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?"

Mary A. Paterson, **Ph.D.**
Catholic University School of Nursing

July 28, 2006

Good morning Chairman Dorgan, members of the Democratic Policy Committee, ladies and gentleman. My name is Mary Paterson. I was posted to Baghdad, Iraq, on May 31, 2003, as the Chief of Party for the USAID-funded Iraq Health Systems Strengthening Project. The short biography you have lists my qualifications for this assignment. I remained in Iraq until August 13, 2003, when I returned to the United States for a planned three-week visit to the head office of Abt Associates, my employer. I did not return to Baghdad.

The USAID Project was a one-year contract with a forty million dollar ceiling intended to support basic health care in the post-conflict Iraq. Its goal was to help Iraqi doctors, health professionals, and provider facilities to reestablish basic services to the vulnerable populations after the military stage of Operation Iraqi Freedom. The contract was particularly focused on maternal/child health and communicable disease control in the post-conflict situation. The project was not focused on health facility reconstruction, but rather on strengthening existing essential health systems in the post-conflict environment. In order to deliver the intended results, my team understood that a priority was to work with the Iraqi health care providers to review the pre-war and post-war conditions in the health care sector of Iraq and decide on where resources should be allocated and professional guidance provided to restore and appropriately modernize the essential health care systems. Prior to my travel to Iraq, Abt Associates hosted start-up meetings with all of the partners involved in the USAID project. I also provided a briefing to Mr. James Haveman, The CPA Senior Advisor to the Iraqi Ministry of Health at the Pentagon on the USAID project and expected scope-of-work.

At the initial stage of this project our team was established in a small hotel in Baghdad, outside the green zone. With the approval of our USAID cognizant technical officer (CTO) and at the request of the U.S. Army Civil Affairs, we established a working relationship with the Iraqi nurses and doctors at the Al Karkh district health administration, which operated 25 primary healthcare clinics and provided services to 1.2 million people in Baghdad. My staff began to assess primary healthcare delivery in Al Karkh in order to understand what could be done to assist these professionals to maintain

and strengthen service delivery. During this period, other project staff teams traveled throughout Iraq to assess the primary healthcare situation, visit hospitals and clinics, and recommend site locations for the planned additional field office sites. These activities were initiated at a time when the main emphasis at the CPA was on reconstruction projects, with the underlying assumption that there was no health infrastructure in Iraq worth preserving and that understanding the existing situation was not important since everything would be replaced. This ideology had the effect of isolating Iraq health experts since they represented the old, obsolete system that no one needed to understand. Despite this CPA orientation, we were contractually obliged to continue with our workplan. Main findings from our work can be summarized in a few major points:

Iraq had well-trained physicians. The Iraqi medical students were taught the English language and used textbooks and medical literature in English during their training. The Iraqi doctors and health administrators understood basic primary healthcare services and in many cases were delivering essential services competently despite very challenging conditions.

Iraq health sector suffered from adverse socio-political environment and extreme under-financing. Despite a capable health workforce, the Iraqi public health system suffered enormously from the trade embargos and a history of systematic resource deprivation in the predominantly Shiite areas and Kurdistan. Disease control and maternal and children's services were deliberately denied to the politically repressed communities. Needless to say, such a policy affected health outcomes nationwide. Among the 17 countries of the Middle East, Iraq had the second-lowest life expectancy at birth (59.2 years for men and 62.3 years for women), second-highest maternal mortality rate (370 per 100,000 live births), and the highest infant mortality rate (83 per 1,000 live births), as measured over the three to five years preceding the conflict. Was Iraq always an under-performer in terms of health? No. However, as the religious and ethnic segregation has been supplemented by the international sanctions and resulting drains on the national economy in the 1990's, the health status has deteriorated in line with the economic crisis. When Saddam came to power in 1980 the GDP per capita was $3,600. By 2001 it declined to about $1,000 per capita, and most of the decline occurred in the 1990's. In 2003, the per capita GDP was estimated at $450-$610. Concomitantly with the shrinking GDP, the infant mortality rate that in the first 10 years of Saddam's regime declined from 63 to 40 per 1,000 live births, has grown to 95 in 1995 and 98 in 1999 – back to the levels of the 1960's.

In 1999-2000, Saddam's government had revoked the public commitment to health care financing. Public funding was drastically reduced and limited largely to the hospital sector. Under the new legislation, primary health care clinics were encouraged to charge their customers and use the revenues to finance salaries, pharmaceuticals, and health supplies. This policy has motivated doctors to see more patients at the expense of the quality of care. A two-tier system of primary health care clinics emerged. Since the public clinics were allowed to charge patients for pharmaceuticals only, they had to process 100-150 patients daily to earn some revenue. Yet even this 'revolving door' approach to health services could not provide for a decent salary for the clinics'

personnel. Many doctors used their time in the afternoon to set up and/or work in the so called 'popular clinics' where patient fees could be extended to cover physician's time, diagnostic services, and a wider range of drugs. Patients thus had a choice between rudimentary 'hands-off' services in the public clinics and a more customer-focused care in the popular clinics.

When we came to Iraq, we found primary health care professionals under enormous financial and psychological strain, yet seeing patients, dispensing drugs, immunizing children, reaching out to communities, managing their limited finances, communicating with us in good English, and treating us with a sense of professional dignity: proud to have survived through the crises of the past 15 years, and willing to explain their system, jointly plan resources that we had to offer, and learn from us through a peer-driven experience-sharing process. In summary, we have found ourselves in a once middle-income but now the third-poorest Arab country, yet with the capable doctors and health administrators who continued to receive good education despite resource challenges in all sectors of the economy.

Relatively inexpensive solutions would have markedly improved the situation for many primary healthcare clinics, maternity hospitals, and emergency rooms. For example, the health care administrators of the Al-Karkh district asked our help to renew clinics' access to prewar bank accounts. Balances on those accounts were small but important for financing non-labor costs, such as fuel for backup generators, taxis to bring children's vaccines from the warehouse, etc. The CPA dispensed funds for health worker salaries, and those salaries were significantly increased, but the financing of non-labor expenses was not provided, and pre-war accounts were frozen after the war disrupted the banking system. We have thoroughly reviewed the pre-war spending on non-labor costs and have concluded that a monthly amount of $16,000 would get 25 primary health clinics back into normal operation. Our counterparts have also requested permission to re-establish the pre-war system of patient fees to allow clinics to become financially viable again. The CPA has eliminated patient fees as it declared a "free for all" access to care in the post-war health sector of Iraq.

Addressing pressing needs to support existing essential services in existing clinics was a clear priority and could lead to quickly improved services more effectively than large-scale new construction and renovation plans. Simple equipment such as stethoscopes, blood pressure monitoring equipment, sterile supplies, essential drugs and vaccines and basic infrastructure such as generators were needed in most areas, and could have been supplied from existing stocks, or from willing donors.

The centralized drug acquisition and distribution system needed immediate support and assistance since some warehouses were severely damaged, distribution systems were disrupted, and employees had left the warehouses unattended in some cases. This situation has resulted in a serious shortage of 'officially supplied' essential drugs while their reselling on the black market dramatically increased.

To improve the health care financing in the future, it was important to negotiate a larger share of the national resource pie for the health sector of Iraq. Staffed with experienced economists, our interdisciplinary team has asked for professional contacts and discussion with the "non-health" segments of the CPA, particularly, the "Ministry of Finance" component. We planned to design and validate formulas that would link the national health budget to GDP and future revenues from oil exports. We were not supported in this effort.

During the immediate post-conflict period, the United States had a clear opportunity to establish good relations with willing Iraqi health care providers. There was a willingness to work as a team to improve the delivery of essential services in Iraq, and the Iraqi physicians, nurses, and healthcare administrators understood this need very well. We were not able to progress quickly on the practical work needed due to a clear lack of understanding of the purpose, goals, strategies and expected outcomes of the USAID-supported project. Much of my time in Iraq was not focused on work with the Iraqis to improve primary healthcare, but in discussion with Mr. Haveman on why the work needed to be done at all. Particularly, we were unable to make a convincing case with him why it is vitally important to re-engage with the health administrators and providers of health care of Iraq in order to understand their professional values, ways of doing business, motivation, work environment, and resource needs. Mr. Haveman's response to this line of discussion can be best illustrated by his remarks addressed to one of my team leaders: "We are done with the corrupt government of Saddam Hussein. Why do we need to study what they had in the past?" It was equally difficult for us to face the frustration of Ms. Thamira, Chief Engineer of the Baghdad/Al Khark Health Governorate, a health administration office in charge of health services for half of the Baghdad population, approximately 3.8 million people. "When the street fighting and looting were over and we took a preliminary look at the amount of damage to our healthcare network," she was telling us, "I summoned all my former staff of engineers from retirement to increase our staffing by 2.5 times. I thought, now the new administration will come to us to request our knowledge of every facility, blueprints, damage assessment, so that we could work together with the Americans to restore clinics back to normal."

At the end of the day I was not a successful advocate for the participatory strategy of reconstituting the Iraqi health care system, whereby we would be learning from the Iraqis as much as they would be learning from us, so that the most appropriate solutions could be identified in close professional collaboration, and mutual respect could be gained in the process of a culturally sensitive collaboration. I was asked not to return to Iraq by Mr. Haveman. As an experienced development professional and healthcare provider, I firmly believe that much could have been accomplished if we had been allowed to implement the project work plan.

Improvement of the primary healthcare situation in Iraq has become much more complicated now. However, even in this complex situation there are capable healthcare development workers who know how to support essential primary healthcare services in conflict areas, and who are experienced in working in such conditions. The essential

lesson to be learned is to let professionals do their work. It is entirely right and appropriate to carefully monitor U.S. government contracts and to request accountability for U.S. government resources. It is not appropriate to mix the political agenda with ongoing development work that is based on established best practices. The principles of respect for other professionals, team work, and good professional practice will be accepted by concerned health care providers worldwide and should be the guiding principles to assist health service reconstruction. I ask this important Committee to enable this approach as much as possible.

Thank You.