

POLICY BRIEF

October 2008

Policy Brief # 24

Iraqi Mental Health

Hamada Hamid
ISPU Fellow

Iraq serves as a prime example of how global forces, political culture, and national history shape and constrain mental health programming.



Recent studies project mental illness and substance abuse will soon constitute five of the leading ten causes of disability and premature death globally (WHO 2004). Societies torn by natural disaster and war face higher levels of emotional distress (Mollica 2004) and yet are most in need of productive, healthy citizens. Therefore, preventing mental disability caused by mental illness and substance abuse in otherwise physically healthy individuals is critical to help rebuild those societies. According to the World Health Organization (WHO), the fourth leading cause of morbidity in Iraqis older than five years is mental illness, ranked higher than infectious disease (WHO 2005). Iraq, like most low and lower-middle income countries (Saxena & Maulik 2003), has struggled to establish a national mental health policy: Iraq has dedicated less than 1% of their health care budget to mental health, failed to establish community mental health centers, not been able to secure essential pharmaceuticals, and not developed a viable mental health care monitoring system. Iraq serves as a prime example of how global forces, political culture, and national history shape and constrain mental health programming. This policy brief will explore the current state of Iraq's mental health policy and provide suggestions for future direction and development.

Although Iraq's political circumstances are chaotic and in continuous flux, there are several stable global stakeholders that

will drive Iraq's national mental health policy regardless of who secures political power. However, before describing the various roles of the current global players, it is worth reviewing the historical context of Iraq's current health care circumstances.

Historical Context

While British colonial rule was short-lived (1919-1927), it had a profound impact on medical education and health care delivery style (Al-Jadiery & Rustum, 2006). Iraq's health system, throughout the middle and late 20th century, had been highly centralized and regulated by the Iraqi Ministry of Health. During the 1970s large sums of oil revenue allowed the government to function without a need to rely on tax revenue or become dependent on economic interest groups (Dodge 2005). Annual oil revenue soared from \$US 600 million in 1970 to \$26 billion by 1980, which was invested in government programming such as the Iraqi military, social welfare, education, and health institutions. Approximately 21% of the Iraqi workforce and 40% of Iraqi households depended directly on government salaries. As recently as 2003, 92% of Iraqi physicians had government salaries as well as private clinics and only 5% of physicians exclusively worked as private practitioners. Funding and allocation of health services, organization

management of care consumption, and provision of care were always centralized. Almost all medical staff were employed by the Iraqi government; medications were produced, stored, and distributed predominantly by the two state owned pharmaceutical companies (KIMADIA and Samara Drug Industries); and the management and administration of health care delivery was under the auspices of the Ministry of Health (MOH). The Iraqi government paid for primary care and hospital services, and specialized consultations were paid on a fee for services basis (Iraqi MOH, 2004). After the Iran-Iraq war (1980-1988), Iraq's invasion of Kuwait (1990), the United States led economic sanctions (1990-2000), and the U.S. invasion of Iraq (2003) the Iraqi government could no longer afford to bear the costs of the nation's health care.

The Political Impact on Health

The devastating impact of the United Nations Security Council's economic embargo enforced from August of 1991 through March 2003 (when the U.S. invaded Iraq) directly reflects the profound impact of the global economy on Iraqi health. During the 1990s, Iraqi MOH funding dropped by 90% and the nation's health expenditure was reduced from 3.72% of the GDP in 1990 to 0.81% in 1997 (Iraq Ministry of Health, 2004). During the 1990s there was a sharp increase in infant and child mortality rates (from 60 deaths/1000 live births in 1988 to 120 deaths/1000 live births in 1999 in children less than 5 years). Maternal mortality has more than doubled from 117 per 100,000 live births in 1989 to 294 per 100,000 live births in 2004. Malnutrition rates also increased, as measured by percentage of low birth rate babies from 4.5% in 1990 to 23.8% in 1998 (EMRO 2005). The international community took

notice of the devastating impact wars and sanctions had on Iraqi health and the reconstruction phase of Iraq, since the U.S. invasion has seen a new global interest in Iraqi health care reform (Panch, Reed, Rowsen, Salvage, 2004). However, out of the approximately 4 billion dollars in reconstruction funding, only 4.8% went to the health sector, and 2% of that was allocated to systems improvement and training (over 97% of the health sector funding was spent on construction and equipment). Although mental health was never a major priority of Iraqi health care policy, more attention was paid to Iraqi mental health care as international non-governmental organizations (NGOs) provided mental health services and governmental agencies provided funding for mental health programming during the beginning of the reconstruction effort. As of 2003, \$7 million of reconstruction funding was dedicated to mental health training and services, almost entirely donated by the Japanese government. The new attention to mental health by the global players provided an opportunity for Iraqi mental health professionals to rethink Iraqi mental health policy.

Defining the Problem

Since 2003, the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) and the WHO have been among the primary agents defining the mental health problem in Iraq. SAMHSA in conjunction with experts from the United Kingdom's National Health Service, the U.S. National Institute of Health, and Iraq's MOH has coordinated Iraqi mental health planning committees and hosted two major conferences in Amman, Jordan. In

the March 2004 conference, participants were divided into four workgroups: mental health services, mental health training and education, scientific programs and research capacity, and mental health policy and support (SAMHSA, 2005). The main themes which emerged across the workgroups include lack of human and financial resources, stigma against mental illness, and the lack of a system that integrates the different disciplines involved in mental health care such as primary care, social work, psychology, and nursing. The WHO's influence in defining Iraq's mental health problem was facilitated by Dr. Muhammad Lafta, the former President of the Iraqi Board of Psychiatrists, who drafted the Iraqi WHO Assessment Instrument for Mental Health Systems (WHO-AIMS). This instrument, specifically designed to assist developing countries collect data to inform mental health policy, focuses on the following objectives as defined by WHO:

1. Provide treatment for mental disorders in primary care
2. Ensure wider accessibility to essential psychotropic drugs
3. Provide care in the community
4. Educate the public
5. Involve communities, families and consumers
6. Establish national policies, programs and legislation on mental health
7. Develop human resources
8. Link with other sectors
9. Monitor community mental health
10. Support relevant research

(WHO, 2005a)

The final WHO-AIMS report is organized into six domains: policy and legislative framework, mental health services, mental health in primary care, human resources, public education and links to other sectors, and monitoring and research. In both the SAMHSA and WHO-AIMS examples, academic experts mostly from the U.S. and U.K. influence policy by providing the framework for assessing mental health systems. The themes that emerge reflect the U.S. and U.K.'s mental health reform experience. For instance, the recommendation to shut down Iraq's only long-term inpatient psychiatric hospital (Clay, 2005) reflects the renewed emphasis in primary care and community mental health delivery. The deinstitutionalization movement, however has particular ideological, social, and political significance in the U.S. and U.K. (Shadish, 1984, Keisler et al. 1983), which may not be applicable to Iraq's current post-war circumstances. For example, in contrast to the U.S. and U.K. Iraq has no community mental health center system, vocational training system, homeless shelter or residential mental health programs, and less than 150 psychiatrists to serve 25 million Iraqis.

Current Mental Health Policy Proposal

The mental health policy proposal generated by the SAMHSA sponsored meeting include 43 specific recommendations which may be categorized by four general themes: 1) developing standards for clinical care, delivery of services, research and education; 2) training experts in administrative, public health and policy, and mental health subspecialties; 3) integrating services across disciplines, including primary care; and 4) addressing stigma against mental illness among the public as well as with other medical professionals and government

agencies. The efforts of the WHO, SAMHSA, and NHS sponsored Iraqi Planning Committee should be credited for establishing the first comprehensive Iraqi mental health policy plan. With more tangible objectives and specific recommendations for policy intervention, once the political circumstances are favorable, perhaps more progress in mental health care reform will occur.

One of the major limitations of the current mental health policy plan is the neglect of what Robert el al (2004) describe as the "control knobs" of health reform, including financing, payment, organization, regulation, and behavior. Currently, Iraq has no national or social insurance system. Iraq's undervalued currency and economic recession results in a poor tax base, while the high rate of unemployment and weak labor force are poor sources of financing a nationalize health care system. Once financed by oil and other governmental revenue, the health care sector is now primarily dependent on foreign aid. Payment of health care services is predominantly based on government salary in the public sector and fee for services in the private sector. The current security situation makes it nearly impossible for the Iraqi government to regulate the health care market, and as demonstrated by the looting of government, including health care, institutions many Iraqis have little faith in the state or a sense of civil responsibility. Nevertheless, Iraq historically was highly industrialized, had high rates of literacy and a skilled work force. As the security situation improves in the next several years, it is worth planning for a sustainable health care system, which includes mental health.

Policy Recommendations

As the United Nations and the World Bank continue to develop health care needs assessment and strategic planning reports (Nabarro 2003), Iraqi mental health policy makers should engage in the financing and regulatory aspects of health reform with the political processes kept in perspective. Beginning with stakeholder analysis, they should recognize the integral role of global players such as WHO, the World Bank, IMF, and SAMHSA in both the problem defining and financing of mental health programming. Furthermore, domestic players such as other ministries and other health care specialty groups will compete for the diminishing reconstruction funding. Therefore, policy makers should continue to strengthen their partnerships with primary care services and other health care specialists when setting the health care reform agenda. However, essential mental health care services such as long-term inpatient care should not be cut off in order to conform to the emphasis on community services. Since there are limited sources of financing, policy planners should support strong state regulation of foreign industries, such as pharmaceutical and private insurance companies, to maintain profits within Iraq. Conversely, indigenous private Iraqi health industries should be provided financial incentives to both stimulate economic growth as well as begin to shift the management and provision of care to the private sector.

Iraqi mental health will continue to be marginalized if mental health policy makers do not participate in the broader aspects of health reform such as financing, regulation, and organization of the health care system. While some global forces such as war and international economic policy are seemingly not within the influence of

mental health policy makers, the global and domestic players in health reform must be engaged.

Conclusions

1. Iraqi mental health policy makers should engage in the broader aspects of Iraqi health reform such ensuring universal coverage and improving the regulation of medication dispensing.
2. Mental health policy makers should continue to support and finance programs to train Iraqi primary care physicians and community health workers to help manage mental illness.
3. Training programs in clinical psychology, psychiatric nursing, and social work should be developed
4. Public inpatient mental health units and facilities, such as Al-Rashad Hospital, should not be shut down as the severely and chronically mentally ill will require comprehensive inpatient care.
5. Outpatient and community mental health programs should be developed to decrease inappropriate long term hospital stays as well as help encourage integration of the mentally ill into the community.

Dr. Hamada Hamid is the Director of Center for Global Health and a Fellow at the Institute for Social Policy and Understanding (ISPU).

References

- Al-Jadiery & Rustum (2006) Mental Health Training and Education in Iraq: An Overview. *The Journal of Muslim Mental Health* (in press)
- Alnasrawi A (2001) Iraq: economic sanctions and consequences, 1990-2000. *Third World Quarterly* 22, 205-218
- Bristol N (2006) Iraq's health requires continued funding commitment. *Lancet* 368, 906-906
- Burkle F & Noji E (2004) Health and politics in the 2003 war with Iraq: lessons learned *Lancet* 364, 1371-1376
- Chernichovsky D (1995) Health system reforms in industrialized democracies: an emerging paradigm. *The Milbank Quarterly* 73, 339-372
- Clay R (2005) Helping Iraq Restore Its Mental Health System. SAMHSA NEWS 13, http://www.samhsa.gov/samhsa_news/Vol_umeXIII_3/index.htm last visited on October 24th, 2006
- Dodge T (2005) Iraqi Transitions: from regime change to state collapse. *Third World Quarterly* 26,705-721
- Herrman H, Saxena S, Moodie R (2004). *Promoting mental health: concepts, emerging evidence, practice*. Geneva, World Health Organization.
- Iraq Ministry of Health (2004) Health in Iraq. The Current Situation, Our Vision for the Future and Areas of Work. Baghdad: Ministry of Health
- Kiesler C, McGuire T, Mechanic D, Mosher L, Nelson S, Newman F, Rich R, & Schulber H. (1983) Federal Mental Health Policymaking. An Assessment of Deinstitutionalization. *American Psychologist* 1292-1298
- Kingdon J (2002) The reality of public policy making. In: *Ethical Dimensions of Health Policy* Eds Danis, M, Clancy C, Churchill L New York: Oxford University Press
- Mollica, R.F., Cardozo, B.L., Osofsky, H.J., Raphael, B. Ager, A., & Salama, P. (2004) *Lancet*, 364, 2058-67
- Nabarro, D. (2003) Working Paper. United Nations/World Bank Joint Iraq Needs Assessment. Health.
- Panch T, Reeve G, Rowson M, & Salvage J (2004) Enduring effects of war health in Iraq 2004. London: Medact
- Robert MJ, Hsiao W, Berman P, & Reich. *Getting Health Reform Right. (2004) A Guide to Improving Performance and Equity*. New York: Oxford University Press
- Saxena S & Maulik P (2003) Mental health services in low- and middle-income countries: an overview. *Current Opinion in Psychiatry* 16,437-442
- SAMHSA (2005) Conference Proceedings Action Planning Conference for Iraq Mental Health. Amman, Jordan. Washington D.C.: SAMHSA
- Shadish W. (1984) Policy Research. Lessons from the implementation of deinstitutionalization. *American Psychologist* 39, 725-738
- WHO Eastern Mediterranean Regional Office Division of Health System and Services Development, Health Policy, and Planning Unit (2005) Health Systems Profile. Iraq. Cairo: World Health Organization Eastern Mediterranean Regional Office.
- WHO (2005a). WHO-AIMS Version 2.2 World Health Organization Assessment Instrument for Mental Health Systems. Geneva: World Health Organization.
- WHO (2004) Prevention of Mental Disorders. Effective Interventions and Policy Options. Geneva: World Health Organization.

The Institute for Social Policy and Understanding (ISPU) is an independent and nonprofit organization committed to solving critical social problems in the United States through education, research, training, and policy analysis. ISPU provides cutting-edge analysis and policy solutions through publications, public events, media commentary, and community outreach. Major areas of focus include domestic politics, social policy, the economy, health, education, the environment, and foreign policy. Since our inception in 2002, ISPU's research has worked to increase understanding of key public policy issues and how they impact various communities in the United States.

US society is far from being monolithic, whether culturally, socially or politically. It is therefore imperative that the thoughts and insights of each aspect of this heterogeneity play a contributory role in the discourse and debate of issues that affect all Americans. ISPU was established and premised on this idea – that each community must address, debate, and contribute to the pressing issues facing our nation. It is our hope that this effort will give voice to creative new ideas and provide an alternative perspective to the current policy-making echelons of the political, academic and public-relations arenas of the United States.

ISPU firmly believes that optimal analysis and treatment of social issues mandates a comprehensive study from several different and diverse backgrounds. As social challenges become more complex and interwoven, ISPU is unique in its ability to bring this new approach to the human and social problems facing our country. Through this unique approach, ISPU will produce scholarly publications, incorporating new voices and adding diversity to the realm of ideas. Our multidisciplinary work in partnership with universities and other research institutes serves to build understanding and create programs that effect lasting social change.

Further information about ISPU can be obtained from our website at www.ispu.us



All ISPU Policy Briefs are
available on our website
www.ispu.us

Institute for Social Policy and Understanding
43151 Dalcoma Road, Suite 6
Clinton Township, Michigan 48038

