Understanding the private health sector
in Iraq

World Health Organization
Eastern Mediterranean Region

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Eastern Mediterranean Region

Title: Understanding the private health sector: in Iraq / World Health Organization. Eastern Mediterranean Region

Description: Cairo: World Health Organization. Eastern Mediterranean Region, 2024

Identifier: ISBN 978-92-9274-229-4 (pbk.) | ISBN 978-92-9274-230-0 (online)

Subjects: Private Sector | Health Status Indicators | Health Care Sector - organization & administration | Health Services | Health Expenditures | Healthcare Financing | Public-Private Sector Partnerships | Universal Health Insurance | Delivery of Health Care | Iraq

Classification: NLM WA 540

Contents

Acknowledgements

This report was developed by Abdul Munem Al Dabbagh, Professor of Family and Community Medicine, and Ms Aya Thabet (WHO consultant), under the supervision of Dr Hassan Salah, (Regional Adviser, Primary and Community Health Care, WHO Eastern Mediterranean Region) in response to a request by the WHO Regional Office for the Eastern Mediterranean. The structure and methods used in this study follow the guidelines and assessment tools developed by the Regional Office in 2018.

Acronyms and abbreviations

GDP	gross domestic product	PHC	primary health care
ISIS	Islamic State of Iraq and Syria	SWOT	strengths, weaknesses, opportunities, threats
MOH	Ministry of Health	UHC	universal health coverage
MRI	magnetic resonance imaging	WHO	World Health Organization
PET	positron emission tomography		

1
Country context

In 2018

Iraq's gross domestic product reached

US$ 160 billion

The growth rate was

11%

and GDP per capita amounted to

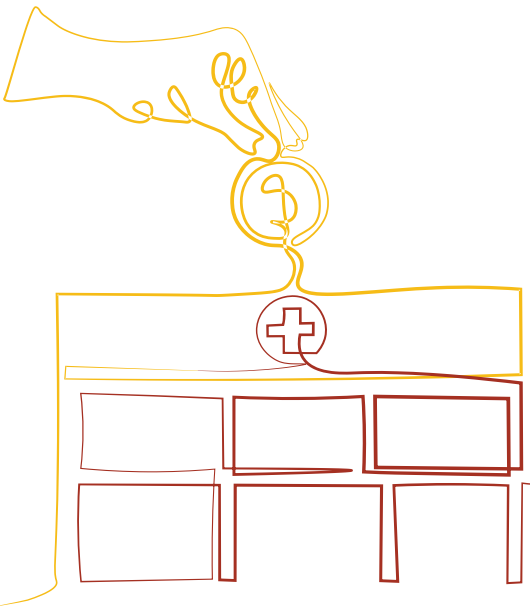
US$ 4301

Iraq, located in the north-east of the Arabian Peninsula, is part of the WHO Eastern Mediterranean Region. The country spans over 435 000 km. It shares borders with six countries – Islamic Republic of Iran on the east, Türkiye on the north, Syrian Arab Republic on the west, Jordan on the south-west, Saudi Arabia on the south, and Kuwait on the south-east *(1)*. On account of its location, it has been the site of interactions between various cultures throughout history. This cultural diversity, as well as its many ethnic and religious groups, has greatly enriched society in Iraq. The population of the country was estimated to be 39 128 million in 2019, with 30% of its inhabitants living in rural areas *(2)*. The fertility rate, among the highest in the Region, was 3.9 in 2019 *(2)*; with the population doubling every 23–25 years *(3)*.

In geographical terms, Iraq is as diverse as its population. Alluvial plains stretch across the central and southern parts of the country, a desert lies in the west, and the Kurd majority north-east (Kurdistan) is characterized by mountains.

The largely state-run economy is dominated by the oil sector – Iraq has the fifth largest proven crude oil reserves in the world. Moreover, it is the world's third largest oil exporter, and the second largest exporter among the Organization of the Petroleum Exporting Countries *(4)*. In 2018, the country's gross domestic product (GDP) reached US$ 160 billion. The growth rate was 11% and the GDP per capita amounted to US$ 4301 *(5)*. This economic growth was not matched by economic development and, therefore, did not serve to improve people's well-being *(6)*.

According to the Multidimensional Poverty index, 8.6% of the population was multidimensionally poor while an additional 5.2% was classified as vulnerable to multidimensional poverty in 2018 *(7)*.



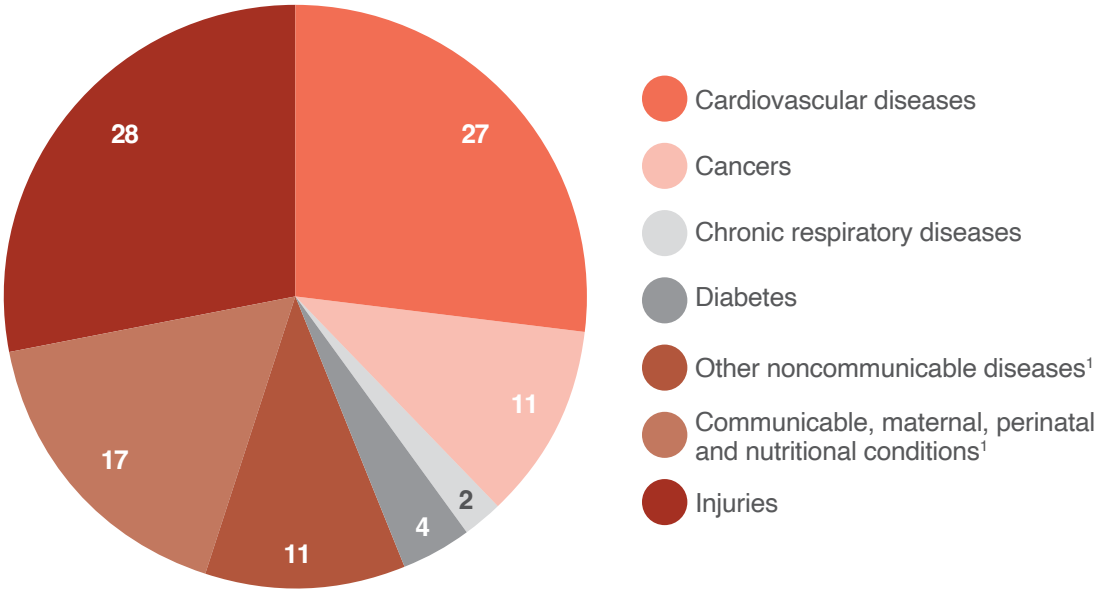
2

Health status and selected health indicators

Iraq's successful health system made it a role model in the Eastern Mediterranean Region in the 1980s. However, decades of war, sanctions, civil violence, economic crisis and inadequate funding of the health sector led to the collapse of health system infrastructure. There was a marked deterioration in national health, which in turn fuelled distrust towards the health system *(3)*. The country is now facing serious health challenges.

In 2018, noncommunicable diseases accounted for 55% of the total deaths in Iraq (Fig.1), which was similar to the global trend *(8)*. As shown in Table 1, the mortality rate of infants and children under-5 years of age has fallen over the last 10 years.[1]

Fig. 1. Causes of death in Iraq in 2018



Source: WHO. Noncommunicable diseases country profiles 2018 *(8)*

Table 1. Some key health indicators, Iraq 2007–2017[2]

Indicator	2007	2010	2013	2017
Life expectancy	68.16	68.47	69.22	69.86*
Infant mortality rate/1000 live births	30.0	24.0	17.9	18.6
Under-5 mortality rate/ 1000 live births	35.0	28.7	22.5	23.1
Normal birth-weight babies (%)	97.0	89.4	90.0	92.9
Maternal mortality ratio/100 000 live births	NA	NA	35.0	31.0

*2016 data

1 Annual statistical reports 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017. Ministry of Health, Government of Iraq.
2 Annual statistical reports 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017. Ministry of Health, Government of Iraq.

3

Organization of health system and delivery of health services

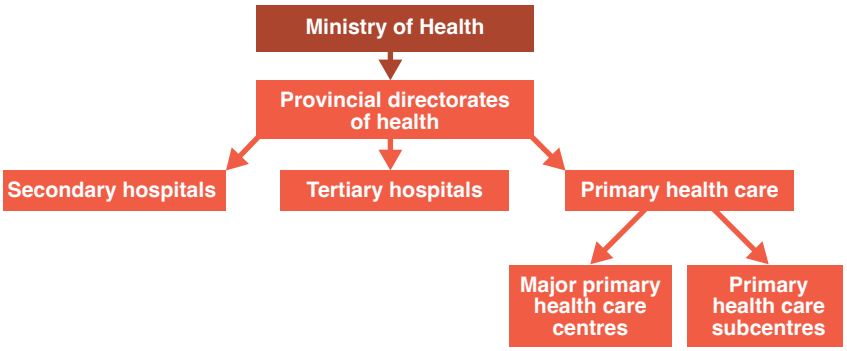
The Ministry of Health is the main health care provider in Iraq. The private health sector also has a long-standing presence and contributes to the delivery of health services. This sector's contributions have grown especially in the last few years.

3.1. Public health sector

3.1.1 Ministry of Health and Environment

The headquarters of the federal Ministry of Health oversees 16 provincial health directorates, which supervise the activities of the secondary and tertiary hospitals and primary health care services. Primary health care comprises major primary health care centres and subcentres (Fig. 2).[3]

Fig. 2. Structural levels of Ministry of Health in 2019



The Ministry of Health in the Kurdistan region supervises three provincial health directorates, which share the same management structure as that of the federal Ministry of Health. The regional Ministry of Health is overseen by the Kurdistan Regional Government, but continuously liaises with the federal Ministry of Health.

3.1.2 Primary care

Primary health care (PHC) services in Iraq are provided through a network of 2765 centres. These are run exclusively by the Government and are further classified as shown in Fig. 3a.

There are two types of PHC centres, which are distinguished from each other by the density of the population served (Table 2). The major centres are principally located in big cities and serve a population of over 10 000, while the subcentres are scattered throughout the outskirts of big cities and in rural areas, serving a population of 3000 to 10 000 people.

3 Primary health care centres reference guide. Public health directorate, quality control unit, Ministry of Health.

Different services are offered by the two types of PHC centres. The major centres provide a wide range of preventive and curative health services, while the subcentres tend to provide more basic services (Table 2). Moreover, most of the major PHC centres are managed by doctors, whereas the subcentres are mostly run by nurses, medical assistants and community health workers (Fig. 3b).

Only 5% of the centres are classed as family centres (Fig. 3c), and the majority of these are in Baghdad. Family centres provide a higher quality of services in comparison to the other centres, as the family physicians present in these facilities have a better knowledge base, reporting skills, and diagnosis and follow-up capacities. Twenty-eight of the family centres are involved in the training of primary health care personnel.

Fig. 3. PHC centres (a) by population density; (b) by management; and (c) by scope of services

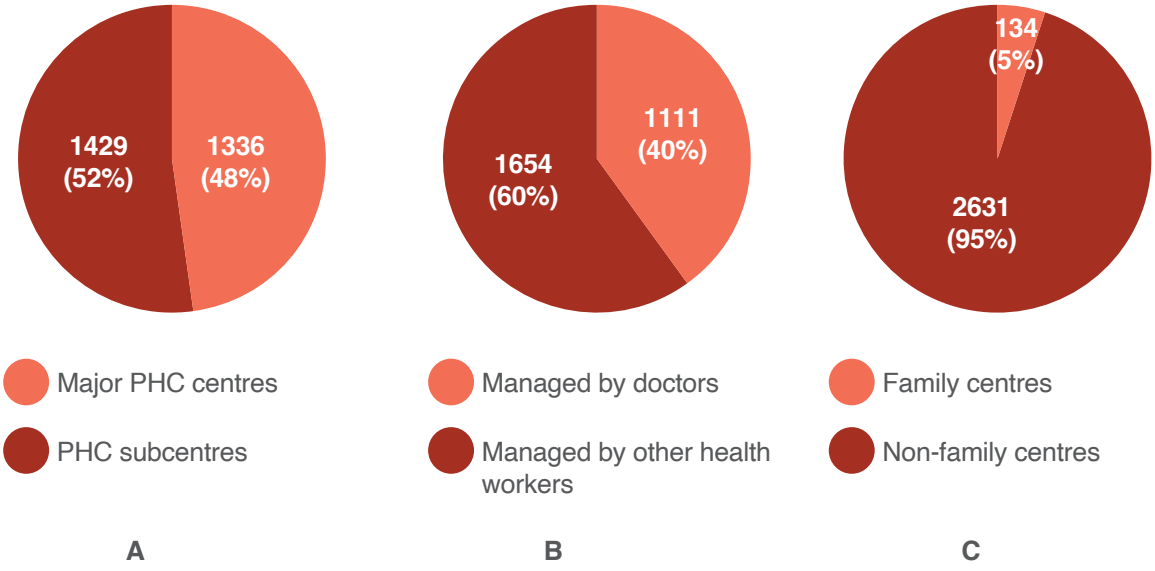


Table 2. Services provided in major PHC centres and PHC subcentres

Major centres	Subcentres
Antenatal care	Antenatal care
Vaccinations	Vaccinations
Integrated management of neonatal and childhood health	Basic curative services and provision of some essential medicines
Management of communicable diseases	
Tuberculosis control	
Management of noncommunicable diseases	
Psychiatry and mental health	
School health	
Family planning (in some centres)	
Nutrition	
Breast cancer screening	
Neonatal screening for metabolic diseases (in some centres)	
Dentistry	
Some emergency services (in some centres)	
Laboratory services	
Basic curative services and provision of basic medicines	
Delivery (childbirth) and postnatal care (in some centres)	

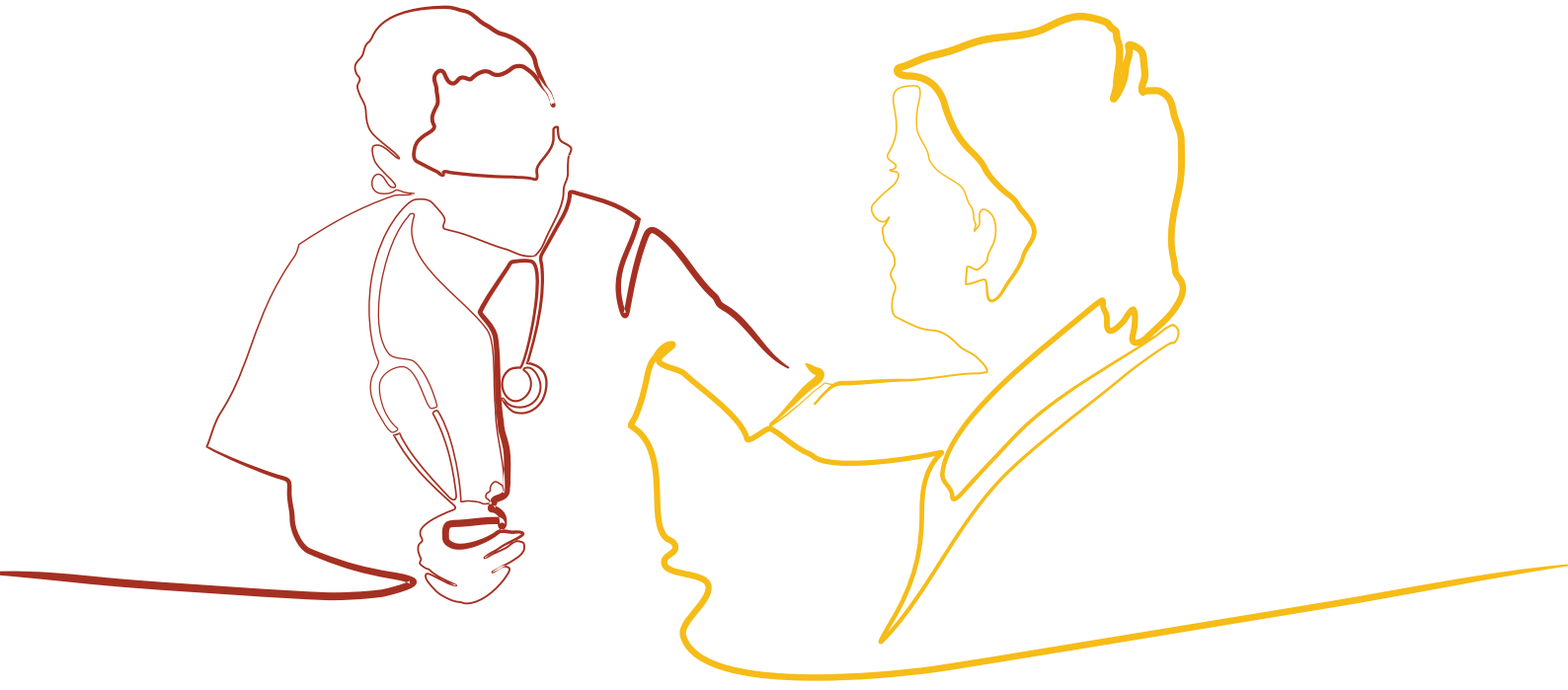


Table 3 shows the number of PHC centres in each province, the number of centre visits per province and the number of visits per centre.

Table 3. Distribution and utilization of PHCs by province in 2018

Province	Number of PHC centres	Number of visits	Average number of visits/ centre
Baghdad	251	6 102 503	24 312.76
Basra	143	2 442 467	17 080.18
Mosul	182	1 746 369	9595.43
Diala	104	1 278 181	12 290.20
Anbar	183	672 521	3674.97
Babylon	121	1 568 284	12 961.02
Kerbela	62	1 347 278	21 730.29
Najaf	84	1 286 053	15 310.15
Wasit	77	1 060 350	13 770.77
Dewaniya	84	787 493	9374.91
Thi-Qar	165	1 366 629	8282.60
Al-Muthanna	70	577 087	8244.10
Maysan	82	726 566	8860.56
Salah Al-Din	125	921 489	7371.91
Kirkuk	135	652 479	4833.17
Erbil	266	1 797 147	6756.19
Duhuk	139	1 815 665	13 062.33
Sulaimaniyah	492	1 568 596	3188.20

As shown in Table 2, the highest number of visits to PHC centres was recorded in Baghdad, owing to the high population density. However, this may have partly been due to the presence of displaced families from the provinces that had been ravaged during the armed conflict in 2014–2018. This number was expected to decrease once families were rehabilitated in their original provinces.

A government report in 2018 stated that 897 PHC centres lacked a sufficient number of doctors.[4] This could have been due to several factors, such as the displacement of people (including doctors and health workers) from the affected provinces, insufficient number of health workers, and lack of incentives for health workers to work in certain remote locations.

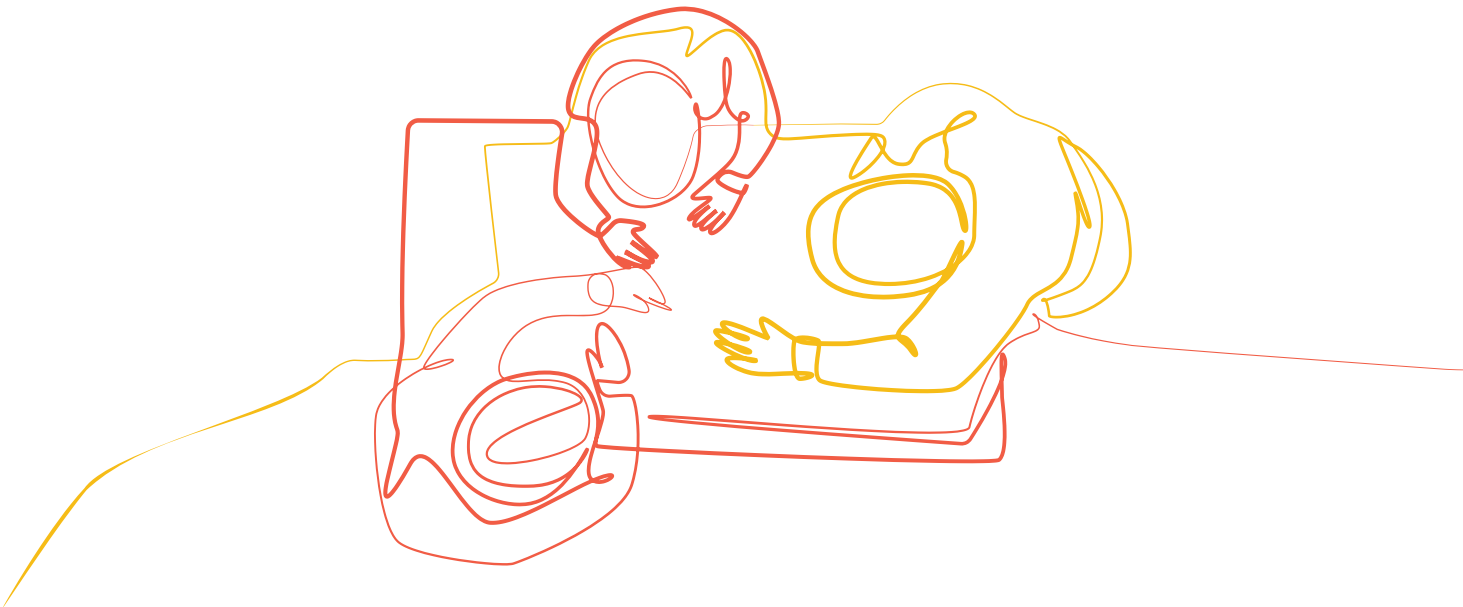
4 Personal communication. Ministry of Health, Government of Iraq.

3.1.3 Secondary care

There are 161 secondary public hospitals in Iraq and 120 tertiary public hospitals; a total of 281. Fig. 5 shows the distribution of these hospitals across the country. As displayed in Table 4, the total bed capacity in 2018 was 37 482, and there were around 3 million admissions recorded in that year.[5] All training hospitals, of which there are 81, are government-run and the private sector does not contribute to systemic staff training to any significant extent. It may, however, promote individual capacities with respect to specific service needs, for example, training individual staff members on a new diagnostic procedure.

The evolution of secondary and tertiary health care in Iraq has not been commensurate with the country's health needs or population growth. When analysing the number of beds in public hospitals per 1000 population, it was found that the increase in the number of public hospitals from 208 in 2008 to 281 in 2018 did not result in an increase in the ratio of beds to the total population. The same applies to the number of public hospitals per 100 000 population.

It should be noted that the increase in the number of private hospitals (from 80 to 135) in the country was far greater than that of the number of public hospitals in the same period. An in-depth analysis of the growth of private hospitals indicated that the increase could be largely attributed to two factors. The first was that the federal law endorsed the establishment of private health facilities, which freed up capital for investment in the private sector, together with the fact that there was no stipulation that the investor must be a health care worker. The second factor was the rapid increase in the number of private hospitals in the Kurdistan region: the number jumped from 22.5% (n=18) in all of Iraq in 2008[5] to 36% (n=49) in 2018.[6] This could be due to greater stability, which encouraged many health professionals to relocate to the Kurdistan region. Meanwhile, the public health sector was not able to grow at a rate comparable to the private sector due to insufficient funding and damage to the health infrastructure from armed conflict.



5 Annual statistical reports 2018. Ministry of Health, Government of Iraq.
6 Primary health care centres reference guide. Public health directorate, quality control unit, Ministry of Health.

Fig. 5. Distribution of public hospitals in Iraq in 2018

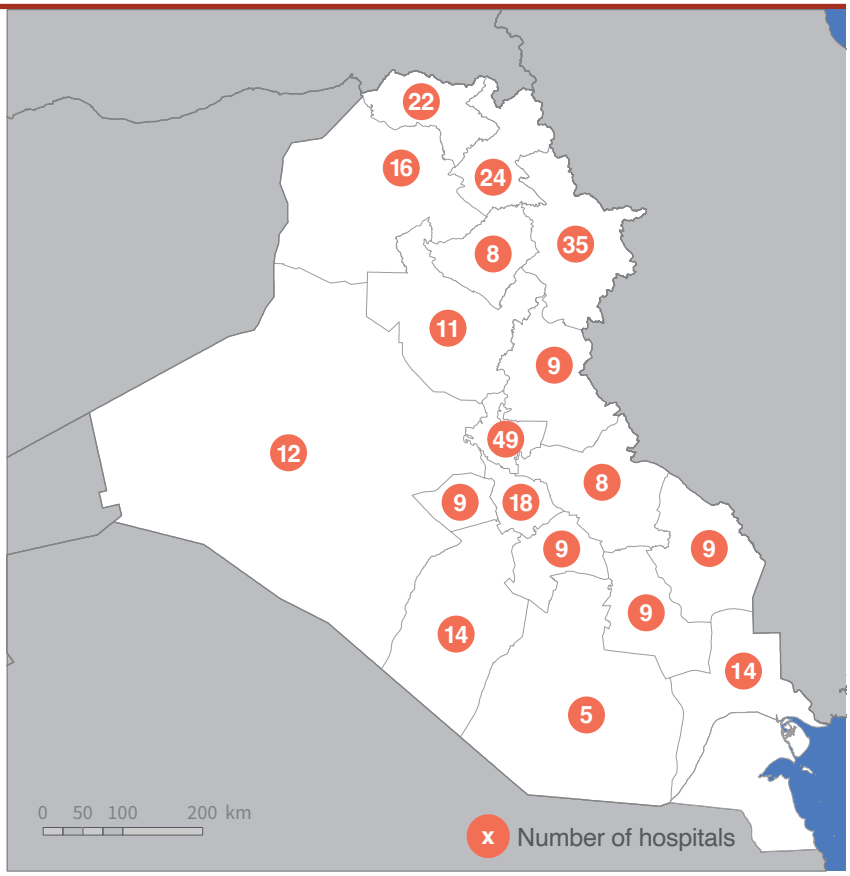


Table 4. Performance of public hospitals in 2018

Indicator	National
Bed capacity	37 482
Number of admissions	2 902 440
Inpatient rate per 1000 population	76.1
Bed occupancy (%)	57.2
Physicians per 10 000 population	9.1
Number of surgical operations	1 507 429
Number of normal deliveries	718 892
Number of caesarean sections	376 875
Average number of surgical	77
interventions per year	312.9
Average number of specialized medical consultations (per year)	1641

Source: Ministry of Health, Government of Iraq. Iraq annual statistical report 2018.

The armed conflicts from 2014 to 2018 had a dramatic impact on the country's health sector. They led to the internal displacement of around 3.6 million citizens from conflict-affected areas to safer cities. Almost all health infrastructure in the five provinces directly affected by the conflict was destroyed, leading to the unavailability of medical services and the creation of a huge service–demand gap. In 2016, for example, there were 51 470 displaced inpatients and 1 816 676 displaced outpatients visiting secondary health care facilities in host cities. In 2017, 36 989 people were injured as a direct consequence of the war against the Islamic State of Iraq and Syria (ISIS) were treated in the host cities of Baghdad, Erbil and other southern cities.[7] The MoH was forced to assign some health facilities and staff exclusively to war victims, and allocate part of the health budget to them. It also needed to give priority to rebuilding health infrastructure in the liberated cities, which meant postponing projects to build new hospitals in other regions.

3.1.4 Referral system

The public health system utilizes a formal referral process, in which PHC doctors play a gatekeeper role. As a result of this process, patients cannot seek medical services directly from the secondary hospitals; they must be referred by primary care physicians working in PHC centres. One exception to this are cases of emergencies, which can be treated directly in the emergency wards of secondary hospitals.

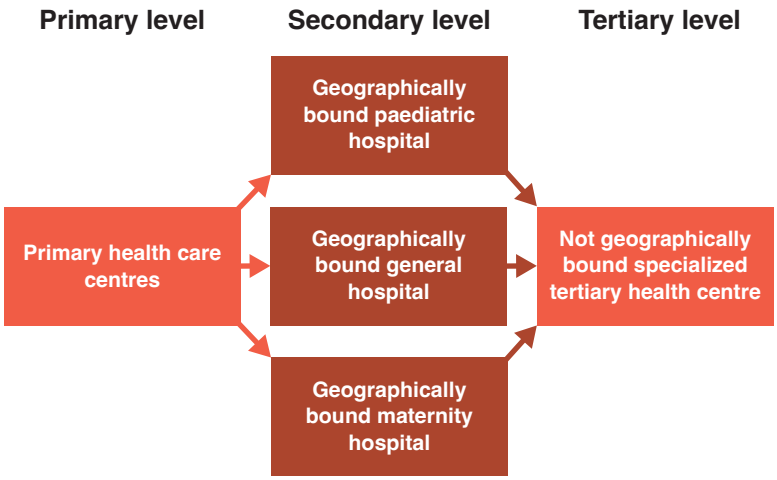
The referral process is geographically bound, on the basis of service delivery in the catchment area, so each PHC centre refers patients to a specific secondary hospital. For the process to be operational, PHC centres use a unified referral form; one copy is kept in the referring centre, while another is given to the patient, to be handed over to the secondary hospital to which s/he is referred. The referral form specifies the cause and aim of referral, which can be for diagnosis, treatment or a second opinion. Subsequently, the hospital is required to provide feedback to the referring centre regarding the patient's care and recommendations on the treatment plan. Unfortunately, the feedback process is not as stringent as the referral process, so the patient is not always followed up. This indicates a dominant secondary health care system that usually takes over the management of patients referred to the secondary level and ignores feedback.

Issues in the primary care sector are partly attributable to the referral system, which has made it more difficult for the sector to fulfil its role in achieving universal health coverage (UHC). However, the approach to referrals from the secondary to the tertiary level is more flexible. These referrals are based on the availability of services rather than the geography of health facilities (Fig. 6).

The private sector does not utilize or require any referral process. If patients can afford to do so, they can choose any private facility to meet their medical needs.

7 Annual statistical reports 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017. Ministry of Health, Government of Iraq.

Fig. 6. Public health referral system



Health services are also provided by other ministries and public sector entities, such as companies, quasi-government bodies and the armed forces. It is difficult to obtain data related to health services offered by other ministries. Data from interviews of employees of the Ministry of Defence indicate that there are five medical service offices five medical service offices that provide limited PHC services and one general hospital where minor surgical procedures are performed. No data are available from the ministries of interior, electricity and oil as there is no data reporting framework for the operational multisectoral action system.

3.2 Private health sector

3.2.1 For-profit private health sector

The private sector consists of hospitals, clinics, laboratories, pharmacies and pharmacy warehouses, and diagnostic centre.

All private hospitals in Iraq are for-profit. The first private hospital was built in 1910 in Baghdad, in the pre-monarchy era. Now, there are 131 private hospitals in Iraq.[8] The distribution of these hospitals is largely determined by population density and urbanization (Table 6). Thus, most of them are located in cities, with the rural areas being left underserved.[8] This situation is not conducive to the achievement of UHC.

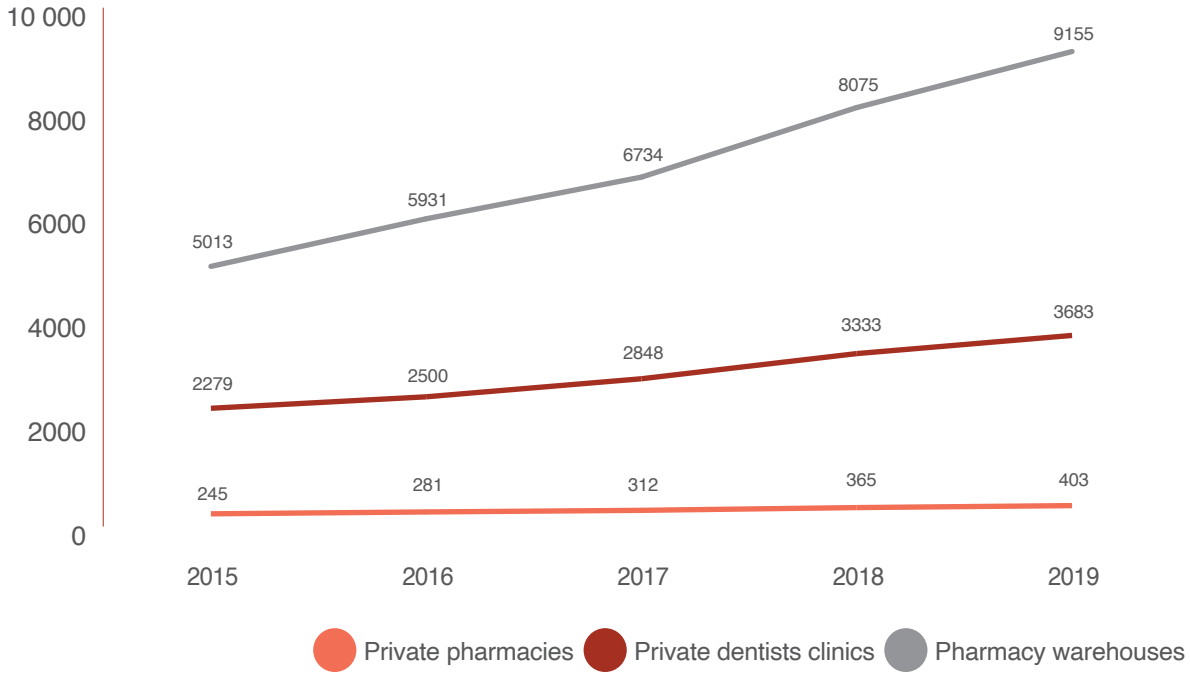
8 Annual statistical report 2018. Ministry of Health, Government of Iraq.

Table 6. Distribution of hospitals in 2018 *(2)*

Province	Private hospitals	Public hospitals	Total population	Urban population (%)	Rural population (%)
Baghdad	47	49	8 126 755	87.5	12.5
Basra	5	14	2 908 491	81.2	18.8
Mosul	2	16	3 729 998	60.6	39.4
Diala	3	9	1 637 226	49.2	50.8
Anbar	3	12	1 771 656	50	50
Babylon	5	18	2 065 042	48.3	51.7
Kerbela	4	9	1 218 732	66.9	33.1
Najaf	4	14	1 471 592	71.4	28.6
Wasit	1	8	1 378 723	60.2	39.8
Dewaniya	3	9	1 291 048	57.3	42.7
Thi-Qar	3	9	2 095 172	64.2	35.8
Al-Muthanna	1	5	814 371	45.4	54.6
Maysan	1	9	1 112 673	73.9	26.1
Salah Al-Din	2	11	1 595 235	45.1	54.9
Kirkuk	2	8	1 597 876	73.9	26.1
Erbil	24	24	1 854 778	83.2	16.8
Duhuk	7	22	1 292 535	74.1	25.9
Sulaimaniyah	18	18	2 162 279	84.7	15.3

As shown in Table 6, a high percentage of the population in some provinces, such as Diala, Anbar, Babylon, Al-Muthanna, and Salah Al-Din, is rural. Considering that the few private hospitals are located in the urban areas, it is difficult for the rural population to access private health care. An analysis of the data indicates that the achievement of UHC is being hindered by barriers to private health services due to long distances or geographical location.

Fig. 7. Number of private dentists, private pharmacies and pharmacy warehouses, 2015–2019

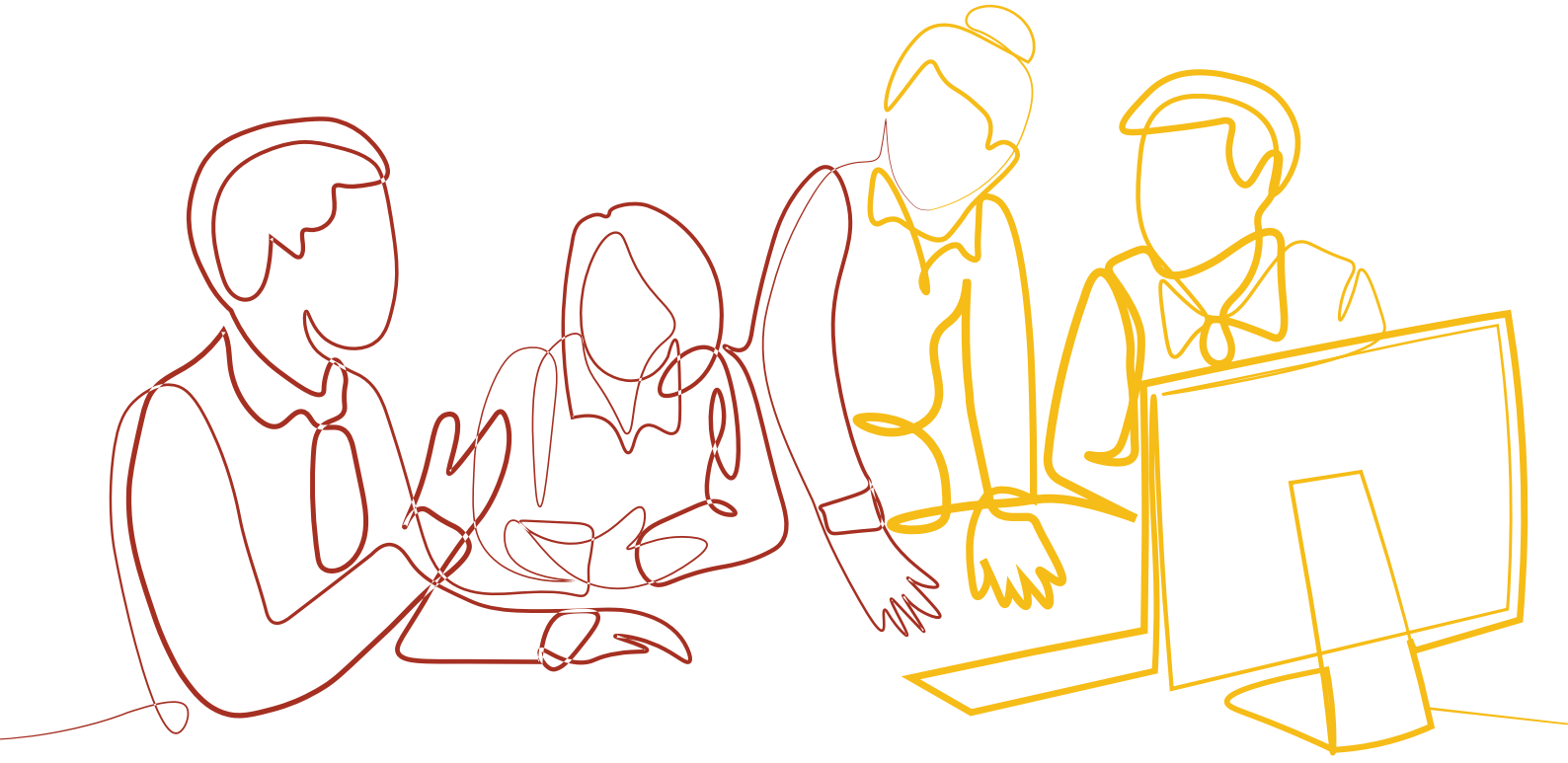


Sources: Dentists syndicate, Pharmacists syndicate

The number of private pharmacies almost doubled between 2015 to 2019. Government pharmacies only operate in the daytime, so night-time services are provided exclusively by private pharmacies. The situation is the same with regard to dental clinics. The lack of public services open at night has made people dependent on private clinics, which have considerably increased in number.

3.2.2 Not-for-profit private health sector

There is no regular, sustainable not-for-profit private health sector in Iraq. The only examples of such activity are mobile clinics that are run on certain religious occasions and human relief operations, which are conducted in collaboration with the public sector (but not with international agencies).



4

Health sector resources

Table 7 shows the number of health sector facilities by type in the country. As mentioned before, the private sector does not have PHC centres, so the first point of contact is private clinics. As doctors, dentists and pharmacists often practise in both sectors, it is not possible to determine the total number of practitioners. Unfortunately, there is no reliable record or even estimate of the number of ambulances, doctors, nurses, paramedics or laboratory staff in the private sector.

Table 7. Main health sector facilities by type in public and private sectors in 2018

Type of facility	Public sector	For-profit private sector	Total	Source
Individual clinics/ outpatient posts	1645*	4001**	5646	Annual statistics report 2018, Central Syndicate of Doctors
Clinics/dispensaries	2765	0	2765	Annual statistics report 2018
Secondary hospitals	161	135	296	Annual statistics report 2018
Specialty hospitals/ centres	120	0	120	Annual statistics report 2018
Laboratories	1864*	9155	11 019	Annual statistics report 2018 Technical Directorate, MoH
Blood banks	20	0	20	National Blood Bank of Iraq
Ambulances	1728**	NA	1728	Annual statistics report 2018
Medical colleges	27	1	28	Annual statistics report 2018
Training institutions	109*****	0	109	Annual statistics report 2018
Pharmacies	3046*	9155	***	Annual statistics report 2018, Pharmacists Syndicate
Pharmacy warehouses	24	403	427	
Beds	37 482	5300	42 782	Annual statistics report 2018
Doctors (general)	34 807	4001**	***	Annual statistics report 2018, Central Syndicate of Doctors
Specialists	13 112	NA	13 112	Annual statistics report 2018
Dentists	11 997	3683	***	Annual statistics report 2018, Central Syndicate of Doctors
Pharmacists	12 552	9155	***	Annual statistics report 2018, Pharmacists Syndicate
Nurses	78 588	NA		
Paramedical staff	73 876	NA		
Laboratory staff	10 812	NA		
Midwives	4400	1244	5644	Annual statistics report 2018

* In primary health-care centres, hospitals and specialized governmental centres
** Only includes registered clinics
*** Including dual practitioners (could not be added together)
**** Does not include the Kurdistan region
***** Facilities that provide on-site medical training, including PHC centres, secondary and tertiary hospitals and specialized centres

Table 8 shows the total number of health workers in Iraq in 2018.

Table 8. Health workers in 2018[9]

Health worker	Male	Female	Total
Doctors	19 147	15 660	34 807
Dentists	5191	6806	11 997
Pharmacists	4806	7716	12 522
Nurses	38 107	40 481	78 588
Paramedics	44 149	29 727	73 876
Laboratory personnel	5015	5797	10 812
Veterinarians	120	152	272

The public health sector faces significant challenges in terms of its health workforce as there are not enough sufficiently trained doctors and nursing staff. They are inequitably distributed and often work in difficult, remote conditions with a heavy workload and lack resources, and may be exposed to violence or threats. Figs. 8 and 9 show the comparatively low number of doctors and nursing staff in Iraq in contrast to other countries in the Region. Second, there is an absence of strategic planning that results in modern management systems not being properly utilized to manage human resources.

The situation is further complicated by political pressure. There is a need for improved coordination with the institutes of the Ministry of Higher Education and Scientific Research. In December 2019, for example, the Pharmacists Syndicate declared that from the beginning of 2020, it would not be obligated to register new pharmacy graduates as the required number had already been exceeded.

Finally, gaps in the distribution of the workforce have widened due to poor implementation of the decentralization process, including handing over authority to local governments. As a result, certain facilities have a surplus of some health specialists, while others have too few. The shortage of family medicine specialists is of particular concern. The number of well trained family physicians is only around 500, compared to the estimated need of thousands.

9 Annual statistical report 2018. Ministry of Health, Government of Iraq.

Fig. 8. Number of doctors per 1000 population in countries of the Region, 2007–2016

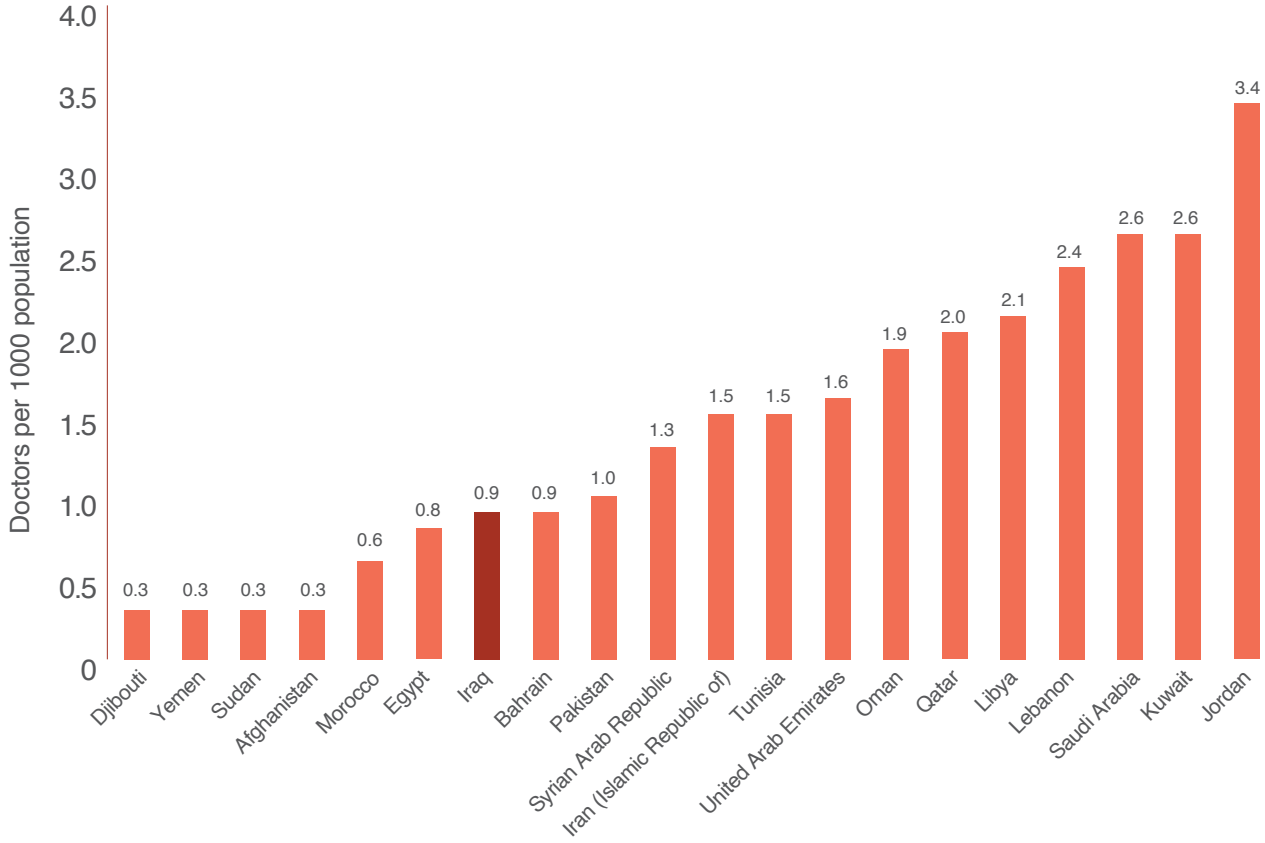
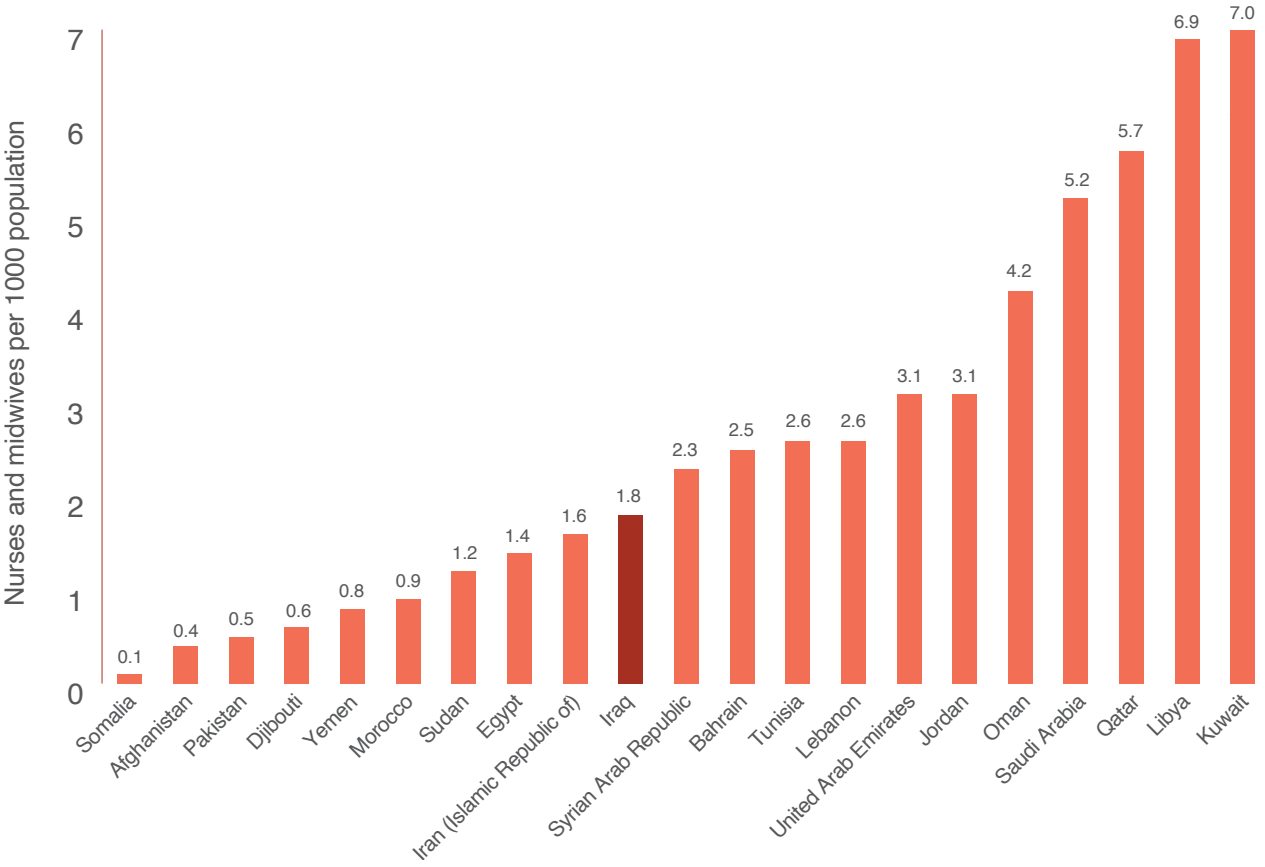


Fig. 9. Number of nurses and midwives per 1000 population in countries of the Region



5
Health financing

5.1 Health expenditure

MoH facilities provide almost all health care services to patients free of charge. Iraq has no taxation system to enable the garnering of funds for the provision of free health services.

The health financing system in Iraq has witnessed continual changes over the last 50 years. It has shifted from a type of welfare state in which the Government was the principal provider and financer of all health services, to a country in which patients often have to pay out of pocket and user charges have been introduced. Recently, discussions were held on the introduction of a contributory mechanism in the form of health insurance. Both the health system at large and the health financing system, in particular, have changed significantly since the Iraq War in 2003. Article 31 of the Iraqi Constitution requires the State to protect the health and ensure the social security of its citizens. At present, the MoH is the primary public financing agent and households are the main private financing agents.

Preventive and emergency services are free of charge, while the lowest possible rates are charged for other services. In a public hospital, inpatient services cost a patient just US$ 4, regardless of the duration of stay, the number and types of tests carried out, and whether or not they need surgical intervention.[10]

Data on total health expenditure are mainly taken from the national health accounts, the last of which was collated in 2013 (unpublished). The national health accounts data included information on private sector expenditure. Unfortunately, the national health accounts stopped being collated from 2013 onwards, reflecting a significant weakness in the health management system. There are no recent data to determine the true size of capital investment by the private sector and its total expenditure. Only government expenditure is still calculated and published annually.

Fig. 10 shows the flow of funds in the Iraqi health system and Table 9 provides data on health expenditure, according to the 2013 national health accounts.

10 National Health Account 2012. Ministry of Health. Government of Iraq.

Fig. 10. Flow of funds in Iraq's health system

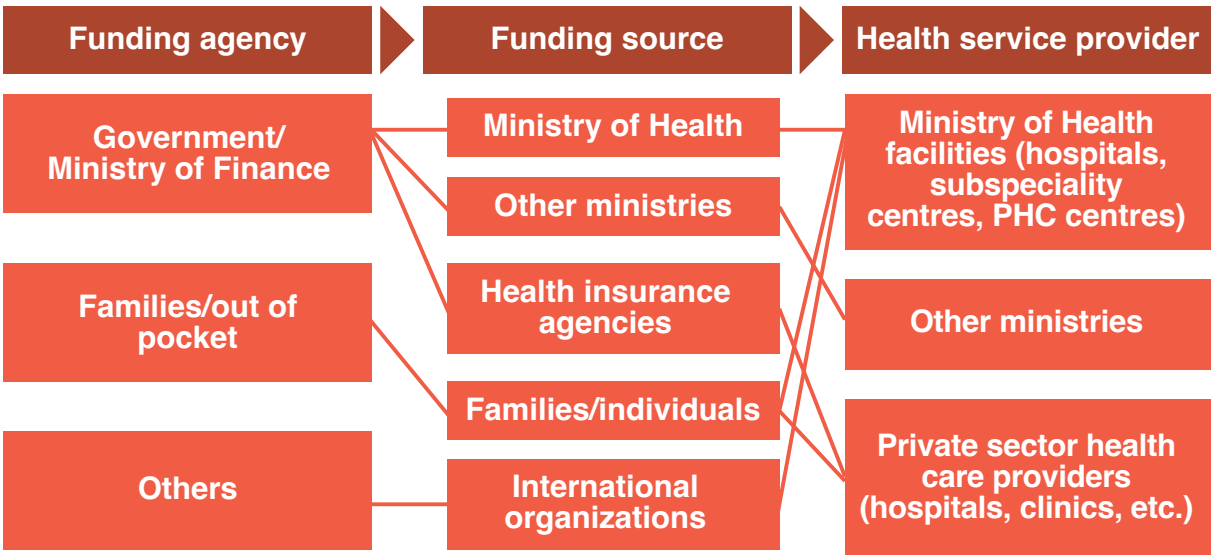


Table 9. Iraq's health expenditure in 2013

Health financing indicator	Value
Total health expenditure	US$ 10.065 billion
Total health expenditure per capita	US$ 294
Total health expenditure as percentage of nominal GDP	4.4
Out-of-pocket expenditure as percentage of total health expenditure	42.1
Government health spending as percentage of total health expenditure	57.9
Recurrent health budget as percentage of total health expenditure	88
Health capital budget as percentage of total health expenditure	12
International donors (%)	0.3

As shown in Table 9, out-of-pocket expenditure as a percentage of the total health expenditure was calculated to be 42.1% in 2013. However, WHO estimates in 2015 place the figure at 76.5%. Two facts may account for this marked difference, the first being the fall of four major provinces in 2014 following the ISIS invasion. The population was deprived of public sector services in the occupied areas. The second reason is that in 2014 there was a considerable drop in the price of oil; the main source of national revenue; to almost half of its value in 2013. This affected the Government's health spending, and it was then forced to reallocate health expenditure to other priorities. Consequently, people were compelled to purchase private sector services.

Although total health expenditure and government health expenditure were on the rise between 2008 and 2012 (Fig. 11), the Government's health expenditure decreased after that, and continued decreasing. After reaching a record figure of about US$ 5 billion in 2012, it fell to US$ 3.6 billion in 2018 (Table 10).

Fig. 11. Total health expenditure and MoH expenditure, 2008–2012

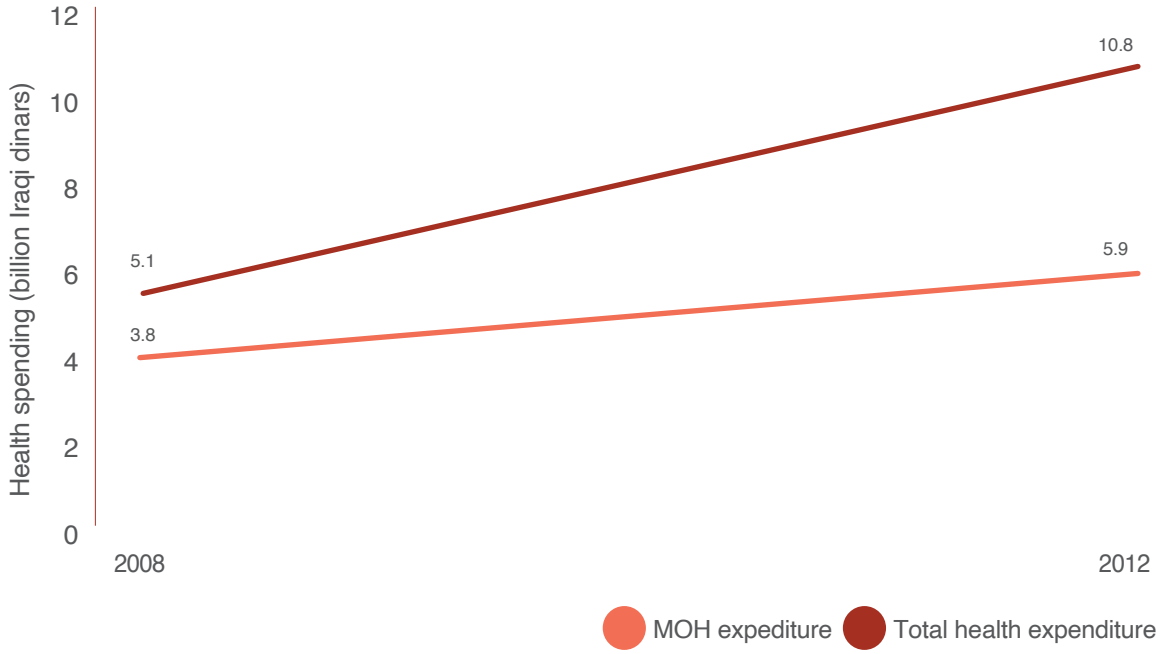


Table 10. Government health spending in 2018

Health financing indicator	Value
Total budget for health	US$ 3.6 billion
Recurrent health budget as percentage of total budget for health	98.5
Health capital budget as percentage of total budget for health	1.5
Health budget as percentage of government budget	4.1

It is understandable that the health capital budget is only 1.5% of the total health budget in a country in emergency and for which relief operations were the top priority in 2018.

A consequence of the prevailing situation was that the private sector gained in importance as it attempted to close the gap between the population's health needs and the services available. This is evident from the fact that of the 531 items in the essential medicines list in Iraq, 49% were not covered by the MoH budget, 39% were partially covered, and only 12% were fully covered in 2018. The deficit was covered by the

private sector and almost entirely paid for by households and individuals. No recent official data are available to determine how much of the total health expenditure is funded by the private sector.

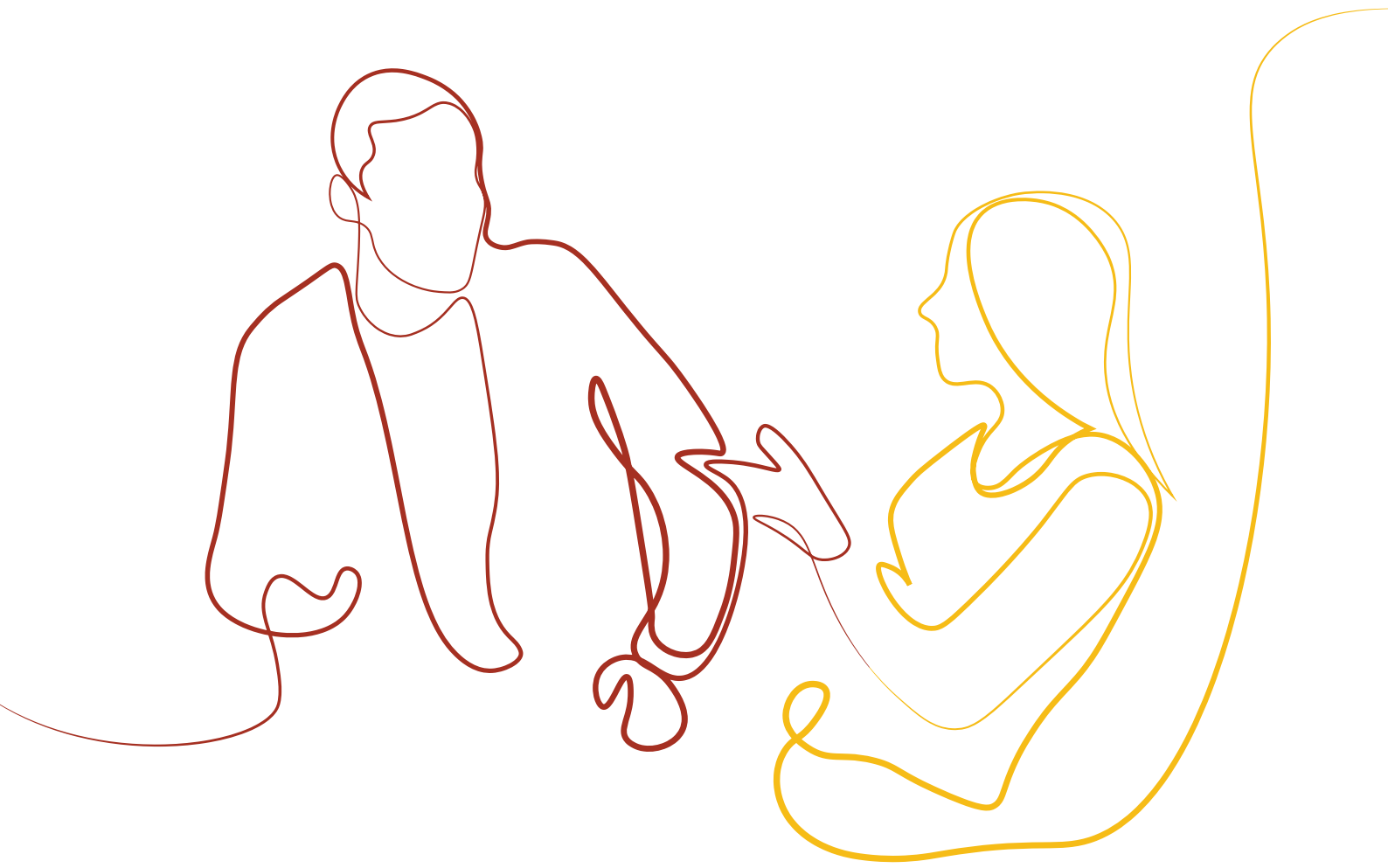
5.2 Health insurance

Iraq does not have a national health insurance system. There are isolated small-scale health insurance programmes for the employees of certain companies and three ministries (the Ministries of Interior, Electricity, and Oil) whereby they purchase, subsidize or reimburse a specific set of health care services *(9).* In 2014, following the severe financial crisis resulting from the sharp drop in oil revenues, a health insurance law was drafted and submitted to Parliament. Since then, the draft Law has been under constant review and discussion. The Law included provisions whereby nominal fees would be charged for services, with rules exempting the poorer sections of the population, who would be identified by the Ministry of Social Welfare. The Kurdistan Regional Government also made efforts to enact a health insurance law (WHO Health Financing Atlas 2018).

In the past, health insurance was a component of the services offered by the National Insurance Company, established in 1959 by the Ministry of Finance as a self-funded company, offering insurance for houses, cars, shops, health and so on. In the 1970s and 1980s, the idea of having health insurance was not appealing to the population as the public health system offered high quality services to all people, almost all of which were free of charge. In addition, the overall socioeconomic situation of the general population was, at the time, satisfactory. From 1990 to 2003, Iraq was subject to harsh sanctions, which led to the collapse of the health system and the dissolution of health insurance system. The economy declined rapidly, which impeded the growth of the private sector.

In the years after 2003, and especially after 2008, the private sector grew in size. This could be attributed to the marked increase in the salaries of government employees, lifting of sanctions, the private sector being granted permission to import medicines and medical supplies, and the enactment of new laws granting greater flexibility to new private sector facilities. In particular, Federal Law No. 25 on the establishment of private sector facilities, enacted in 2015, has contributed greatly to the growth of the private sector. The growth of the private sector has, however, not been associated with the growth of the public health sector.

Discussions on the issue of health insurance have centred on the hope that the provision of health insurance to the public sector workforce will boost the growth of the private health sector. It is also anticipated that the move will reduce the financial obligations of the public sector, particularly with respect to tertiary and advanced care. As declared by the Minister of Finance in 2019, approximately 6.5 million government employees could benefit from a health insurance strategy. Considering the number of people who might avail themselves of insurance schemes (including employees' families), the total population covered is expected to be around 30 million; more than 75% of the Iraqi population. Parliament endorsed the health insurance law in December 2020.



6

Perspectives of the private health sector and stakeholders

6.1 Growth of the private sector and determinants of growth

The public sector is still the main provider of health services in Iraq. As an example, all paediatric hospitals in the country are run by the Government. Legally, the Government is obligated to provide health care services to all, but such legislation has become outdated and impractical in the current geopolitical situation. The present context of decentralization and fragmentation of authority demands the adoption of different approaches. The Federal Government, represented by the MoH, is no longer capable of securing comprehensive health services. The private sector, on the other hand, is not able to cover the gaps due to legislative and administrative limitations, especially in the area of funding of health services.

Initiatives by the not-for-profit private sector were limited to its contribution to annual religious ceremonies conducted by parts of the population in various locations, and the organization of relief campaigns during the waves of mass displacement of the population at times of internal conflict. Both activities were temporary (not sustainable) and targeted (not universal).

Among the many factors contributing to the growth of the private sector was the low quality of services in public sector facilities due to the lack of, or limited availability of, high-tech equipment, such as MRI and PET scanners, or the unavailability of advanced laboratory investigation and radiotherapy treatment. The lack of specialist services in the public sector and comparatively more effective treatment outcomes in the private sector were also contributory factors.

Weak or insufficient entry barrier regulations served to strengthen the presence of the sector, as did rising demand for health services, resulting from population growth, increase in income, and the public sector's inability to cope with the growing demand. The latter was due to inadequate government health spending, especially in the last few years, outdated managerial and administrative systems, the absence of policies on incentives/performance and extra working hours, particularly in PHC facilities.

Owing to the Government's low health expenditure, together with the absence of a national health insurance system, lack of active public–private partnerships and absence of a legal framework for cooperation between nongovernmental international agencies and the private sector, the private sector has come to depend on out-of-pocket payments from households as its mode of generating revenue.

Since 2015 and following the adoption of federal Law No. 25 on the establishment of private sector facilities, it has become possible for any investor to establish a private health facility, regardless of his original profession, once he has fulfilled the conditions required by the MoH regulations. Although this law freed up capital for investment in the private health sector, certain pitfalls remained, for example, the role of mayoral health councils in project evaluation and their authority to reject it. As part of the decentralization of the health sector, the mayoralties established their own health councils which were run by inexperienced

staff. The absence of a national health insurance system and regulations permitting international agencies and NGOs to partner with the private health sector has added to the hardship of the population.

6.2 Rationale for private health sector expansion

The private health sector needs to be developed for several reasons, such as the lack of large health care facilities and plans for the expansion of services in the public sector, and the lack of or inadequate health services provided by the public health sector. Further, health professionals want to increase their income because of the low salaries paid in the public health sector, and a way of supplementing this is by also working in the private sector alongside it. Another issue is that of health professionals' working hours: outpatient and primary care services are not offered at night. Finally, as mentioned already, the growth of the population necessitates additional services *(9,10).*

6.3 Private health sector resources

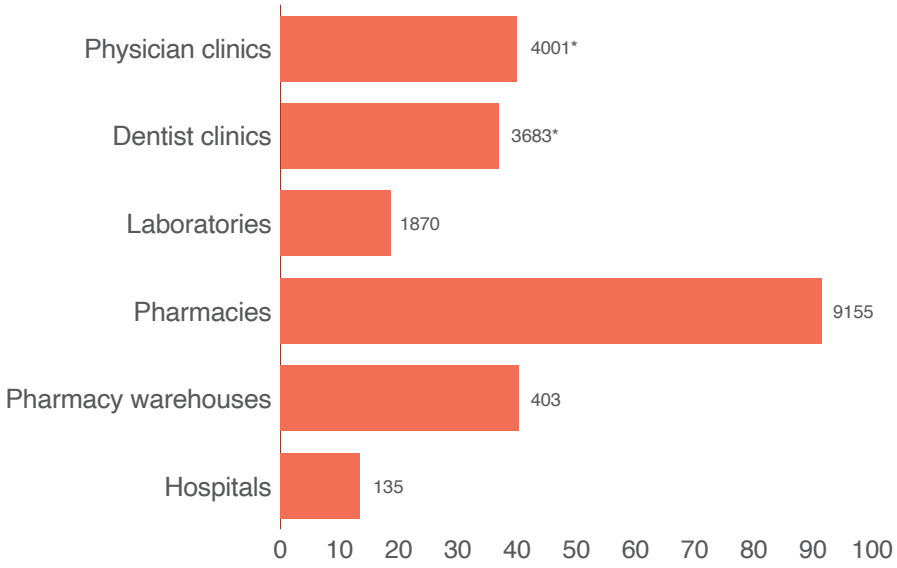
There has been an increase in the size and share of the private health sector in the health market in the last 10 years, however, it is not possible to say whether the increase is proportional to the demand due to the lack of utilization data from the private sector.

Table 11. Comparison of hospitals and beds by population in public and private sectors[11,12]

Year	Public hospital beds/1000 population	Public hospitals /100 000 population	Private hospitals/ 100 000 population	Private hospital beds/1000 population
2008–2015	1.3	0.7	0.3	No data
2016–2018	1.2	0.7	0.3	0.11 (in 2018)

11 Annual statistical reports 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017. Ministry of Health, Government of Iraq.
12 Primary health care centres reference guide. Public health directorate, quality control unit, Ministry of Health.

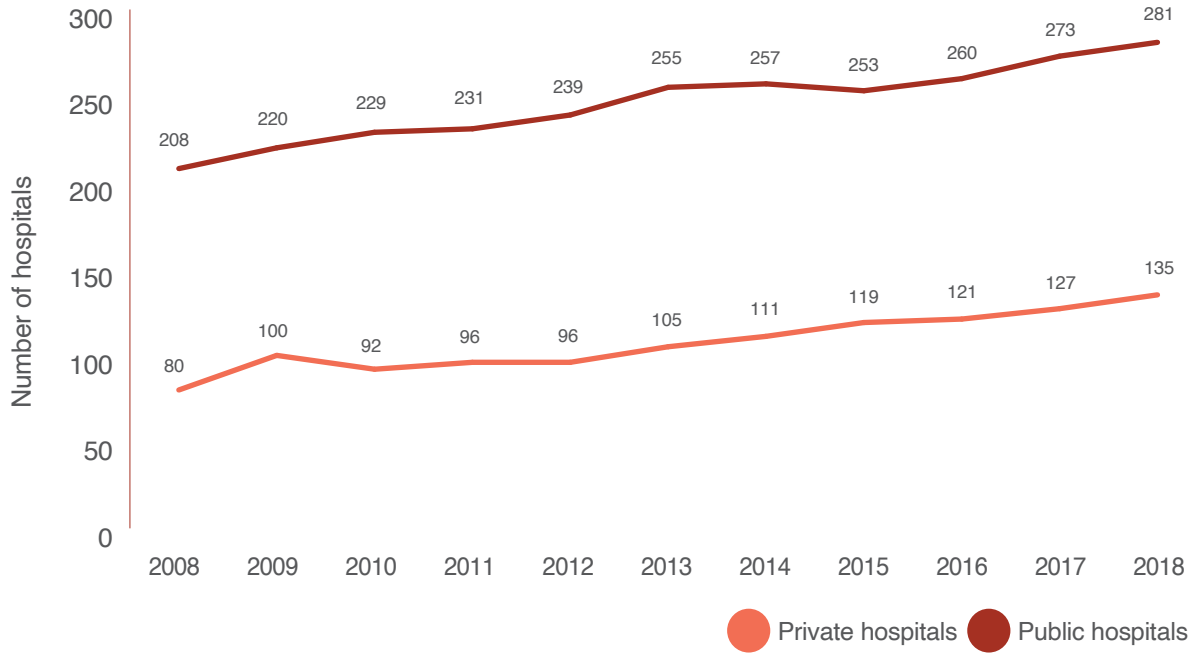
Fig. 12. Infrastructure of the private sector, 2018



Source: Central syndicates of doctors, dentists and pharmacists, Kurdistan syndicate of doctors, and technical directorate of Central Ministry of Health and Environment
* refers to registered clinics.

The growth of the private sector in the last decade is evidenced by the surge in the number of private hospitals, increasing from 80 in 2008 to 135 in 2018 (Fig. 13). The number of public hospitals increased from 208 to 281 in the same period.

Fig. 13. Trends in the number of hospitals, 2008–2018[13,14]



13 Annual statistical reports 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017. Ministry of Health, Government of Iraq.
14 Primary health care centres reference guide. Public health directorate, quality control unit, Ministry of Health.

There are no complete and accurate data on the workforce in the private health sector. The information available on the number of registered physicians and dentists does not give the whole picture because that of other health workers, such as nurses, laboratory personnel and technicians, cannot be calculated accurately. This is because the private hospitals, laboratories and diagnostic centres are not mandated by the MoH to have a reporting system. Moreover, the number of dual practitioners (those who practise in both the public and private sectors) cannot be estimated.

Although there are no accurate data on the number of Iraqi doctors practising outside the country, it was estimated in early 2019 that there were about 20 000, the majority of whom were in the United Kingdom of Great Britain and Northern Ireland and countries in western Asia. The main reasons behind this brain drain were the unsafe environment in Iraq, continuous threat to life, and low salaries.

6.4 Scope of the private sector

The services provided by the private sector are limited mainly to primary care services, elective surgical procedures, and obstetrics and gynaecology services *(10)*. Several factors are responsible for the limited scope of the services offered. First, the at times unsafe environment makes the provision of emergency health services potentially problematic for private sector personnel. Second, some services are too expensive for the private sector to provide. These include neonatal care, as well as services for long-stay inpatients. Setting up a national health insurance system could help to solve this problem.

There is no referral system within the private health sector and patients are free to seek services from a private health facility at any level *(9,10)*. Legally, public health providers should not refer patients to private health facilities *(11),* but private health providers can refer patients to public facilities. A private health provider has to refer the patient if the service concerned is unavailable in the private facility, such as emergency services, or when the patient needs to be admitted to hospital for a prolonged period. The latter becomes easier if the health care professional is working in both sectors.

As mentioned already, hospitals in the private sector do not usually offer emergency services, partly due to the poor security environment. For this reason, despite the legal regulations that necessitate the inclusion of an emergency unit in each private hospital, the vast majority of these units are not functional. Consequently, private hospitals tend to depend on the public sector to cover medical emergencies, managing elective cases themselves *(10)*.

Public hospitals received 8 030 560 emergency visits in 2018. The corresponding number for private hospitals was about half of this figure. Thus, the private sector's potential capacity to treat medical emergencies is considered to be high.

While public sector facilities offer care at all levels, as well as all types of services, including preventive, diagnostic, curative and rehabilitative services, private sector facilities provide diagnostic and curative services, but no preventive services and limited rehabilitative services.

Private clinics should function as the PHC centres in the private sector and offer preventive services. However, they focus on providing curative care through the prescription of medicines or surgical intervention in private hospitals. Preventive services, such as vaccination, screening programmes, health education and health promotion measures, are all provided by the centres in the public sector.

In the private sector, rehabilitative services consist merely of physiotherapy sessions conducted by a physiotherapist during home visits, and the household has to make direct payments for these services. There are no private physiotherapy centres in Iraq. This could be due to the high cost of equipment and the long duration of the rehabilitation process, which is financially draining for patients. Physiotherapy centres in the public sector have their own drawbacks, such as inadequate funding, outdated equipment and lack of modern protocols *(9)*.

6.5 Legal and regulatory framework and governance of the private health sector

6.5.1 Registration, contracting and licensing of private health facilities

In accordance with Iraq's federal Law No. 25, passed in 2015, the licensing of private hospitals and diagnostic centres should be approved by the mayoralty health council. Technical clearance comes from the private sector department in the Ministry of Health. All private hospitals, diagnostic centres and major laboratories comply with the requirements on the licensing of private health facilities specified in the MoH regulations. Most of these facilities are located in the urban and most populous regions and hence, are licensed, especially because almost all inspections are carried out in central, urban areas. However, private clinics located in rural and remote areas are not registered, which accounts for the lack of accurate data on the number of private clinics and pharmacies.

The entire licensing process at the ministry level is hindered by the issues and lack of professionalism within the administrative system, which can prolong the process. According to Iraqi law, public practice is licensed through the MoH, and private practice through the syndicates of physicians, dentists and pharmacists. The exceptions are private hospitals and diagnostic centres, which are licensed through mayor-councils and the MoH, respectively.

Registration is a requirement for private clinics, which can register with the syndicates concerned. Registration is also mandatory for pharmacies and pharmaceutical warehouses.

6.5.2 Licensing of health care personnel

Registration and licensing of doctors, dentists and pharmacists is the responsibility of their own syndicates. The two processes take

place simultaneously and authorize these personnel to practise their specialities both in the public and private sectors. Practitioners in a public facility are allowed to practise in a private facility so long as their working hours do not coincide with those of the public facility.

Private doctors, dentists and private pharmacies and warehouses fall under the regulatory purview of their own syndicates. However, if health professionals also work in participate in health projects, which are the responsibility of the health and environment committees under the mayor-councils. Recently, these committees have been conferred the authority to evaluate the projects. It is clear that the governing structure is dividing the authorities that conduct the processes of registration, licensing, monitoring compliance with regulations, and monitoring and evaluation of health care facilities in the public and private sectors. This is largely a result of poorly planned decentralization.

There is a need for the biannual relicensing of doctors, dentists and pharmacists, following the payment of the required fees to the respective syndicates. Laboratory personnel pay relicensing fees to the laboratory department of the MoH. Private health facilities, such as private hospitals and diagnostic centres, have to pay an annual inspection fee. Laboratories too have to make payments to the relevant department of the MoH.

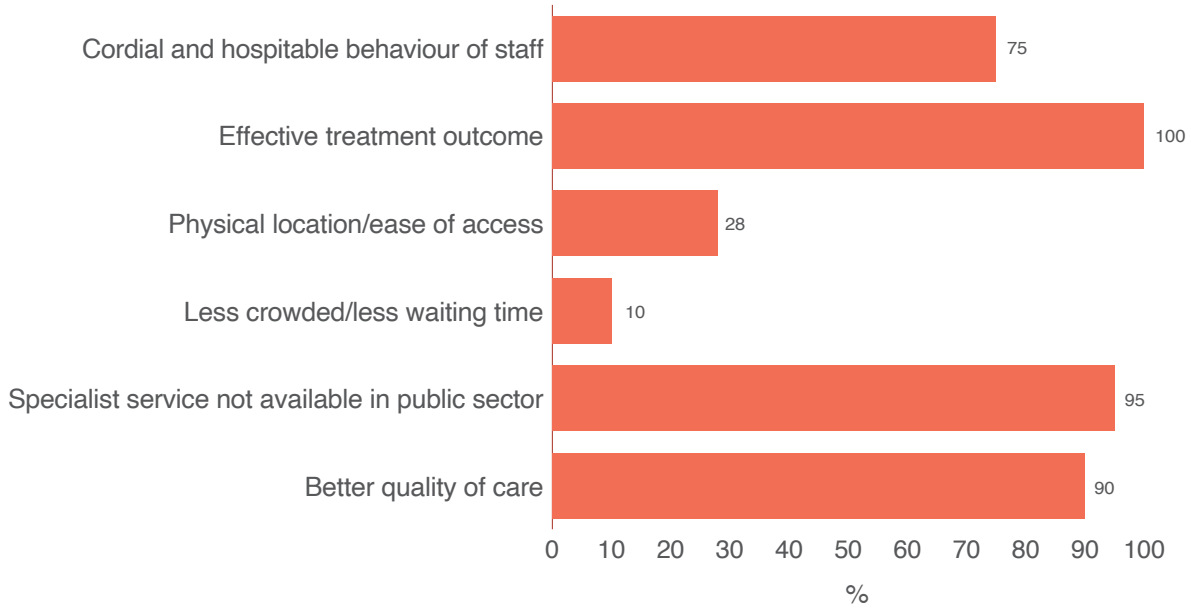
6.6 Quality, accreditation and oversight of services

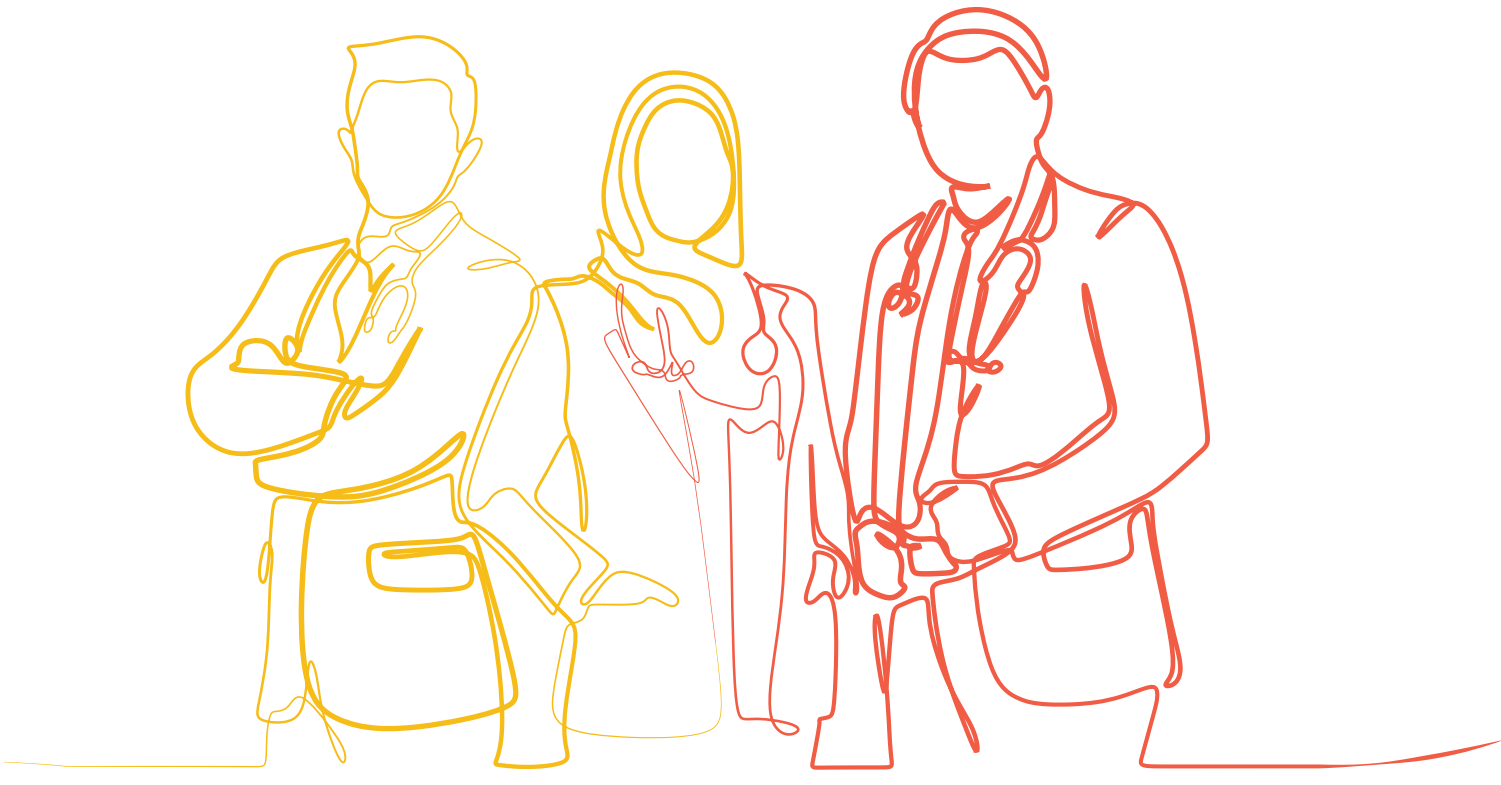
The Department of Inspecting of Private Health Facilities, under the Inspection Directorate of the MoH, monitors quality in private hospitals, diagnostic centres and laboratories. Quality issues do not stem from the structure of the governing body, rather, they arise from low standards of implementation, fraud and weak decision-making.

In accordance with the national health policy and strategic plan, there have been some attempts to standardize the accreditation process in collaboration with some regional accreditation agencies, such as with the Health Care Accreditation Council of Jordan for the accreditation of the four main PHC centres in Baghdad. However, the process has been stalled repeatedly because of the health system's inability to adapt to the accreditation requirements mainly related to governance and financial aspects *(12).*

An analysis of a sample of 40 patients who had just been discharged from private sector facilities showed that the most common reasons for choosing private sector services were: effective treatment outcome (cited by all 40 participants); the absence of specialists in the public sector (38 participants); and better quality of care in the private sector (36 participants) (Fig. 14).

Fig. 14. Patients' views: reasons for choosing private health services





7

Private sector engagement in health service delivery

7.1 Legal and institutional framework

Iraq has no laws on public–private partnerships or private sector engagement. In fact, public health Law No. 89, enacted in 1981, is considered an obstacle to the effective scale-up of public–private partnerships/private sector engagement because it makes the MoH entirely responsible for the provision of health services, as is evident from the following. MoH officials as well as private sector representatives feel that this law needs to be amended.

- **Article 1 states that each citizen has a right to complete physical, mental and social health. This right is guaranteed by society and the State must provide all that is necessary for its attainment.**
- **Article 2 states that the MoH is responsible for organizing all health-related efforts and activities, and must take the measures necessary to achieve this mission. It is specifically responsible for:**
  - preparing a plan on the provision of integrated health services, using all the human and physical resources necessary; and
  - ensuring the optimal utilization of the health workforce, maintaining the necessary number and level of quality, with personnel undergoing continuous training to update their skills.
- **Article 3 states that the Ministry should work with other bodies and stakeholders to guarantee citizens' physical, mental and social health by:**

1. establishing and managing health facilities and centres throughout the country, developing and improving them, and contributing to the improvement of the health status of other Arab countries;
2. controlling and managing communicable diseases with continuous surveillance;
3. providing family, antenatal, paediatric and geriatric health care;
4. providing school health care services;
5. improving the nutritional status of all people;
6. Enforcing health regulations, conditions and specifications for factories and public shops, and monitoring their application;
7. providing health care services to workers in factories and public shops, promoting health, preventing occupational diseases and protecting them from occupational hazards and accidents;
8. protecting the environment, improving environmental conditions, and working to prevent pollution;
9. strengthening health education and the disseminating messages on health and the environment through all media;

10. providing mental health care services and creating an atmosphere conducive to the implementation of these services;

11. providing medicines, vaccines, antisera, injectables and various medical supplies;

12. working towards creating a pharmaceutical industry that is integrated with those of other Arab countries;

13. establishing centres for rehabilitation, physiotherapy and prostheses at the national level;

14. expanding health education, occupational education and training of employees, improving medical studies, and encouraging medical research; and

15. Organizing and monitoring medical and health practitioners in cooperation with their professional syndicates. *(13)*

The second law that should be mentioned is Law No. 25, a federal Law enacted in 2015, that deals with the establishment of private health facilities. Originally meant to encourage investment in the private health sector, the Law makes the following stipulations with regard to private hospitals, primary health care centres, diagnostic centres and surgical clinics.

- **The State shall allocate a piece of land, free of charge, to any investor for the purpose of establishing a private health facility and also arranges for a bank loan, which does not exceed 30% of the total building costs. The loan is to be repaid with interest within 15 years.**

- **The technical manager of the facility must be a doctor with at least 10 years of experience. S/he is not permitted to work in the public and private sectors simultaneously.**

- **The owner of the facility may hire non-Iraqi health personnel, who can form no more than 60% of the total number of doctors, 50% of nurses and 40% of non-medical staff.**

- **The owner is not required to be a health professional or worker.**

- **The private facility founded under the provisions of this Law shall be exempt from income tax for three years, starting from the opening date.**

Considering the limited capability of personnel in the public health sector, as well as the Government's reluctance to increase its health expenditure for many reasons, it was inevitable that the legislators should encourage the private sector to participate in a more active fashion. This was the main purpose of the federal Law on the establishment of private health sector facilities. The private sector is the only alternative available at present.

7.2 Current partnerships (contractual agreements)

There is currently one private hospital subsidized by the Government that offers dialysis services in Baghdad. Another example is the cardiology centre in Erbil. The centre is located in a government building and the provision of services is subsidized by the Government. The staff are from both the public and private sectors.

There is another form of health service provision by the public sector: governmental private service. This is a public service for which the patient has to pay out-of-pocket. For example, a person can be provided with MRI diagnostic services promptly on direct payment rather than being on the waiting list for a month (which is the case with public health services). A person may also choose to be admitted to a private medical or surgical ward in a public hospital through the same system. The benefits are better infrastructure and nursing services, as well as greater availability of medicines. The services provided are comparable in quality to those of the private sector and, at the same time, are less expensive. And for the public sector, it means the generation of extra revenue. This arrangement can, however, be considered as an example of the privatization of public services, rather than a true public–private partnership.

As mentioned earlier, the Ministry of Oil, the Ministry of Interior and the Ministry of Electricity all have a health insurance system for their staff. Under this system, employees receive health care services from certain private sector facilities which are contracted to the ministry concerned to provide services covered by the ministry's insurance.

7.3 Scope of and priority areas for public–private partnerships

According to stakeholders in the MoH and representatives of the private sector, the private sector should invest mainly in secondary and tertiary services, especially highly sophisticated diagnostic and therapeutic techniques, leaving most primary health care services, secondary paediatric services and emergency services to the public sector *(10).*

The current laws do not allow for such divisions, so there is a need to enact new legislation on the basis of the prevailing beliefs of stakeholders in the public and private sectors.

It is necessary to establish and activate a functional system for data reporting from the private to the public sector. In this regard, some regulations are in place but not functional, while others need to be put in place.

8

Strategic SWOT analysis for public–private partnerships in the health sector

One of the main weaknesses that may affect public–private partnerships is that the private sector does not have any associations dedicated to sector-specific issues

The major strengths of public–private partnerships are the political will to legislate new laws to facilitate partnerships, such as the national health insurance Law; the private sector's willingness to partner with the public sector *(10)*; and the high quality of private sector services, which may be conducive to the creation of an environment of participation.

One of the main weaknesses that may affect public–private partnerships is that the private sector does not have any associations dedicated to sector-specific issues. The existing syndicates focus on registration, licensing and tax collection, rather than the discussion of issues pertaining to private sector services. These issues include protecting facilities and staff and assigning private sector representatives to the public sector to encourage collaboration and establish relationships.

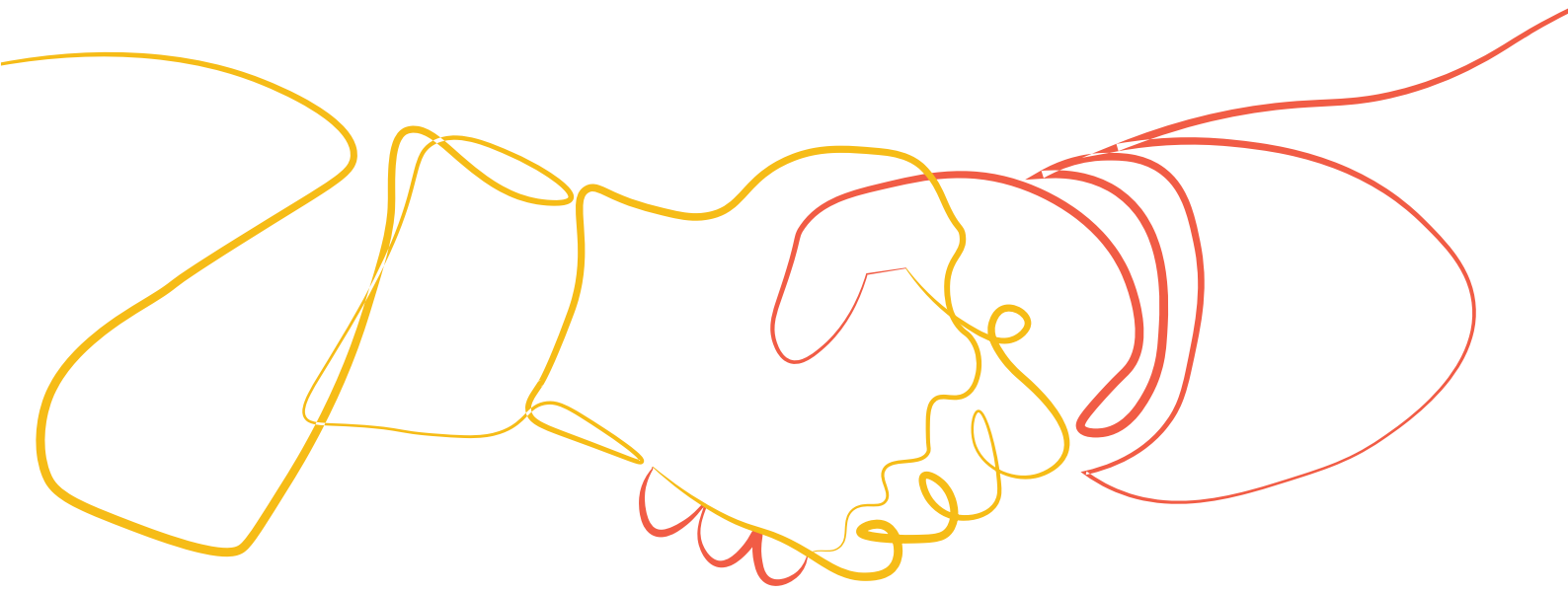
Another weakness is the existence of outdated legislation, such as the public sector Law, which obligates the public sector to provide all health services, which is no longer realistic or feasible. Therefore, these laws must be modified to reflect the current situation. Another problem is that Iraq's pharmaceutical industry is too weak to help promote public–private partnerships by providing low-cost medicines. Further, the tax policy is irrational, leading to tax evasion and the failure of registration of private health facilities. Finally, there is the issue of the absence of systems for reporting data from the private to the public sector.

The unprofessional and poorly managed public health sector could be a real threat to the planning of any public–private partnerships. Private health facilities not being registered, as well as the existence of dual practice, also pose problems as dual practitioners tend to get benefits from redirecting patients from public to private health facilities, thereby abusing their authority in the public sector.

The fact that there have been no national health accounts since 2013 may hinder efforts to inves tigate private sector expenditure and consequently, may affect the planning of public–private partnerships.

The endorsement of national health insurance, for which a law is being finalized, would be a great opportunity to boost public–private partnerships as it would offer insurance services to millions of Iraqis. This would promote the expansion of the private sector by creating new sources of funding.

Fig. 15. SWOT analysis for public–private partnerships



9

Recommendations on private sector and policy directions

These recommendations are based on the opinions of the main MoH stakeholders, the representatives of the private sector and the general public (who use both public and private health facilities). Further, the recommendations draw on reports analysing the health situation in Iraq.

- Review and modify the current health legislation (e.g. public health Law No. 89 and federal Law No. 25 on the establishment of private sector facilities) and enact new laws to promote public–private partnerships (e.g. the health insurance Law).
- Promote the national pharmaceutical industry and regulate the inspection and registration of medicines.
- Reconsider tax policies which are regarded as irrational by private sector practitioners and which contribute to non-registration and tax evasion.
- Promote the establishment of independent private sector associations that support the private sector's needs and negotiate with the Government for any possible partnership.
- Organize a national health forum to discuss public–private partnerships.

Outlining policy directions is difficult in a country with a fragile political system. Still, the following basic principles can be set out based on an analysis of the current situation:

- adopt policies aimed at achieving UHC to fill the gaps in the health system;
- review health funding mechanisms and increase the allocation to the health budget;
- encourage private sector investment aimed at integrating services through public–private partnerships;
- increase the size of the health workforce, addressing its distribution and building the capacity of health care workers;
- tackle corruption and wasteful spending of the Government's budget; and
- reorganize the pharmaceutical sector and modify legislation that regulates the selection of medicines for the national essential medicines list and post-marketing surveillance.

The National Health Policy 2014–2023 states that the Government will adopt diversified complementary health care financing options that include private sector investments in health and health care services, education in the medical and health sciences, and training. These options, which should be sustainable, will be adopted in close coordination with and under the regulatory frameworks of the MoH and the Ministry of Higher Education and Scientific Research. The Government will also encourage and provide operational frameworks for public–private partnership. The MoH anticipates that mutually beneficial cooperation between the public and private sectors will entail the joint mobilization and sharing of resources to promote the development and efficient delivery of well-regulated health services, while also ensuring accountability to the public. The MoH shall continue to communicate, coordinate and collaborate with providers in the private health sector. Health services provided by the private sector shall abide by the standards and guidelines set out by the MoH *(14).*

In addition, Iraq Vision 2030 will act as the developmental framework under which national medium-term development plans will be chalked out with a view to aligning government programmes with their goals and priorities *(14).* The aims are to enhance sustainability and investors' trust in the Iraqi economy, and to expand the private sector's role as a strategic partner in managing development, stimulating growth and prosperity and ensuring environmental protection.

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