Senate Democratic Policy Committee Hearing

"An Oversight Hearing on the Bush Administration's Plan to Rebuild Iraq's Hospitals, Clinics and Health Care System: What Went Wrong?"

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My name is Richard Garfield. I am a Professor of Nursing and Coordinator of a World Health Organization Collaborating Center at Columbia University.

I work in countries with wars or economic sanctions to assess humanitarian conditions. This has sometimes thrust me into political situations, but I am an epidemiologist and nurse, not political scientist. I mainly work with national authorities to improve their ability to manage the crisis, improving data collection and its use to make scarce resources go further

I have done this in Cuba, Haiti, Yugoslavia, Afghanistan and Liberia for national governments and UN organizations over the last two decades. It was in this context that I first visited Iraq in 1996. Since then I have visited Iraq almost every year to assist UNICEF, the World Food Program, and the Iraqi Ministry of Health. I evaluated the quality of mortality studies and created independent estimates of mortality changes, evaluated the overall humanitarian impact of the Oil for Food program, participated in research on income and living standards in northern Iraq, and carried out an analysis of nutritional status during the 1990s.

After the 2003 invasion, I assisted the World Health Organization, UNICEF, and the American NGO International Medical Corps to assist in reconstruction, manage health services, and prepare the post-Oil for Food UN program. I collaborated with the Coalition Provisional Authority (CPA) and the Ministry of Health to reactivate the health system throughout the post-war summer, authored the post-war "Watching Brief" on Health for the World Bank in the summer of 2003, designed a child survival strategy for USAID in Iraq in early 2004, and participated in research to identify changes in mortality since the 2003 invasion. During my most recent visit to Iraq in January 2005, I assisted the Ministry of Health to redesign health worker training and human resource development. I was also a member of the Humanitarian Assessment group of the Independent Inquiry (Volker) Committee into the UN Oil for Food Programme, which in 2005 finished assessing the effectiveness and efficiency of the Oil for Food Program in alleviating the country's humanitarian crisis during 1997 to 2003.

I met most of the people working for the CPA in the health sector and observed their activities and priorities. I had to deal with them in some manner as an on-the-ground consultant for the World Health Organization, and as one of two authors of the main analysis of the health system at that time, the "Watching Brief" prepared by UNICEF, the World Bank, and WHO. I thus am in a position to comment on the efficiency and effectiveness of the CPA's work in health, but not specifically about their budgeting or spending of Development Fund for Iraq (DFI) funds as it was never clear what activities were based on these funds.

Composition of the CPA Health Team

There were serious deficits in the composition of the team. Perhaps most importantly, the team did not begin to arrive in Iraq until nine weeks after Baghdad fell to the Coalition. The vacuum of leadership that occurred during those nine weeks greatly weakened the initiative of the reconstruction effort.

Among members of that team, there was not a single individual with an advanced degree in public health. I think not one member of that team, including its chief, James Haveman, had ever lived outside the United States, and none had ever taken part in a post-war or post-disaster reconstruction. This lack of experience and expertise was another blow to the widespread desire among Iraqis to fix the health system and improve the health of the population.

CPA Work in Health

Aspects of Mr. Haveman's leadership style represented a further blow to that effort. Mr. Haveman saw to it that the only other U.S. citizens in Iraq in an official capacity were dismissed from their posts. This included Jack Thomas of USAID, and Mary Patterson of the firm Abt Associates, the main USAID health subcontractor. These individuals each had many years of international health project management experience in the Middle East, and could have been key in developing efficient and effective program priorities and administration. Instead, Mr. Haveman had the support and advice mainly of clinicians from the Department of Defence (DoD), none of whom had run or built health systems. Inevitably, the work of the CPA would then focus on running hospitals and providing medicines. While these activities are essential, they would have less impact on improving the health of the Iraqi people at that time than a focus on community health, health education, outreach for basic health promotion programs, and the elaboration of financial management, systems planning, and pharmaceutical administration systems appropriate to a middle-income developing country. The failure to focus on these issues mirrored the major problems of the Oil for Food program over the prior eight years, where commodities were delivered but training, maintenance, and management of the health system had deteriorated enormously. The aspiration of making the health system appropriate to the health conditions of Iraq could not be achieved by the CPA team.

The mystery surrounding CPA functioning did not end when the team arrived. Little of their work appeared to result from consultation with Iraqis, and few announcements of their decisions ever appeared, even within the Ministry of Health. Although the team did take up posts in the Ministry of Health building, there was virtually no use of mass media, then growing rapidly to either share decisions with the public or to reach the public for health promotion. Not only was a great opportunity lost, but most people in Iraq were left in the dark about the interests and actions of the US in health. More of their publicity was oriented toward the U.S. than toward Iraq.

One area where this would have been important was with regards to user fees at ambulatory clinics. Such a system had been set up four years before the fall of the Hussein regime. These user fees paid supplements to physicians that kept them at work and provided for the purchase of cleaning supplies, bandages, oxygen, and other essential local goods. The normal way to examine this situation would have been to identify the role of these fees in unit budgets, identify alternative sources of funds, and determine who didn't use health services because of these fees. Instead, and without consultation with knowledgeable Iraqis, Col. Garner simply abolished the fees, throwing clinics into a disarray as great as the recent looting. Doctors didn't come to work without the accustomed salary supplements and a crisis in oxygen supply resulted. CPA was forced to quietly withdraw the abolition of user fees, and they were reestablished under subsequent Iraq administrations. CPA should have provided the example of well informed studies leading to policy analysis on user fees; instead Iraqis continue to consider this strictly a political matter. Lacking expertise, under CPA, indeed, it did remain a political issue alone.

Failure to address, or even recognize, these functional issues in the training of physicians and the organization of the health system doomed the CPA and DoD approaches to failure. CPA and DoD focused on:

- investing in supplying medicines to a system where medicines were used poorly;
- holding short training courses to teach techniques that were not practiced in the country;
- catering to professional organizations, when these organizations represented few people; and
- contracting to U.S. firms for the building hospitals and clinics, few of which were built and fewer still could be used well.

One reform that was carried out well was the centralization of a database and funding for salaries, which was a very effective reform. Health workers received much better salaries and the system was seen to be equitable. Similar systems should have been developed to monitor utilization of health services, adequacy of the supply of medicines, and the causes and outcomes of hospitalization. Consultants were needed for these things, but they were not developed. Consultants and international firms were not needed

for building clinics and hospitals, which Iraqis could do just as well as American firms at much lower cost. In short, CPA and DoD used a top-down approach that was expensive, ineffective, and did not draw on decades of expertise and experience in making health programs work. Instead, CPA and DoD decided that they alone could invent new and better approaches, without experience, training, knowledge of past mistakes, or monitoring of present conditions. It is little wonder then that their approaches cost enormous amounts of money and left Iraq few benefits. I am sure these leadership failures cost the system far more than corruption.

One of the biggest issue for CPA in health was "corruption." The term was never defined, and Iraqis had a very different understanding of what is and was corrupt than the Americans did. Anti-corruption efforts were highly moralistic rather than administrative. They provided little to improve the management and oversight in a period when supervision of work declined and punishments for not obeying orders disappeared. In this context, the robbery of medicines and other goods in the health system flourished. The first post-CPA Iraqi Minister of Health believed that he largely rooted out corruption in the medicine supply system, while people in the system say it became more corrupt than under Saddam!

More important, but virtually unaddressed, was the misutilization of medicines. It appears that the majority of antibiotics, for example, are given to patients whose condition does not warrant their use. Use of antibiotics per capita in Iraq is higher than in the U.S. The solution to this problem would have involved training and retraining, supervision, and monitoring. Since steps weren't made in this direction, the system still hemorrhages a massive amount of the goods for health at a time when the people can least afford to be without medicines. The elaboration and distribution of treatment algorithms, chart reviews, and in-service education seminars could have greatly improved training of health workers, but it never occurred. The value of medicines lost this way far outweighs the amount lost to corruption, either before or after the 2001 invasion.

Lacking planning and management skills, the CPA led staff at the Ministry of Health in "visioning" exercise. Even during my visit in January 2005, senior staff described the vision of an affordable, equitable system, but hadn't begun to develop skill in basic planning tools. Our Iraqi counterparts need and deserve to learn these skills and we missed a great opportunity in the first post-invasion year to lead this effort.

CPA frequently described the "bad old days" under Saddam and described the present with an "everything-is-coming-up-roses" tone. Critical analysis did not occur and CPA staff misunderstood the limited data generated by the health system. Little attention was devoted to improving the collection and analysis of health services data, though this should have been among the CPAs first tasks.

To their credit, the CPA team remained engaged in Iraq and highly dedicated to their work throughout their tenure. CPA set as a main health goal the halving in one year (and then two years) of the Infant Mortality Rate (IMR). Yet they never knew what the IMR was, and never established plans to measure it! It could have been a centerpiece of the

work of the health system, but instead became merely a rhetorical goal. CPA used a survey that had been carried out 4 years earlier, using data 6.5 years earlier, as their assumed current IMR. Anyone with minimal skills in demography knows that this was an invalid indicator of the current rate. Even worse, CPA never put in place a plan to monitor mortality rates to see how well the country was achieving their main goal. CPA never overcame its own rhetoric to get passed "happy stories" for U.S. consumption to identify valid health monitoring methods. We have no reason today to believe that the IMR is any lower than it was when the invasion occurred.

Health Conditions Today

The only major effort to assess living conditions since UNICEF's MICS survey in 2000 was carried out last year under contract to the UNDP. The Norwegian Statistical Agency carried out a large scale representative sample survey to assess living conditions in Iraq in spring and summer of 2004

The survey showed that most people do now have access to health services provided by the Government, and most of those services are better stocked and staffed than they were before 2003. The quality and effectiveness of services are not very good, however. Popular dissatisfaction is common (38%). Most children going to a clinic with diarrhea are given antibiotics (68%) rather than the oral dehydration fluids (37%) they should receive. While 98% of births are attended by a nurse, doctor, or midwife, death due to childbirth continues to be quite high (193 per 100,000 live births). Ten percent of households are overcrowded. Six percent of homes have been damaged by wars. Only 60% have regular access to clean water (down from 90% in 1989). The percentage of the population with piped connections for waste water disposal increased in the early 1990s, but the proportion with treatment of that water was small in the beginning of the period and approached zero by 1996. Little recovery occurred through 2003, and this improvement was largely lost through looting and the loss of electricity generating capacity in the months following the 2003 war. In the 2004 survey, sewage was observed in the street near 39% of all houses. Malnutrition among children under five years of age has declined from the very high rates observed in 1996, but shows much less recovery since 2000 and remains much higher than it was early in the crisis, in 1991.

	1991	1996	2000	2004
Acute Malnutrition	3.0	11.0	7.8	7.5
Underweight	9.0	23.4	19.5	11.7
Chronic Malnutrition	18.7	32.0	30.0	22.7

Occasional large scale surveys give little more than a glimpse of social indicators, and CPA didn't organize or fund any of these. Ongoing monitoring of a few sensitive

indicators would tell us much more, but no such monitoring existed under the Hussein government, nor was such a system set up under CPA administration.

What Should be Done Now?

It is easy to criticize the massive mistakes of the last four years, but much harder to identify what can and should be done now to finally improve the health system in Iraq. First, health workers need to be protected from the constant threat of violence if they are to work. This means that health services should be moved to protected areas and health workers should be offered safe havens in which to live.

National technical priorities should be set. Does the country want to focus mainly on primary care in clinics, or secondary care in hospitals? Both cannot be done well in a period of institutional reconstruction. This priority setting will have implications for building, supply, teaching, and research.

Plans for strategic decentralization should be developed rapidly. This would mean operative decision-making at the local level and normative decision-making at the national level. It would require the strengthening of information systems on the flow of medicines and diagnoses, while service organization will be allowed to vary depending on local conditions and priorities. A small group of consultants committed to carrying out these reforms should be contracted from outside the country for a process to last at least five years.

Iraq should be reconnected to the rest of the world. This can now be done via computing equipment in a way unlike any time in the past. This can help overcome some of the intellectual isolation Iraq experiences in training and provide opportunities for hands-on, off-site supervision.

These actions will not revolutionize health and health care in Iraq, but they will improve health and the conditions of work and study of health professionals in a way that has not been done in the last four years. Progress will inevitably be limited until stability and economic prosperity return to Iraq, but progress cannot and need not await those conditions. We already have, in the U.S. and elsewhere, the expertise to help make these reforms happen. New leadership directions are needed in the U.S. administration to make it happen.