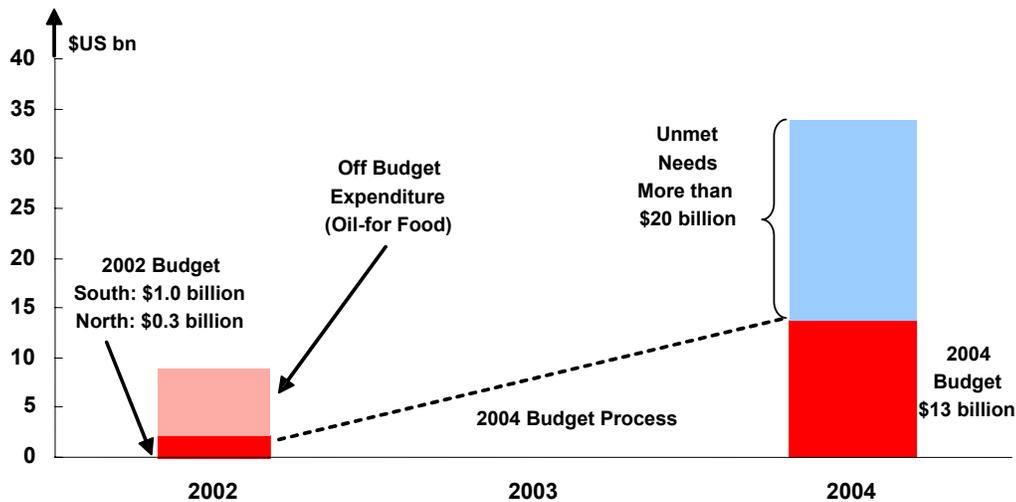
Dashed arrows represent expenditures that were transferred directly to providers from sources.

These funds flow maps remain preliminary until research is conducted concerning the importance of the different actors in the health sector. Based on better evidence, some of these entities could be ignored because they do not represent a significant part of the sector, and some entities could be added. This will depend on the consensus of the NHA team concerning the relative importance of different actors in the health sector.

## 3. Background about the situation in Iraq

In the pre-conflict period, Iraq's budget framework was characterized by a dichotomy between public entities that are 'on-budget' (all Ministries and their agencies that perform a public function) and 'off-budget' entities (also known as 'self-financing' entities), which included almost all health provision facilities. All revenues of 'on-budget' entities are required to be put into consolidated revenue, controlled by the Ministry of Finance. Expenses of 'on-budget' entities are made against Budget appropriation lines. (1)

Further, the vast bulk of public expenditure under the previous regime was 'off-budget', reflecting goods received under the Oil-for-Food program. The manipulation of this program by the former regime presented a significant challenge in preparing the 2004 Budget. (1)



Source: Republic of Iraq, 2004 budget- Ministry of Planning & Ministry of Financing

## 4. Central Ministry of Health (South and Center)

The Ministry of Health is the largest institutional financier and provider of health care services in Iraq. Therefore, it is essential to have a basic understanding of how the MOH is funded and how funds flow from the MOH to providers. Available information about the system pre- and post-conflict is presented below.

This section excludes the Kurdistan region Governorates (Sulimanyia, Dehouk and Erbil) that had their own ministries of health, which operated separately from the central MOH in Baghdad.

### 4.1 Pre-conflict

The MOH provided services through its network of facilities. There were different types of MOH providers for which different regulations were implemented:

Primary Health Care (PHC) Centers: outpatient clinics, which operate from 8 am to 2 pm.

General and specialized hospitals: MOH hospitals, which operated 24 hours.

“Popular Clinics”: also referred to as “Evening Clinics”, which operated from 3 pm to 7 pm, usually at the same location as PHCs.

Health Insurance Clinics: outpatient clinics in rural areas, which operated in the evening usually at the same location as PHCs. They are not part of any insurance scheme and they are in fact simply rural clinics which offer services at slightly lower prices.

The “auto-financing” scheme was implemented in the majority of hospitals and health centers in Iraq. There are a number of decrees, which describe the details of implementing the auto-financing scheme. The most important of these are Decree 124 and Decree 132.

### **Decree Number 124 of the year 1997 (2):**

According to this decree, 9 out of the 142 hospitals, 976 health centers, 24 dental clinics and 9 specialized health centers were to implement the Auto-financing scheme. Rules and regulations governing the implementation of the scheme stipulate: a) the authority for setting visit fee and drug co-payment rates, and b) facility revenue distribution rules.

The rules for distributing Primary Health Care Centers’ (PHCs) and hospitals’ revenues can be summarized as follows:

Visit fees: 50% of revenues generated from visit fees are paid in the form of incentives to health care providers and the remaining 50% are for operating expenditures and administrative staff incentives (about 20% of the 50%)

Drug co-payments: facilities purchased drugs from Kimadia<sup>2</sup> at a certain specified price and were allowed to sell the drugs to the public at 130% of this price. 50% of the extra 30% profit was used to pay for pharmacist’s incentives and the remaining was used to pay for operations expenditures.

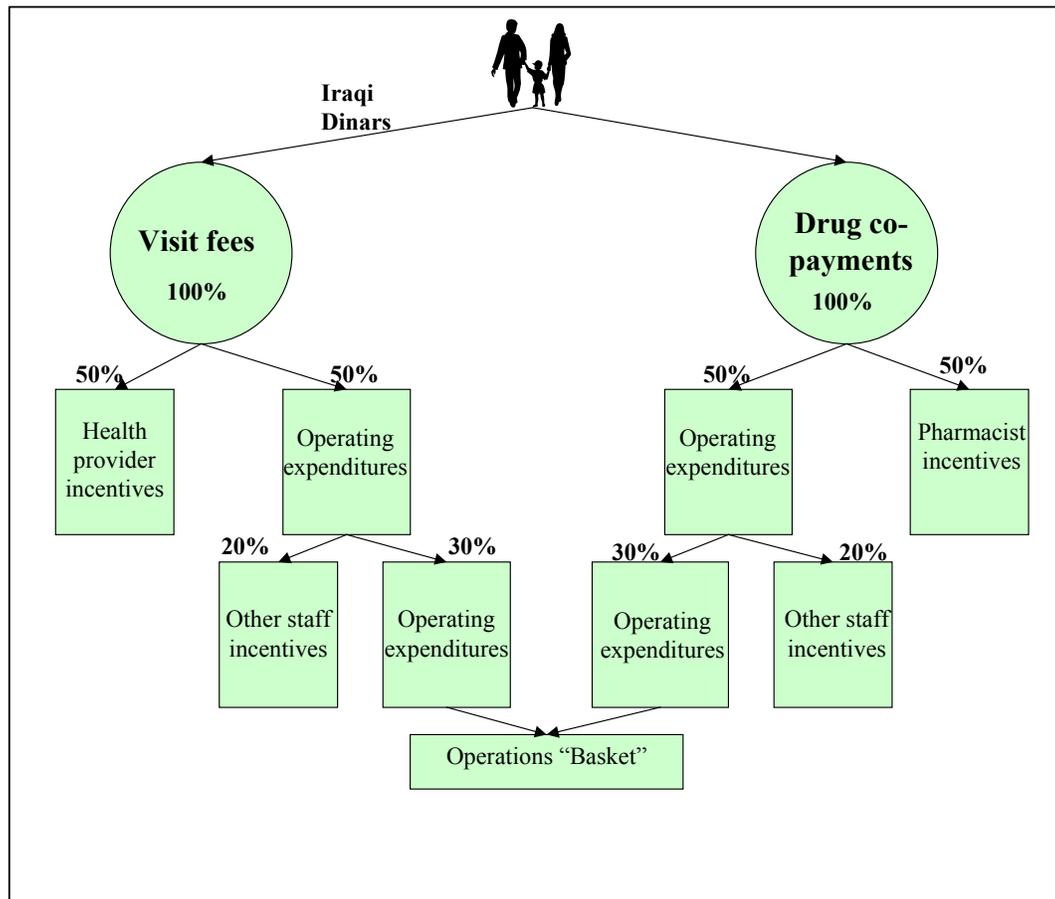
Inpatient cases: 60% of the revenues generated were used to pay for incentives for health care providers, 10% for the hospital and 30% for other staff in the hospital.

Facilities were then required to send up the system 10% of the incentives paid to its staff (3% to the central level and 7% to the Directorate level) The money used to pay for the higher administrative levels of the system came out of the operating expenses “Basket”.

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<sup>2</sup> Kimadia was a governmental organization responsible for importing, procurement, storing and distribution of pharmaceuticals in Iraq. It was located inside the MOH. However, it operated independently.

**Use of revenues generated at a PHC facility according to the rules of the auto-financing scheme**



**Decree Number 132 of the year 1999**

This decree was issued to include the remaining 134 hospitals in the Auto-financing scheme. The decree stated that 50% of beds in each hospital would follow the auto-financing scheme. These would be referred to as “private beds” and the remaining 50% of beds would offer services at a reduced price (equaling 10% of the price of the “private beds”). These beds were referred to as “public beds.”

Health Insurance Clinics (clinics in rural areas), operating in the evening at the same locations as PHCs, were also operating under the Auto-financing scheme. The rules for distributing revenues from visit fees were 60% for health providers, 30% for other staff, and 10% for the institution. Drug co-payment revenues were divided as at PHCs.

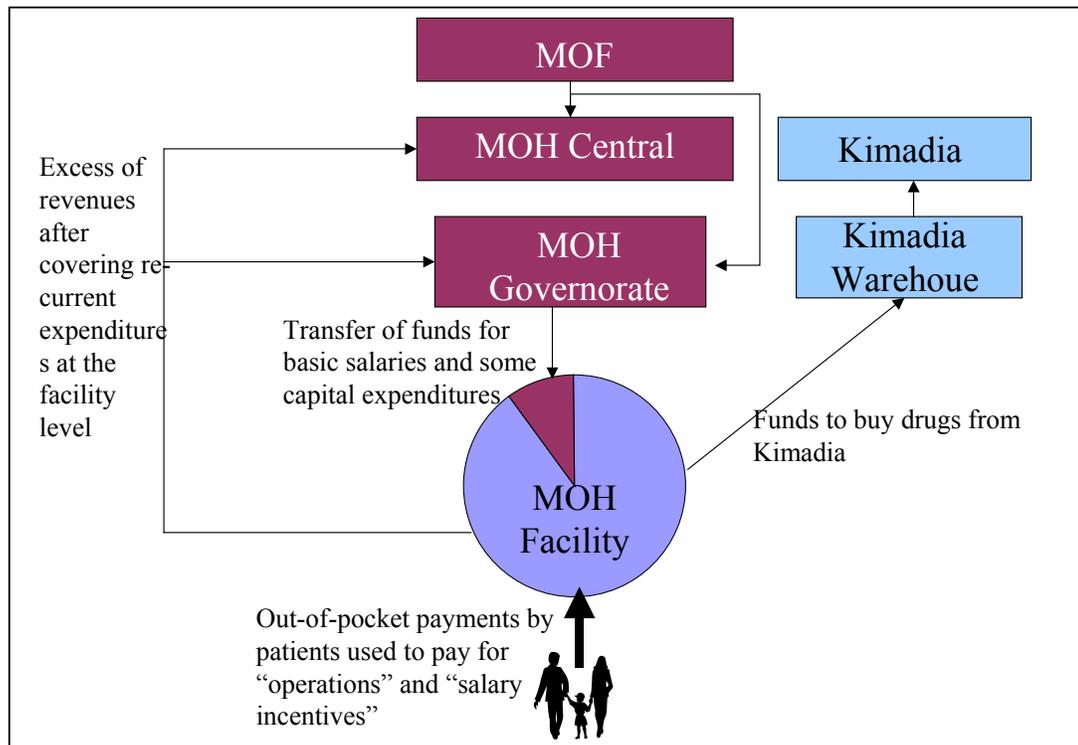
“Popular clinics” could be considered semi-private clinics. These are clinics, which operate, in the evening, and in most cases at the same location as PHCs. They operated under different rules and regulations. Health care providers received 50% of visit fees (for the patients they received), and the remaining 50% was used to pay for operating costs and other staff salaries. The “Popular Clinics Board” made decisions concerning salary rates for non-medical staff. Excess of revenues over the specified expenditure

items was then distributed as follows: 75% was transferred to the MOF, and 25% for the Popular Clinics organization.

Psychiatric and Fever hospitals were excluded from the Auto-financing scheme.

#### 4.1.1. Sources and uses of funds

##### MOH Flow of Funds, Pre-conflict Situation



The implementation of the auto-financing scheme has meant that the major source of funds for the MOH had become household out-of-pocket expenditures. Private out-of-pocket expenditures were paid in the form of visit fees and drug co-payments\* to the health facility.

The fees varied by type of provider to the facility as follows:

Type of facility	Visit fees	Drug co-payment
Primary Health Care Center	250 ID	P* +30%
Hospital outpatient	350 ID	P+30%
Hospital –operations	One third of private sector price	P+30%
Health Insurance Clinic	350 ID	P+30%
Popular clinic*		
▪ Specialist	500 ID	P+20%
▪ Other	350 ID	P+20%
▪ Generalist	250 ID	P+20%
▪ Specialized popular clinics	750 ID	P+20%

P\* is the price at which facilities purchase drugs from Kimadia<sup>3</sup>

The majority of funds generated from visit fees through the auto-financing scheme were retained at the facility level and were used to pay for staff “salary incentives” which comprised the biggest part of staff’s income from the facility and operating costs for facilities. Facility’s income from drug co-payments was used to purchase drugs from Kimadia and pay for pharmacists’ incentives and also for paying operating expenses. The excess of revenues over expenditures at the facility level was transferred to higher levels of the system to pay for salary incentives for management and administration staff at the Governorate and Central levels.

The Ministry of Finance (MOF) continued to transfer funds to the MOH. These funds were used to pay for basic salaries for MOH staff (which were a small part of staff’s income from facilities), and for some capital expenditures. Some special programs such as Maternal and Child Health, School Health, Mental Health, Communicable Disease and Family Planning were funded through donors (mainly through UN agencies) and were supported by the state.

#### Where did the MOH Iraqi Dinar come from – 2002?

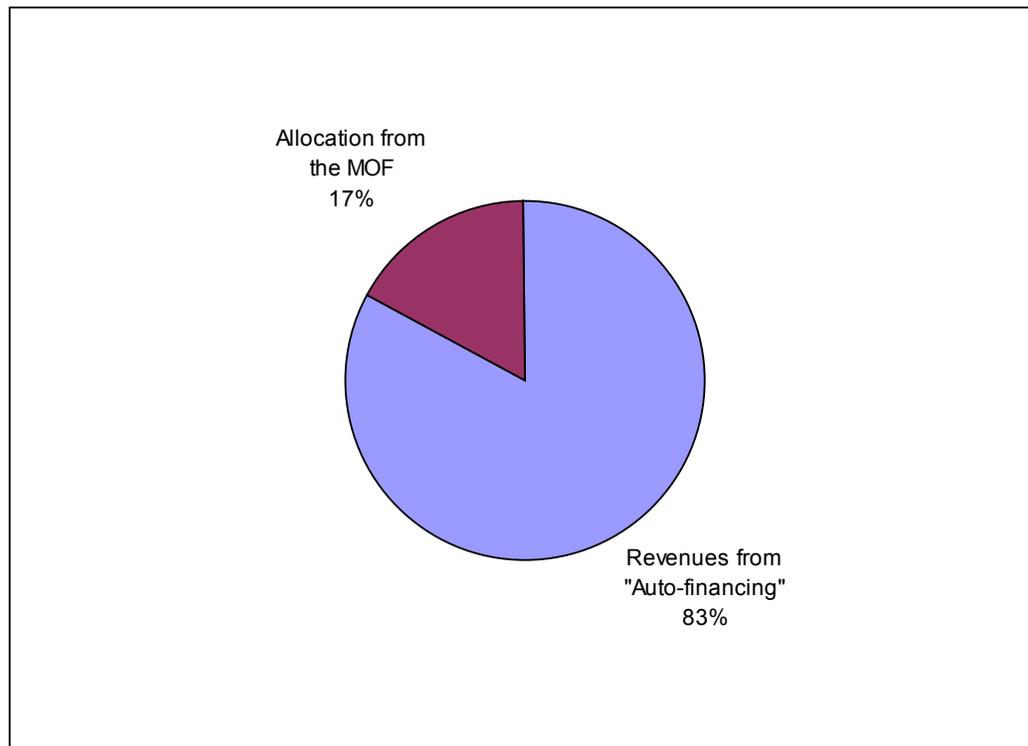
Sources of funds (for operating expenditures)	Amount in \$ US (exchange rate = 1200 ID/ 1\$ US) <sup>4</sup>
Revenues from “auto-financing”	41,400,000
Allocation from the MOF	8,666,000
Total	50,066,000

Source: MOH Budget and Finance Department (Directorate of Planning)

<sup>3</sup> Kimadia purchased drugs according the Memorandum of Understanding (MOU) as part of the Oil- For-Food program. Kimadia sold the drugs to facilities, which in turn sold drugs to patients.

<sup>4</sup> The official exchange rate for 2002 was 1200 ID per 1 \$ US, while the market exchange rate was 2000 ID per 1 \$ US.

### Sources of MOH Funds – 2002

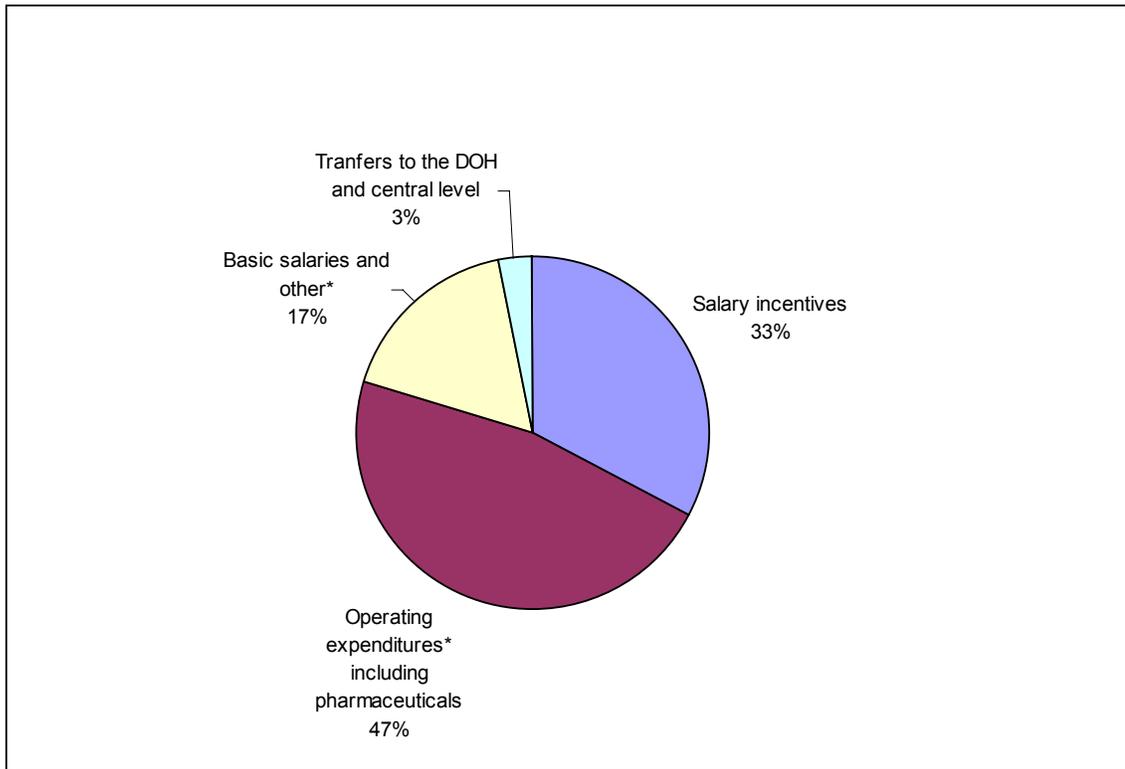


### Where did the MOH Iraqi Dinar go -- 2002?

<b>MOH Operating Expenditures</b>	<b>Amount in \$ US</b>
Salary incentives	16,450,000
Operating costs*, including pharmaceuticals	23,458,000
Basic salaries and other*	8,666,000
Transfers to DoH and central level	1,492,000
<b>Total</b>	<b>50,066,000</b>

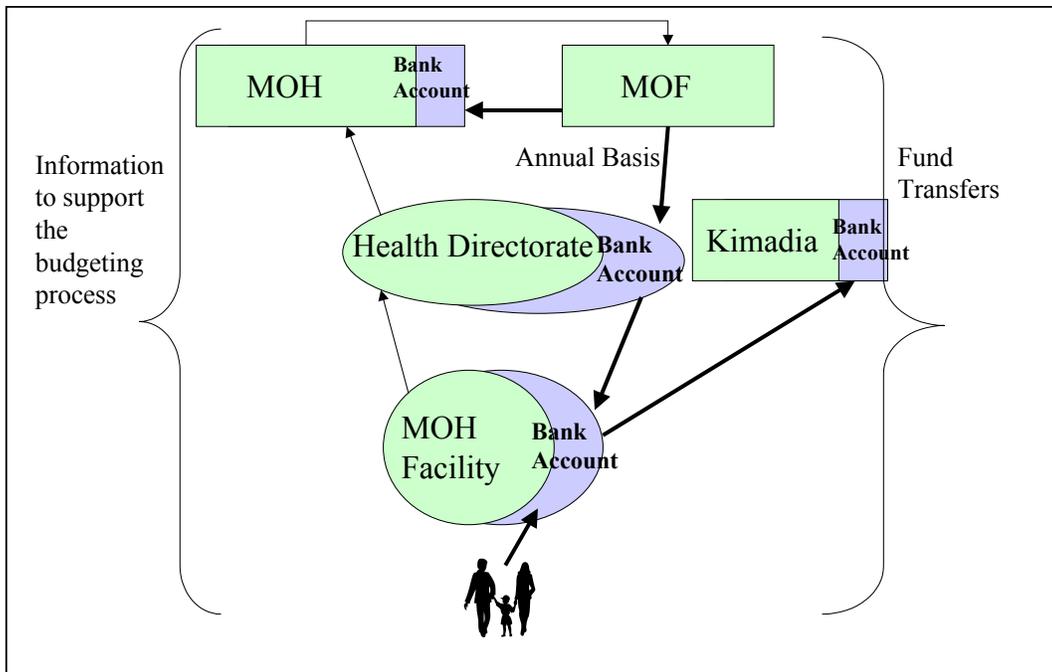
Source: MOH Budget and Finance Department (Directorate of Planning)

## Use of MOH funds- 2002



Note: It was not possible to separate pharmaceuticals from operating expenditures using available data.

### 4.1.2. Process of requesting and transferring funds



As is clear from the diagram, information concerning budget estimates and requests were sent up the system to the directorate where it got reviewed and aggregated. The information was then sent to the Department of Financial Planning at the central MOH where information was aggregated and reviewed for all Governorates. The process of preparing the budget took a period of two months and resulted in a consolidated MOH annual budget. Budgets were prepared on a historical basis. This means that the year's budget was based mainly on the previous year's budget.

According to the agreed upon budget, the MOF transferred funds annually to the central MOH account and Governorate Health Directorate accounts which in turn transferred funds to facilities' accounts.

Most funds used to operate facilities came from patients' visit fees and drug co-payments. These were collected at the facility level, which deposited these collected revenues in their bank accounts and used the funds to pay for facility's staff salary incentives and operating costs, including purchasing drugs from Kimadia.

#### 4.1.3. Categorizing expenditures

The MOH used more than one system for classifying expenditures and revenues. The first is referred to as the “**Unified system**” used by facilities operating under the “auto-financing” scheme. The second is the “**Decentralized system**” which is what the Directorates and central MOH use to classify expenditures and revenues which is mostly transfers of funds from the MOF. The third is the “**Centralized system**” used to deal with the treasury.

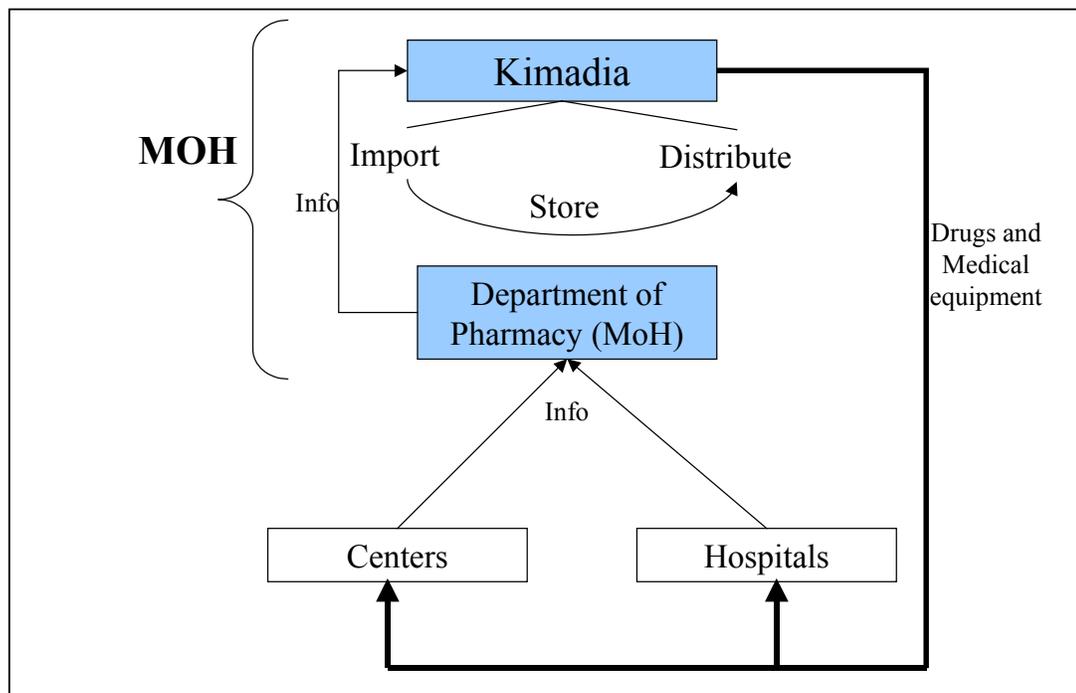
In general the Iraqi budget system distinguishes between capital expenditures and operating expenditures, which are classified as follows:

Chapter 1	Staffing expenditures
Chapter 2	Service requirements
Chapter 3	Goods requirements
Chapter 4	Asset Maintenance
Chapter 5	Capital expenditures (only rehabilitation)
Chapter 6	Transferred expenditures (compensation for damage)
Chapter 7	Foreign obligations (usually used only by Ministry of Foreign Affairs)
Chapter 8	Special Programs (examples TB, AIDS...etc.)

New investments were decided upon through a consultative process between the Ministry of Planning, MOH Directorate of Planning and the Engineering Department of the MOH. The plans were laid out in what was referred to as the “Investment Plan”. MOF transferred funds to the MOH according to the agreed upon plan.

#### 4.1.4. Pharmaceuticals

Kimadia was the organization responsible for importing, procuring, storing and distributing pharmaceuticals. The MOH Department of Pharmacy aggregated pharmaceutical needs of health facilities and presented it to Kimadia to assist it in making decisions concerning purchasing (according to the Memorandum of Understanding). MOH health facilities purchased the pharmaceuticals they needed from Kimadia at reduced prices using the funds generated from selling drugs to the public.



#### 4.2. Post-conflict

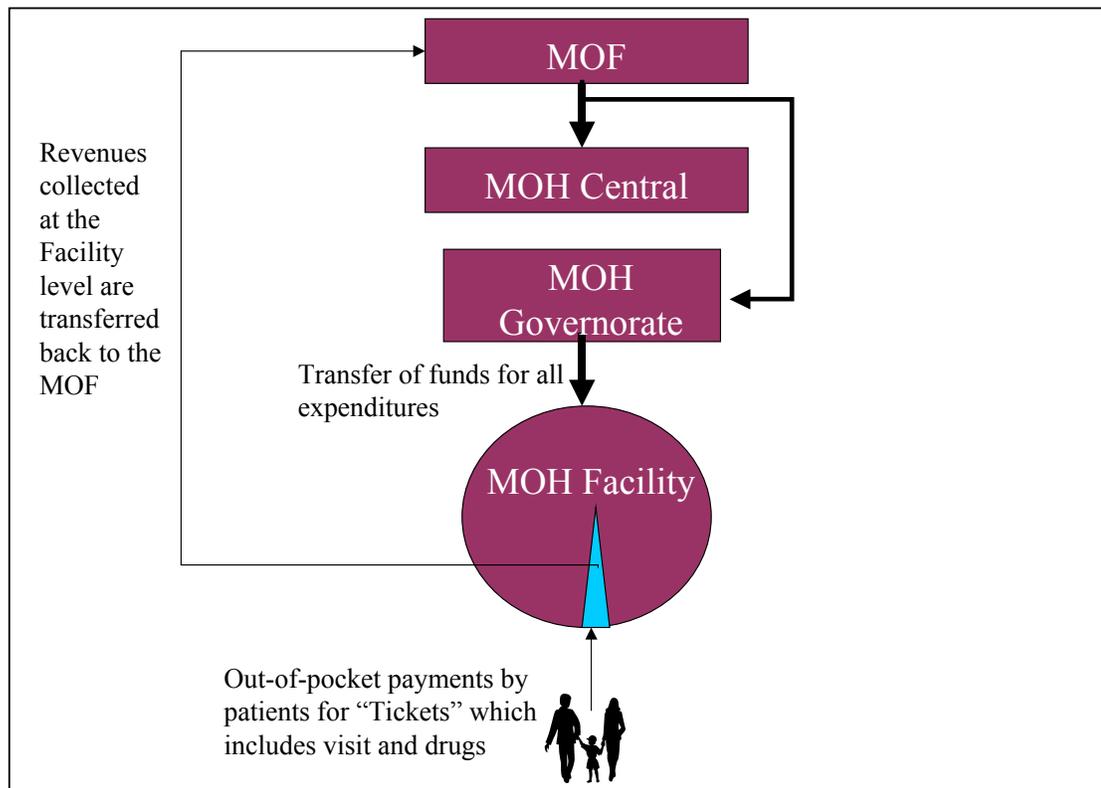
The situation in 2003 was different in many respects from the pre-conflict situation. It was the result of several interventions, which took place after the war. The relevant changes to this paper can be summarized as follows:

- The Ministry of Defense medical system and the Ministry of Military Industry facilities have been absorbed into the MOH system. Therefore military facilities are now owned by the MOH and ex-military staff are now on the MOH payroll.
- Presidential Directorate facilities were also absorbed into the MOH.
- The auto-financing scheme has been stopped in all MOH facilities except for Popular Clinics. Facilities and directorates' bank accounts have been frozen as a necessary precaution to avoid chaos after the war. All services including drugs were provided free of drugs until nominal fees were introduced, which include fees for visits and drugs.

- Kimadia, which operated on an auto-financing basis before the war no longer had revenues because pharmaceuticals were provided for free to facilities, and therefore Kimadia has been transformed into the “Storage and Distribution” directorate, which receives funding from the central MOH.
- The majority of funding for the MOH at the present time comes from direct transfers from the MOF.

#### 4.2.1 Sources and uses of funds

##### Flow of Funds in the post-conflict situation



In the post-conflict period, the major source of funds for the MOH has become the MOF transfers, which covered all salaries, operating expenditures and pharmaceuticals for all MOH facilities in Iraq except for Popular Clinics. In the period directly following the war, all services were provided free of charge to patients. Then facilities started charging “tickets” for visit and drug fees. The funds generated from “tickets” were transferred back to the MOF. The visit-fee schedule is as follows.

Type of facility	Visit and drug fees
Primary Health Care Center	250 ID for drugs, 250 ID for visit fee

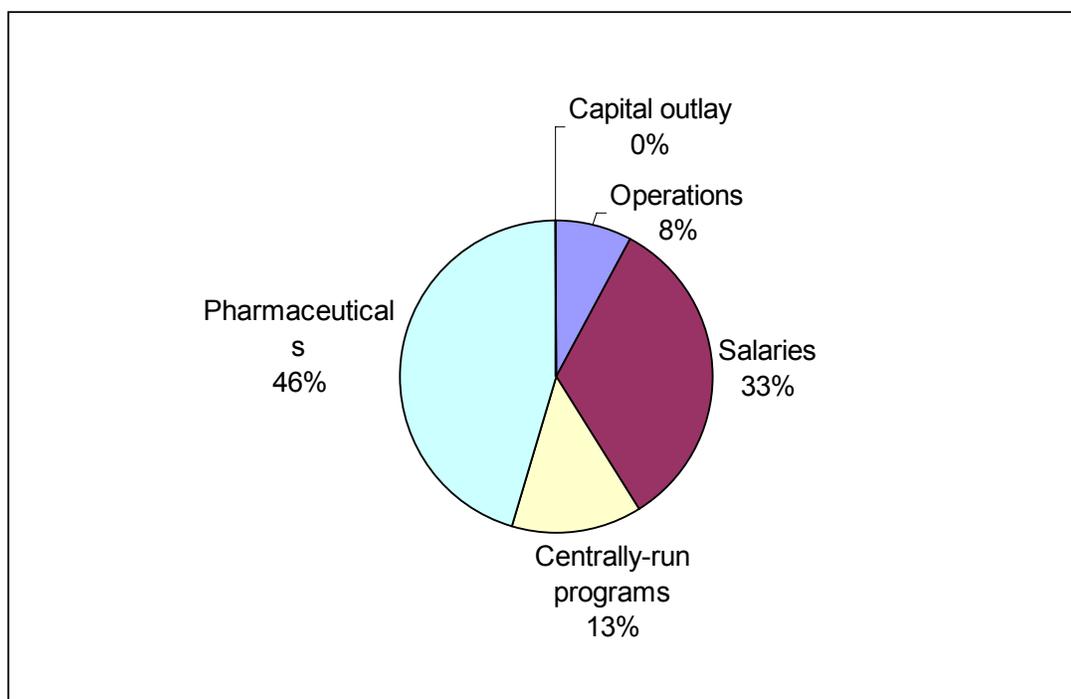
**Where did the MOH Iraqi Dinar come from, June-December 2003?**

Sources of funds (for operating expenditures)	Amount in \$ US (using an exchange rate of 1500 ID per 1 \$ US)
MOF	185,240,301

**Where did the MOH Iraqi Dinar go, June-December 2003?**

Operating Expenditures	Amounts in \$ US (using exchange rate of 1500 ID per 1 \$ US)
Operations	14,799,000
Salaries	61,250,000
Central programs	24,776,637
Pharmaceuticals	84,383,789
Capital outlay	30,875
Total	185,240,301

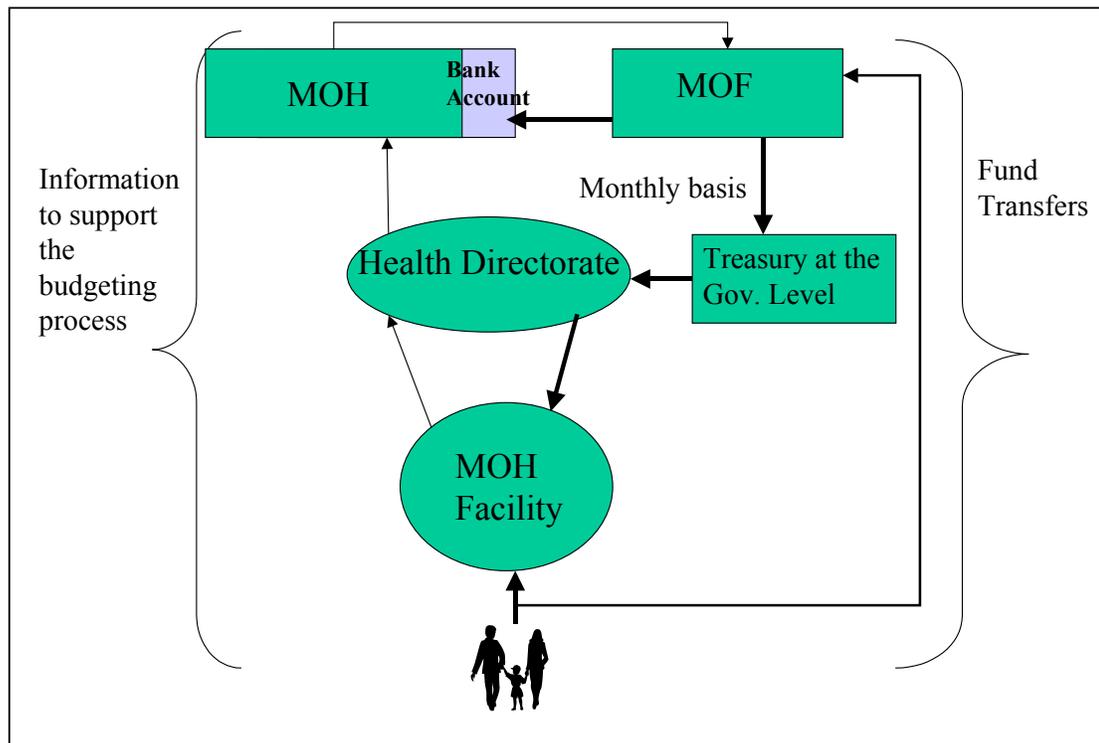
Source: MOH Budget and Finance Department- Resource Mobilization Directorate



Note: The salaries expenditures for the months (June-December) were estimated using number of staff and average salaries after the war.

The reason the amount for the capital outlay is very small is that large investment projects were carried out through the “Supplemental” project. Capital expenditures are not considered in the operating budget presented above.

#### 4.2.2. Process of requesting and transferring funds



In the months directly following the war (March-May), the focus was simply on attempting to enable the health system to function. Starting in June 2003, the MOH-CPA (Coalition Provisional Authority) prepared a 6-month budget for the period June-December 2003. The MOH budget consisted of: 1) allocations to Governorates for operation costs (using the number of hospital beds in each Governorate as the basis, in the absence of more robust information), 2) allocations for special programs (such as the Public Health Laboratory, Infection Control Program, and others), 3) pharmaceuticals, 4) MOH central operations, and 5) allocations for capital outlay.

The MOH-CPA established a process by which a funding request has to be issued and approved by the MOH-CPA before money can actually be spent (for all budgeted items). This rule applies for all the budgeted items except for the “allocation to Governorates” and salaries (which were not included in the MOH 2003 budget as salaries were transferred directly from the MOF treasury). Spending as recorded in funding requests is tracked using an Excel-based program.

The salary budget had to be submitted by the MOH and then approved monthly by the MOF before funds could be transferred from the MOF to Governorate treasury. The main issue has been the increase in employee numbers.

### **4.2.3. Categorizing expenditures**

The MOH continued to use the Iraqi budget system described in the pre-conflict section, which separates between capital expenditures and operating expenditures, which are in turn classified into 8 categories.

### **4.2.4. Pharmaceuticals**

Kimadia, the agency responsible for importing, purchasing, storing and distributing drugs before the war, used to operate on an auto-financing basis. It generated its revenues by selling drugs to facilities that in turn sold the drugs to patients. In the post-conflict period, since drugs were offered free to facilities and patients, Kimadia had no source of revenue. It received funds to purchase drugs from the central MOH budget, and therefore, Kimadia effectively became part of the MOH with an allocated budget to pay for pharmaceuticals. Later in 2004, Kimadia was transformed into the Storage and Distribution Directorate.

### **4.2.5. 2004 Situation**

Rapid progress is taking place in the MOH due to the current circumstances and the need for change, therefore the situation in 2004 has progressed further than the one described in the 2003 section above. Some of the relevant changes are outlined in this section as follows:

- The MOH annual budget for 2004 includes salaries in the allocations, after the implementation of a new 11-grade salary scheme.
- Special programs paid for out of the central budget have changed to adapt to the needs of a changing environment.

## **5. Sulimanyia Ministry of Health**

### ***5.1. Pre-conflict***

#### **5.1.2. Sources and Uses of Funds**

The Sulimanyia Ministry of Health was publicly funded. The main source of financing was the Sulimanyia Ministry of Finance. There was no “auto-financing” system in place. Nominal user fees were collected (a 3 Swiss Iraqi dinar user fee for Primary

Health Care Centers and a 5 Swiss Iraqi dinar fee for hospital outpatient visits, and no drug co-payments<sup>5</sup>).

## 2002 Sulimanyia MOH expenditures

<i>MOH Expenditures</i>	<i>Amount in \$ US ( Sulimanyia MOH )</i>
<b>Salaries</b>	2,974,352
<b>Recurrent expenditures</b> (Communications, printing, renting, vehicles, medical conferences, training, stationary, electricity ...etc.)	1,379,906
<b>Drugs and supplies</b>	842,377
<b>Maintenance</b> (Equipment, cars, machines, houses...etc)	336,211
<b>Investments</b> (Machines, computer...etc )	61,293
<b>Specific Programs</b> Disease prevention (malaria, tuberculoses...etc.	6,223
<b>TOTAL</b>	<b>5,600,362</b>

Source: Sulimanyia MOH

The pharmaceuticals were purchased partly through the Oil for Food program and partly by the Sulimanyia MOH directly, when there were deficiencies and problems with the drugs purchased through the program.

## 5.2. Post-conflict

The Sulimanyia MOH is still funded through transfers from the Sulimanyia Ministry of Finance. In the post-conflict period, the northern regions of Iraq are treated as regional governments, with revenues flowing into the central Treasury consolidated revenue account and expenditures centrally funded by tied grants. (1)

## 6. Erbil Ministry Of Health

The situation at the Erbil Ministry of Health is very similar to the Sulimanyia Ministry of Health. The difference is of course in the numbers; the table below shows 2002 MOH expenditures by category.

<sup>5</sup> 1 dollar = 150 old Iraqi dinar (Swiss) -- 2002 official exchange rate

## 2002 Erbil MOH expenditures

<i>MOH Expenditures</i>	<i>Amount in \$ US (Erbil MOH)</i>
<b>Salaries</b>	3,642,933
<b>Recurrent expenditures</b> (Communications, printing, renting, vehicles, medical conferences, training, stationary, electricity ...etc.)	2,016,732
<b>Drugs and supplies</b>	915,901
<b>Maintenance</b> (Equipment, cars, machines, houses...etc)	381,400
<b>Investments</b> (Machines, computer...etc )	53,533
<b>Specific Programs</b> Disease prevention (malaria, tuberculoses...etc.	7,667
<b>TOTAL</b>	<b>7,018,166</b>

## 7. Conclusions

The nature of this report is descriptive. However, some broad observations can be made about the system.

There is enough evidence to describe that the pre-conflict situation as inequitable (except for the northern region) since health care was mostly financed through private out-of-pocket household expenditures. Out-of-pocket expenditures are a highly regressive form of health financing, and it also means that the underprivileged were deterred from accessing health care because of financial barriers. The health system in the post-conflict period addresses this point as one of its main focuses by increasing public financing to the MOH and significantly reducing the burden on patients.

However, the old system displays some strengths which were the result of the will of the Iraqi MOH staff to have a functioning health system in spite of the fact that the previous government simply absolved itself of responsibility towards the Iraqi people. The design and implementation of systems such as “auto-financing” to adapt to the situation and continue to function have resulted in creating skills and strengths that are worth building on. The most important strength is that health facilities were autonomous to a great extent.

There has been marked and significant increase in the level of overall spending on health. This increase is mostly the result of increased public spending on health, which was in the form of much higher salaries for civil servants, spending on pharmaceuticals, and implementation of specific special needs programs. In addition to the increase in operating expenditures on health, the “Supplemental Project” provided huge investments in infrastructure and capital development.

It would be very useful to measure how the increase in spending has influenced the quality and utilization of health care. However, available data does not allow for making these comparisons pre- and post-conflict. In spite of the unavailability of data to measure quality, it would be fair to say that some improvement in quality took place. Measuring quality traditionally relied on the framework developed by Donabedian (1980) (3) of Structure-Process-Outcome. Considering the severe under-funding and the derelict conditions of MOH facilities, it is expected that at least regarding the “structure” dimension of quality, some improvement did take place.

If we consider the goals of a health system is to achieve equity, efficiency, quality and responsiveness, these observations could be summarized as follows:

<b>Health System</b>	<b>Pre-conflict</b>	<b>Post-conflict</b>
<p><b>Strengths/ Opportunities</b></p>	<p><b>Autonomous Medical facilities</b></p> <p>The fact that medical facilities had bank accounts and ran their own business as autonomous entities managing their own revenues and expenditures created incentives for responsiveness and efficiency.</p>	<p><b>No financial barriers to access health care</b></p> <p>MOH currently provides services at its facilities at a reduced price, which includes drugs. This means that people regardless of their socio-economic status are receiving health care.</p>
<p><b>Weakness/ Challenges</b></p>	<p><b>Huge burden on the patient</b></p> <p>Private out-of-pocket household expenditures as the main source of financing for the health system meant that it was a highly inequitable system.</p> <p><b>Kimadia’s system of procurement and distribution</b></p> <p>There is clear evidence that the system for pharmaceutical procurement and distribution was problematic in many ways. Leakage of MOH drugs to the private sector could easily be witnessed in private pharmacies.</p>	<p><b>Sustainability</b></p> <p>The question that the MOH needs to ask now is “How much Iraq is willing to pay for publicly financing the health care in the future?” and what other sources of finance could be tapped.</p> <p><b>Value for money</b></p> <p>Mechanisms are needed that ensure that the increase in spending is accompanied by the “right incentives” to improve quality and utilization, and some effort needs to be placed on the importance of measuring the impact of increased spending.</p>

The main recommendations based on these observations are to build on the strengths of the old system and promote autonomy at the facility level and attempt to monetize the system again. These features create incentives for accountability and efficiency in the use of resources and to ensure that the increase in spending on health is accompanied by incentives to improve the quality and utilization of health care services.

#### **4. References**

1. Republic of Iraq, 2004 Budget, Ministry of Planning and Ministry of Finance, October 2003
2. Guide to producing National Health Accounts, WHO, WB and USAID
3. Gaafar R. (November 2002) 'Self Financing Manual', Iraq Ministry of Health Publication.
4. Smith, J., Laverentz, M., Liu, X., (September 2003) 'Primary Health Care Quality: What can Iraq Learn from International Experience?' Abt Associates Publication.