

Country Cooperation Strategy for WHO and Qatar 2005–2009

Qatar



World Health Organization
Regional Office for the Eastern Mediterranean

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World Health Organization
Regional Office for the Eastern Mediterranean
Cairo, 2006

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Document EM/ARD/013/E/R/03.06

Design and Printing by Pulp Pictures

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Abbreviations

CCS	Country cooperation strategy
DPT	Diphtheria, pertussis, tetanus
GDP	Gross domestic product
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
PHC	Primary health care
QR	Qatari Riyal
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

Over the past three decades Qatar has invested billions of riyals in developing its health services, which has resulted in significant improvements in the delivery of these services and in the health status of the population as reflected in all the health indicators. By investing in primary health care the Ministry of Health has achieved a high status of health in Qatar in comparison with the developed countries. The Government in its strategic intent to be a regional centre of excellence for health care is reorganizing and developing the national health system. Despite all the achievements, Qatar has still to address major health system issues:

- ❖ lack of clarity between different stakeholders in carrying out health policy analysis, strategic health planning, priority setting, formulation of national health targets and standards, coordination among the different health stakeholders and monitoring and assessing performance of the health system functions;
- ❖ lack of national human resources and institutions to develop structural and functional aspects of the national health system;
- ❖ division of responsibility for the health information system and weak information sharing for coordination and development of health plans; in addition, health system research has yet to be developed as an integral part of the national health system development;

- ❖ limited planning capacities for long-term strategic planning in the Ministry of Health due to the absence of a planning unit;
- ❖ need to assess equity and efficient use of resources allocated to tertiary health services, especially in anticipation of a forthcoming health insurance scheme;
- ❖ increase of noncommunicable diseases, such as cardiovascular diseases, diabetes and cancer, shifting the provision of care to put greater emphasis on health promotion and lifestyle patterns;
- ❖ high mortality and disability rates due to road traffic injuries;
- ❖ organizational issues revolving around relatively weak coordination and linkages as a result of a lack of clarity in the definition of roles and responsibilities;
- ❖ need to redesign care processes and coordination of care across patient conditions, services and sites of care over time.

WHO's cooperation with Qatar will focus on these issues and technical support is needed in the following strategic directions:

- ❖ governance and institutional development;
- ❖ redesigning the health care system;
- ❖ quality, clinical excellence and performance management;

- ❖ health care financing;
- ❖ development of a national health information system;
- ❖ information and communication technology for health care;
- ❖ drugs and health technology;
- ❖ reducing the burden of disease;
- ❖ attainment of better health and quality of life;
- ❖ human resources development.

The implementation of the country cooperation strategy (CCS) will have implications for WHO at all levels in providing the required technical support. At regional level, WHO needs to be strengthened to conduct frequent backstopping and to better respond to the increasing demands for policy advice, strategic thinking and the modelling of health care.

As this country cooperation strategy coincides with the important evolutions in health services in Qatar, it is ambitious and reflects real needs. Recognizing the fact that the Joint Government/WHO programme review and planning mission can provide limited financial input to CCS based plans, the allocation of necessary funds from national resources is a prerequisite for successful implementation of this strategy. A possible mechanism for joint implementation is the Funds-in-Trust where WHO is the executing agency, allowing national financial resources to be managed through WHO as a support to countries.

Section

Introduction

Country focus is an expression of the continuing commitment of WHO to put countries at the heart of its work. It encompasses all three levels (country, Regional Office and headquarters) of the organization working together to meet the health challenges within and between countries while contributing to the equity and solidarity that are the core values of the Health for All goal and primary health care. The overall purpose is to improve contribution to the Member States by strengthening national health systems and by guiding them towards achieving the targets of the Millennium Development Goals (MDGs) and other health outcomes through:

- defining a WHO strategic agenda for working with individual Member States and the implications of such an agenda for the organization as a whole; and
- ensuring that WHO can effectively influence the environment in the health sector, such that the national teams are equipped to implement strategic health plans, based on well designed country cooperation strategies.

The CCS is an analytical framework for WHO's cooperation with individual countries highlighting what WHO will do in the short to medium term (3–5 years) and how it will operate to achieve those goals. The CCS combines the realistic assessment of country needs with WHO's corporate strategy as reflected in the current General Programme of Work. It constitutes an agreed statement of how the

national authorities and WHO will prioritize the use of WHO technical assistance within the country. The CCS will also be used as the basis for WHO's strategic agenda for planning, budgeting and management of WHO's work in the country.

The development of the CCS was based on discussions, field visits and reviewing documents on Qatar. The mission was a timely step towards enhancing the technical assistance provided by WHO during a period in which the national health system is witnessing major organizational and functional changes. This CCS establishes a framework for WHO–Qatar cooperation covering a period of 5 years from 2005–2009.

The identification of future areas for collaboration was the result of broad consultations with key stakeholders in Qatar. The CCS mission was carried out by the WHO team, composed of the WHO Desk Officer for Qatar and a medical officer from the Regional Office in Cairo, working together with a national team composed of senior health managers in Qatar. In the process of the development of the strategy a series of meetings and reviews were conducted with a wide range of officials in the Ministry of Health (Assistant Under-Secretary of Preventive Health, programme managers and secretaries of technical committees), Hamad Medical Corporation staff and the Planning Council. Annex 1 gives a list of officials met during the mission.

This strategy highlights a comprehensive vision of the collaborative work of WHO with the country. It is based on available information on health priorities, needs, aspirations and challenges, and government policies and expectations. The consensus in the strategy is to ensure a greater response to country needs, and to reflect WHO priorities.

The CCS was conducted in a context of overall evolution, of which health development has been a priority, aiming at improving the quality and cost-effectiveness of the existing free health care services. The CCS thus can contribute to discussions on the organization and design of the envisaged new national strategic health goals and targets including the role of the public and private sector in health services delivery.

To support the Government, in its effort to formulate the health sector strategy, WHO cooperation from 2005–2009 will focus on selected themes, including reduction of the burden of diseases, institutional capacity-building, human resources development, health economics, information systems and organization and management of services.

The CCS implementation will be within the context of the Joint Government/WHO Programme Review and Planning Mission, national funding and regional and international technical cooperation. In the course of implementation, WHO technical support will be provided through regular visits and evaluation missions. The Government of Qatar might consider the use of Funds-in-Trust within the WHO context to help in the CCS implementation.

Section

2

Country Health and Development
Challenges

2.1 Geographic and administrative profile

Qatar's total population, including expatriates, has grown quickly, from 70 000 in the late 1960s to 724 000 by 2003.¹ Of that total only about 30% are Qatari nationals. The remainder are expatriates, mostly from India and Pakistan. The total area of Qatar is 11 493 km².² It is a flat arid peninsula jutting northward into the Persian Gulf from the east coast of the Arabian Peninsula. Its highest elevation is a mere 40 metres above sea level, and average annual rainfall is low. Summer temperatures soar to 50°C and surface water and vegetation are scarce. Some water is available through underground aquifers but domestic water supply is heavily dependent on desalination plants. Ninety per cent (90%) of the population lives in an urban setting, and the urban population is increasing at an average rate of 2% per year.

The country is currently witnessing a relatively expansive growth in population partly because of the rapidly growing economy due to the booming petroleum industry and the resultant influx of expatriates in the development process, and partly because of a general increase in fertility and population growth rates. The large number of single male expatriate workers has had a marked effect on the gender balance of the total population,

with females making up only 34.4% of the total population.³

In 1998, when low world oil prices put a damper on the economy, the population of Qatar dropped by 5.3% as expatriates were made redundant. However, in 1999, the population shot up by 9.3%, probably as a result of increased investment in industrial projects and the consequent rise in demand for expatriate blue-collar labour. There was a slight fall in the total population in 2000, followed by increases of 2.9% and 3.9% respectively in 2001 and 2002, as the Government started to move ahead with a host of new construction projects. The population is disproportionately young, with the UN estimating that 27% of the total population is under the age of 15 (Figure 1).⁴

2.2 Political structure and government

Qatar declared its independence in 1971 after the United Kingdom announced its withdrawal from the region. The highest authority is the Emir but the cabinet, which is appointed by the Emir, carries out the day-to-day administration. According to the new constitution approved by a referendum on 29 April 2003, some powers are devolved to a 45-seat consultative assembly, two thirds of which will be elected.

¹ *Annual report 2003*. Department of epidemiology and statistics. Hamad Medical Corporation, Doha, State of Qatar.

² *Joint Programme Review and Planning Mission report*. WHO Regional Office for the Eastern Mediterranean, 2004.

³ *Population, health and human well-being*. Qatar, Earth Trends 2003. (<http://www.earthtrends.wri.org>, accessed 1 June, 2005).

⁴ United Nations Development Programme. *Arab human development report 2003. Building a knowledge society*. New York, 2003.

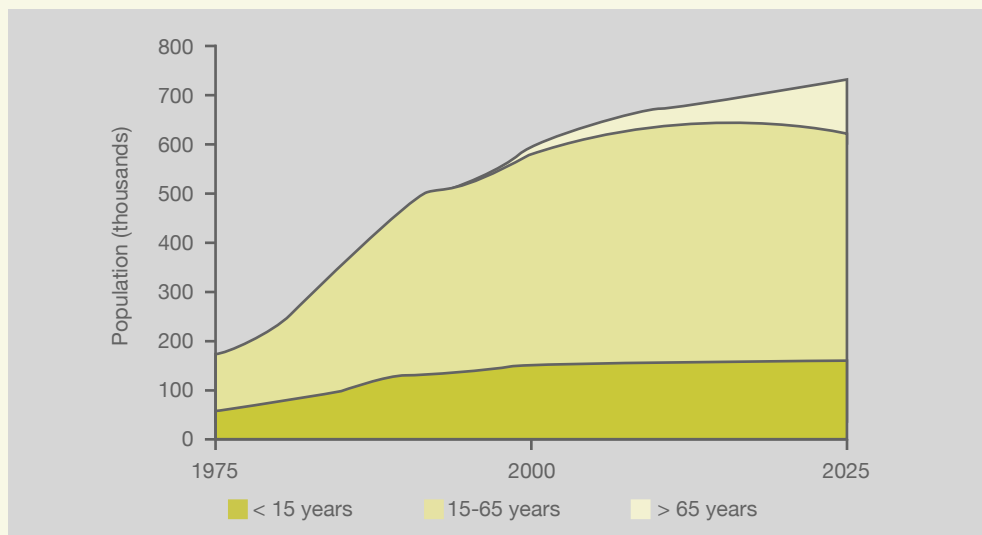


Figure 1. Population by age group 1979-2025 ³

The recent reforms introduced by the Emir towards political liberalization and democratization are widely supported by the Qatari people, particularly by young Qataris. The population have started to reap the benefits of the prosperity that has come with accelerated development of Qatar's gas riches, and have welcomed the efforts that the Emir has made to open up the political system. In March 1999, Qatar held its first ever nationwide election for a Central Municipal Council in which both men and women were allowed to vote and stand for office. In mid 1999, a constituent assembly was established to write a permanent constitution for the State, including provision for an elected parliament. The constitution was finally approved in a referendum in April 2003. Press laws are increasingly being relaxed and Qatar's Aljazeera satellite channel is acknowledged as the freest television station in the Middle East. Another area of liberalization has been women's rights,

strongly promoted by Her Highness the wife of the Emir. May 2003 saw the appointment of Qatar's first female cabinet minister, who was given the education portfolio.

2.3 Demographic and health profile

The quality of health care in Qatar is high, even by the standards of the industrialized countries. Life expectancy has risen sharply as health care provision has improved (Table 1). There are more than 1400 hospital beds and further specialist hospitals are planned. As Government income increased in the wake of the oil price boost, Qatar was able to provide free health care to all nationals and expatriates. However, rising costs and increased pressure on the budget led the Government in 1999 to require expatriates to purchase health cards. The costs are still low and do not come close to meeting the actual cost of health provision, but signal a shift in the policy of the Government. The country is currently actively pursuing an

alternate system of health care financing through health insurance. This shift in the Government's attitude to the public provision of health care is reflected in the establishment of several new private hospitals.

In Qatar, there is an ongoing vital registration system in which every individual has in its possession a record in which all family members are registered and vital events such as births, deaths, and marriages are recorded. Issuance of birth and death certificates is mandatory for all births and deaths respectively. The main demographic challenge that affects the health situation and services in the country is the relatively large number of expatriates working in Qatar whose demands and

utilization patterns for health services are distinct from the national population.

2.4 Economic and social profile

As Qatar is an oil-producing country, the main income is from oil revenue, in addition to some revenues from the petrochemical industry. Per capita spending on health by the Government reflects a steady rise in total expenditure aimed at providing better health care services to the population.

Qatar has an estimated per capita income of over US\$ 29 000 per annum. The share of public health expenditure is 2.1% of the total GDP expenditure (Table 2). All payments in the private sector come directly as an out-of-pocket payment with the exception of some banks, private companies and the

Table 1. National demographic indicators, Qatar, 2003

Crude birth rate (per 1000 inhabitants)	17.8*
Crude death rate (per 1000 inhabitants)	N/A
Population growth rate (%) (per 1000 inhabitants)	4.8**
Total fertility rate	3.0*
Life expectancy at birth (years):	
Male	74.4*
Female	74.7*
Total	74.6*
Population aged 15 years and above	N/A
Population density per km ²	51.4**
Urban population (%)	93**
Rural population (%)	7**

Sources:

* Annual health report 2003. Department of Epidemiology and Medical Statistics, Hamad Medical Corporation, Qatar.

** Population, health and human well-being. Qatar, Earth Trends 2003. (<http://www.earthtrends.wri.org.html>, accessed 1 June 2005).

oil sector which subsidize their employees' medical coverage in the private sector. The private sector is used by wealthier citizens.

The female participation rate in providing health care is increasing at all levels of care, a fact which was observed by the WHO team, not only at the level of service delivery but also at planning, management and policy-making levels.

2.5 Health profile

2.5.1 Overview

The Government provides free health care to all citizens. Major hospitals are located in urban areas. The Hamad General Hospital is the biggest tertiary level hospital having more than 661 beds including almost all the major and minor specialities and sub-specialities. The Hamad Medical Corporation houses a separate 334-bed women's hospital and the 362-bed specialist Rumailah Hospital catering to the needs of geriatrics, paediatric rehabilitation and

some other specialities. A new oncology hospital will shortly be commissioned to provide services to the whole country.

2.5.2 Health status indicators

Table 3 shows health status indicators.

Communicable diseases

Prevention and control. The Department for Control of Communicable Diseases has identified the following priority areas: sexually transmitted infections including HIV/AIDS, hepatitis and prevention and control of tuberculosis and surveillance of communicable diseases. These priority areas are interrelated (except tuberculosis) as far as the mode of transmission is concerned and are listed in order of priority according to the case-load. The reporting system is operational in all PHC centres.

The strategic plan for 2005–2009 for prevention and control aims to achieve a successful control programme in order to reduce the incidence rate. An understanding

of the national situation can be achieved through conducting a number of national surveys. Formulation of the national guidelines for management of main health problems at PHC centres will be developed and should be adopted. A renewed focus is being placed on the quality aspects of health care delivery at all levels.

HIV/AIDS operates as a programme with two distinct arms; the clinical management is catered for by the Hamad Medical Corporation whereas the logistics and counselling components are addressed by the Ministry of Health. The current active case-load stands at 65 cases which were detected as a result of active surveillance of high-risk groups. The country has registered four major brands of retroviral drugs in its formulary which are freely available to patients. Policies regarding safe blood transfusion and compulsory screening are in place and awareness and training programmes for PHC physicians and the general public are regularly carried out. Duplication of efforts and resources, however, between the Ministry of Health and the Hamad Medical Corporation, sometimes occur owing to the division of responsibilities and different components.

Tuberculosis. The national strategy to fight tuberculosis is based on the three main goals of: implementation of DOTS according to the WHO guidelines, revision and updating of the medical faculties curricula in line with the recommendations of the 2001 meeting of the managers of the national tuberculosis programmes, and improvement of tuberculosis laboratories through the establishment of a multiple-drug resistance laboratory and usage of PCR techniques in diagnosis.

Noncommunicable diseases

Noncommunicable diseases have become a major cause of death. The prevalence and incidence of noncommunicable diseases have increased dramatically over the past 20 years. Cardiovascular diseases, hypertension, diabetes and cancer account for significant levels of mortality and morbidity. Stepwise surveillance for noncommunicable diseases has not yet started. The main causes of death (reported by the national authorities) are cardiovascular diseases 20%, road traffic injuries 16.2%, endocrine disorders (e.g. diabetes) 11.9% and cancer 9.1%. Due to changing lifestyles the determinants of noncommunicable diseases and levels of risk factors have risen. More than 37% of the adult male population smoke regularly. Tobacco use among youths of school age (13–15) is of great concern. Obesity is also emerging as a major health problem due to recent dietary habits and sedentary lifestyles.

Road traffic injuries are a major burden of disease. The emergency department has a national strategy for road traffic injuries and better emergency services for the injured. Emergency medical services report effective response of the services to client needs and the maximum reported time in Doha for an ambulance to appear at the site of an accident to collect a road accident victim is 9 minutes. For the country as a whole it is reported to be 20 minutes.

The safety of food supplies is the responsibility of the Ministry of Health with over 1300 samples of food analysed annually. The food safety laboratory is the reference laboratory for the members of the GCC.

Table 2. Health expenditure, Qatar, 1994–2003

Indicators	2002–2003	2001–2002	2000–2001	1999–2000	1998–1999	1997–1998	1996–1997	1995–1996	1994–1995
GDP per capita (US\$)	29 021	29 716	30 701	22 101	18 875	17 463	17 760	16 465	15 570
Per capita spending of Ministry of Health including HMC (US \$)	583	518	404	418	387	371	451	362	440
Total national health expenditure as % of GDP (US \$)	2.1	1.9	1.4	2.0	2.2	2.3	2.7	2.3	3.0
% of government health expenditure out of total government expenditure	9.0	7.0	5.9	5.2	4.9	4.3	5.4	5.1	6.3

Source: Annual report 2003. Department of epidemiology and statistics. Hamad Medical Corporation, Doha, State of Qatar.

Table 3. Health status indicators, Qatar (2002)

Infant mortality rate (Qatari nationals)	11.9
Infant mortality rate (expatriates)	9.5
Total	10.7
Under 5-mortality rate per 1 000 live births	23.0
Under 5-mortality rate per 1 000 live births	16.0
Newborns with birth weight at least 2.5 kg	92%
Children with acceptable weight for age	N/A
Number of reported new cases/10 000 pop (2003) of:	
Malaria	1.3
Cholera	N/A
Poliomyelitis	00
Pulmonary tuberculosis	2.7
Measles	0.3
Diphtheria	00
Tetanus	00
Neonatal tetanus	00
STIs including HIV/AIDS	9.2
Hepatitis B	5.4
Hepatitis C	7.0
Meningococcal meningitis	0.57

Source: Annual report 2003. Department of epidemiology and statistics. Hamad Medical Corporation, Doha, State of Qatar.

Balanced nutrition is an important aspect of maintaining health throughout life. The database for the nutritional values of a typical Qatari diet is inadequate. Statistics show anaemia is a main cause of morbidity particularly in children and women of child-bearing age.

Services for hypertension and diabetes are provided in PHC settings but protocols

and algorithms need to be developed for general practitioners to effectively address the problem.

2.5.3 Health services indicators

Comprehensive health care, including preventive, curative and rehabilitative services are provided to all nationals free of charge by the public sector. The main

public hospitals operate at high occupancy rate, but no information is available regarding unit costing, employment of staff and efficiency in the utilization of the resources.

A growing private health sector is emerging. The Government has decided to encourage the expansion of private clinics and hospitals. In addition, serious attempts are being made to introduce family physician practice encompassing all the necessary rules and regulations. Health insurance is also being considered as an alternative option for health care financing, both for public and private sector health care delivery.

2.5.4 Primary health care coverage

Twenty-one health centres contribute to the high coverage of services (Table 4) and substantial improvement of health indicators (Table 3). The workload varies from one PHC centre to another. But the PHC centres visited showed a high number of daily visits in the two shifts during which the centres are open. A physician sees 40–50 patients in his/her shift, with an average time of 8 minutes per visit. Communication with the users appears to be satisfactory and friendly. The referral to secondary and tertiary care is made through certain agreed upon practices according to the seriousness of the case. To this effect protocols have to be developed, in collaboration with WHO if requested. But before developing clinical guidelines and protocols, there is a need to reassess the role and functions of PHC centres, as epidemiological factors have changed since when these centres were

first established. Job descriptions of the staff should focus more on promotion, communication, administration, quality, safe practice, efficiency and local target setting.

The notion of catchment area based on population is relevant in strengthening efficiency measures and assessing performance, as well as in developing a better rapport with the community. It will also contribute to building the home health care subsystem, which is needed for addressing lifestyle patterns, long-term care and care of the elderly. The responsibility for PHC centres was shifted 2 years ago to the autonomous Hamad Medical Corporation. The rationale behind this is to split the provision of care, and purchasing and policy-making.

The Government contracted out policy and planning, reorganization of services, training, and improvements in the quality of care to foreign consultant firms in 2004.

2.5.5 Health resources indicators

The role chosen by the Government for the Ministry of Health and the Hamad Medical Corporation is to strengthen the delivery of sustainable and high quality health services. This will be achieved through planning for, and the effective and efficient implementation of, essential health services at all levels of care with an emphasis on the community and outreach services. Previous investments in health services have resulted in a network of different health facilities. Table 5 shows the figures for health facilities and services.

Table 4. Primary health care indicators, Qatar (2002)

Population with access to local services (urban and rural)	100 %
Infants immunized against tuberculosis	100 %
Infants immunized with DPT	92%
Infants immunized against poliomyelitis	93%
Infants immunized against hepatitis B	93%
Infants immunized against measles	93%
Pregnant women immunized against tetanus toxoid	N/A
Deliveries attended by trained personnel	98%*
Infants attended by trained personnel	N/A
Population with access to safe drinking-water	N/A
Population with adequate excreta disposal facilities	N/A

* Source: Population, health and human well-being. Qatar, Earth Trends 2003. (<http://www.earthtrends.wri.org.html>, accessed 5 June 2005).

2.5.6 Water supply and sanitation

The water supply and sanitation sector witnessed major institutional improvements during the past 2 decades. Reviews to identify areas for improvement should continue to assess the quality of the water supply and ensure adequate sanitation.

A national unified approach is needed for the establishment of linkages between the environment, the water supply, sanitation and waste management activities, and disease control programmes for health issues, such as: diarrhoeal diseases and acute respiratory infections. Linkages also need to be established with other programmes, including vector control, food safety and child health.

2.5.7 Organization of the health care system

The Ministry of Health is the statutory health authority in the country. It is responsible for the oversight of health system development. The policy environment for health and health systems is in a state of cross-pressures in terms of growing needs and uncertainty and discontinuity in long-term policy-making and strategic management. In order to understand the black box of policy-making and how it might be improved, it is necessary to understand the context, and the political dimensions of health policy processes.

It is agreed that the key roles of government in the health sector include at least the following: setting and coordinating overall policies and strategies for health and health systems; ensuring that the

Table 5. Health facilities/services, Qatar, 2002

Total number of public hospitals	3
Total number of beds in public hospitals	1 362
Total number of beds in private clinics	110
Total number of beds all hospitals	1 472
Rate per 10 000 population of beds	20.3
Primary health care (PHC) facilities	21
PHC facilities per 10 000 population	0.3
Physicians per 1 000 population	22.4
Dentists per 10 000 population	3.9
Pharmacists per 1 000 population	10.1
Nurses and midwives per 10 000 population	55.8

legislative and regulatory framework is in place, is kept updated and is properly enforced; taking responsibility for the generation and improvement of necessary human (manpower) and material (fund flows for recurrent and capital expenditure, appropriate technology, equipment, and pharmaceuticals) resources in a balanced, efficient and equitable way, and for a health financing system that is fair and sustainable. In addition, it is essential for government to steer, lead, supervise and monitor the performance of the overall health system, i.e. the public health functions as well as personal service provision (public and private). All this entails information, communication requirements and intervention when appropriate.

The arena is changing quickly due to many factors beyond the health sector's control. The Ministry of Health as the leading health institution requires a robust human infrastructure and clarity in its relationship

with other institutions especially the Hamad Medical Corporation, the private sector and the Planning Council. This division of tasks should allow national level health planners and policy-makers to use the tools to:

- assess the national burden of disease and highlight healthy life expectancy in Qatar;
- establish levels of fairness of financial contribution and the types of expenditure on health;
- collect information relating to utilization patterns and coverage through household surveys.

Health services are currently structured as follows:

- Primary health care centres. Primary health care level through which basic curative and preventive health care is offered at 21 health centres.

- ❖ Specialized clinics in some health centres. Specialist care, such as diabetic care, is provided to those referred from primary health care centres.
- ❖ Specialized and teaching hospitals. Care is provided to those referred from specialized clinics to Hamad Medical Corporation.

The referral system among these levels is lax allowing direct access to tertiary care once a patient is registered and given a file. Such open access creates a burden on the tertiary level and could partially explain why the outpatient per capita visits to PHC centres are as low as 1.7. This requires a more efficient feedback mechanism between the PHC centres and the tertiary care level. It is thought that the overall utilization rate of primary health care services, as evidenced from the number of patients visiting PHC centres and other primary care outpatient services in the public and private sectors, should be greater.

The Government provides comprehensive health care including promotive, preventive, curative and rehabilitative services to all citizens free of charge through PHC centres and public hospitals. Expatriates are provided with free preventive and emergency care. There is a health card system to obtain services, including subsidized drugs at PHC centres. Expatriates either pay QR 100 for a yearly entitlement or pay QR 30 for each visit to the PHC centres.

The public health sector is the main health service provider in which all services are financed through public funds.

A private health sector is available and has a limited role so far but its role is growing. All charges for the private sector are out-of-pocket due to the absence of health insurance. The private sector is mainly used by the wealthier in society.

2.5.8 Health information system

Health care is increasingly becoming an information-driven service, and information is a major resource crucial to the health of individual citizens, the population in general, and to the success of any health care institution. Preliminary efforts and feasibility studies into digital infrastructure have been initiated in The Hamad Medical Corporation. The planned system is moving towards digital formats to capture, record, retrieve, analyse and communicate data efficiently and quickly.

The national health information system has consistently reported progress and achievement in attaining the PHC/Health for All goals and recently reported on status with regard to meeting the Millennium Development Goals (MDGs) on a regular basis. The Ministry of Health should further build its capacity in strategic elements of the health information system including disease surveillance, trend analysis and burden of disease studies, health care financing, health and biomedical research, privatization and public-private partnership, and health promotion and healthy lifestyle efforts.

2.6 Key issues and main challenges

Health systems currently operate within an environment of rapid social, economic and technological change. Health systems

are also under continuous scrutiny by planners, purchasers and users of the services. Most health managers and policy-makers now view as imperative measuring the impact, evaluation and control of the quality of services.

There are a number of issues and constraints facing health system development:

- ❖ lack of clarity between different stakeholders in carrying out health policy analysis, strategic health planning, priority-setting, formulation of national health targets and standards, coordination among the different health stakeholders, and monitoring and assessing performance of health system functions;
- ❖ lack of national human resources and institutions to develop structural and functional aspects of the national health system;
- ❖ division of responsibility for the health information system and weak information sharing in the coordination and development of health plans; in addition, health system research has yet to be developed as an integral part of national health system development;
- ❖ limited planning capacities for long-term strategic planning in the Ministry of Health due to the lack of a planning unit;
- ❖ need to assess equity and efficient use of resources allocated to tertiary health services, especially in anticipation of a forthcoming health insurance scheme;
- ❖ increase of noncommunicable diseases, such as cardiovascular

diseases, diabetes and cancer; shifting the provision of care to put greater emphasis on health promotion and lifestyle patterns;

- ❖ high mortality and disability rates due to road traffic injuries;
- ❖ organizational issues revolving around relatively weak coordination and linkages as a result of a lack of clarity of roles and responsibilities;
- ❖ need to redesign care processes and coordination of care across patient conditions, services, sites of care over time.

Qatar now faces the following challenges in the development of its national health information system.

Challenge one: Human resources

In regard to human resources planning, there are no clear plans to match needs with number and categories of health personnel. There is poor linkage between continuing medical education (CME) programmes and career development, and inadequate training in management.

Challenge two: Health information system

It is recognized that the absence of an effective national health information system and the high cost of inaccessibility to information result in poor and uninformed decisions, poor planning, weak evaluation and impact assessment; duplicated efforts, waste of time and resources. A weak national health information system will result in the above through less productivity and a general waste of resources.

Challenge three: Information and communication technology for health care

Sizable capital investments in communication technology have been witnessed in the Hamad Medical Corporation. The need is now for building communication systems at the PHC centres. These centres do not have the necessary infrastructure to deploy e-health solutions to emerging lifestyle and behavioural patterns. Widespread adoption of many e-health applications will also require behavioural adaptations for large numbers of clinicians, organizations and patients.

Challenge four: Management and accountability

The shifting burden of disease to noncommunicable diseases caters for longer and more costly care. This is coupled with the ever increasing expectation of the community, technological development, and present health investment in hospital infrastructure. Such shifts may leave little resources for health promotion which is a strategic priority at this stage. In addition to the various efficiency measures which

need to be introduced, there is a great need to make physicians and teams at all levels of care accountable, not only for their patients' health, but also for the wider resource implications of any treatments involved, including referrals from primary care into secondary and tertiary care. There is a need to adopt management protocols in order to curb the cost of services and to improve the quality and accessibility of care.

Challenge five: Coordination

National institutions in charge of health development (Ministry of Health, the Hamad Medical Corporation and the Planning Council) have their own strategic plans and policies but have failed to coordinate efforts to attain a well-coordinated national venture.

Challenge six: Double burden of disease

Some communicable diseases still pose a problem such as HIV/AIDS and hepatitis. Noncommunicable diseases show an increasing trend and cause the highest toll of morbidity and mortality. Contributing factors include ageing, injuries and lifestyle habits.

Section

3

Development Assistance and Partnerships: Aid Flow, Instruments and Coordination

Section 3. Development Assistance and Partnerships: Aid Flow, Instruments and Coordination

Currently, Qatar receives no external funds as development aid from outside sources. However, the technical relation of Qatar, especially with the USA is evidenced by its relationship with such major companies as RAND and PricewaterhouseCoopers and with Joint Commission International who work in health planning, health information systems, quality of care and infrastructure development.

There are no contributions from UN agencies other than WHO, in health development in Qatar.

UNICEF offers some mutual cooperation through their office in Riyadh with regard to immunization and primary education.

Private donations from national charity organizations are considerable and have assisted in the development of some of the major institutions, including the oncology hospital and emergency services in the public sector.

Section

4

Current WHO Cooperation



❖ Section 4. Current WHO Cooperation

4.1 WHO Desk Office for Qatar

The WHO Desk Office for Qatar is managed by a Desk Officer in the Regional Office. The CCS comes at an opportune moment for the national authorities and WHO. The changes being introduced in the country include division of labour between the Ministry of Health and relating to the provision of care, creation of a health insurance scheme, the privatization and the relaxation of foreign investment and trade aspects which might be reflected positively in health services but put extra demand on the work of the Ministry of Health. WHO must be proactive, with an ability to provide guidance and technical support for leadership, training, guidance and follow-up steps taken throughout the implementation of this strategy. This means that WHO must be able to respond to, support and follow up the expected changes and take an active role in supporting the Ministry of Health to address them.

Such an ambitious CCS will require funding beyond the regular budget allocation provided through the Joint Review and Planning Mission process. Funds-in-Trust should be considered, especially as the Government has commissioned some international consulting firms. WHO can provide cost-effective and sustainable support.

4.2 Current biennium programme

At national level the Joint Review and Planning Mission represents an overall framework for collaboration between WHO and the Government of Qatar, with emphasis being given to the capacity-building organization and strengthening of health issues at the primary health care level (Table 6).

Table 6. Qatar health development programme

WHO programme area	Expected results
6.1 Promotion of healthy lifestyles	By the end of 2005, there will be more uniform enforcement of tobacco control laws.
6.4 Substance abuse (including tobacco)	By the end of 2005, there will be more uniform enforcement of tobacco control laws.
6.5 Nutrition and food safety	By the end of 2005, a national nutrition survey, including food consumption patterns and intra-household food distribution, will have been conducted. By the end of 2005, the analytical capabilities of central food laboratories at the Ministry of Health will be strengthened.
6.6 Noncommunicable diseases	By the end of 2005, a national database on noncommunicable diseases and noncommunicable disease risk factors based on the WHO STEPwise surveillance system will have been established.
7.1 Reproductive health and family planning: a) Reproductive health b) Making pregnancy safer	By the end of 2005, plans for making pregnancy safer including monitoring and evaluation will be coordinated to improve maternal and perinatal health practices. By 2005, a comprehensive database on women's health status will be developed and an evidence-based strategy and plan of action will be formulated.
8.1 Environmental health policy	By the end of 2005, a national database of epidemiological profiles and indicators on occupational health, chemical safety and environmental health risks will have been created and updated.
9.4 Other vaccinations	By the end of 2005, immunization coverage rates in Qatar will be sustained.
10.1 Tuberculosis	By the end of 2004, the tuberculosis national strategy will be evaluated and upgraded.

Section

5

WHO Policy Framework: Global and Regional
Directions

5.1 Operating framework

Health systems in developing countries are becoming more complex. The role of the state in provision of health care is diminishing rapidly, with the private sector and civil society becoming active and important players. Also, globally, a number of development organizations and financial institutions have become heavily involved with health development activities in developing countries. It was, therefore, timely for WHO to respond to this changing environment by calling for new ways of working with its Member States.

WHO has adopted a broad approach to health within the context of human development with a particular focus on the links between health and poverty reduction. It is assuming a greater role in establishing wider national and international consensus on health policies, strategies and standards, through managing the generation and application of research, knowledge and expertise. At the country level, through the CCS process, it is envisaged that:

- WHO collaboration will be more strategic and focused on fewer priority areas, which will be an amalgam of global, regional and national priorities;
- increased emphasis will be given to WHO's role as a policy adviser and broker;
- opportunities will be sought for increasing and strengthening partnerships with other international and national agencies, including

nongovernmental organizations working in the field of health;

- innovative approaches will be sought to increase the effectiveness of WHO support;
- attempts will be made to ensure the utilization of the knowledge and skills present in the country for WHO's normative work.

5.2 Country level functions

To carry out WHO operations at the country level four WHO functions have been identified:

- catalysing the adoption and adaptation of technical strategies; seeding large-scale implementation;
- supporting research and development; monitoring health sector performance;
- information and knowledge sharing; providing generic policy options; standards; advocacy;
- providing specific policy advice; serving as broker; influencing policy, action and spending.

It should be noted that the sequence in which the above functions are listed is not an indication of their priority. In fact, the relative importance of these functions would vary from country to country depending on its state of development and strategic priorities identified for collaboration with WHO during the process of formulation of CCS.

5.3 WHO-wide strategic directions

WHO's current (2002–2005) General Programme of Work lists the following four inter-related strategic directions to provide a broad framework for focusing WHO's technical work.

- ❖ Strategic direction 1: reducing excess mortality, morbidity and disability, especially in the poor and marginalized populations.
- ❖ Strategic direction 2: promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioural causes.
- ❖ Strategic direction 3: developing health systems that equitably improve health outcomes, respond to people's legitimate demands and are financially fair.
- ❖ Strategic direction 4: framing an enabling policy and creating an institutional environment for the health sector and promoting an effective health dimension to social, economic, environmental and developmental policy.

5.4 WHO global priorities

Based on the analysis of major challenges in international health, WHO has established a set of global priorities. The selected global priorities as stated in the General Programme of Work for 2002–2005 are as follows:

1. Malaria, tuberculosis and HIV/AIDS: these three major communicable diseases pose a serious threat to health and economic development and have a

disproportionate impact on the lives of the poor.

2. Cancer, cardiovascular diseases and diabetes: there is a growing epidemic of these diseases in the poor and in transitional economies.
3. Tobacco: is a major killer in all societies and rapidly growing problem in developing countries.
4. Maternal health: the most marked difference in health outcomes between developed and developing countries show up in maternal mortality data and it is difficult to reduce maternal mortality without a well-functioning health system.
5. Food safety: poses a growing public health concern with potentially serious economic consequences.
6. Mental health: five of the ten leading causes of disability are mental health problems; major depression is the fifth contributor to the global burden of disease and may be second by 2020.
7. Safe blood: is both a potential source of infection and a major component of treatment, and crucial in the fight against hepatitis and HIV/AIDS.
8. Health systems: development of effective and sustainable health systems underpins all the other priorities; demand is substantial from Member States for support and advice on health sector reform.
9. Investing in change in WHO: is a prerequisite for WHO to become a more efficient and productive organization and one capable of response within an

increasingly complex environment. The development of new skills, systems and process is central to the effective management of WHO's core functions.

5.5 WHO regional priorities

The Eastern Mediterranean Region has the demographic profile of a developing region. It is a low–middle income region. Poverty and unemployment affect a large number of people. Communicable diseases are still prevalent in the least developed countries and tuberculosis, malaria and HIV/AIDS are major killers. A number of countries in the Region are in a state of conflict and emergency. Malnutrition is still a significant problem in some countries. Water scarcity is a region-wide challenge. Also, the lack of adequate safe water supply and proper sanitation are major health hindrances in the least developed countries, which constitute a large percentage of the population in the Region. Similarly, rapid urbanization and increase in car ownership have resulted in severe air pollution in major cities of the Region. Solid waste management, particularly of hazardous and medical wastes, is particularly weak in a significant number of countries of the Region.

An epidemiological shift is being witnessed in the Region. Currently, due to changes in lifestyles, noncommunicable diseases constitute 40% of the disease burden. It is projected that by 2020 the share of the burden for noncommunicable diseases will increase to 60%. This is creating a double burden of both communicable and noncommunicable diseases. Maternal mortality is still unacceptably high in some countries. The

average maternal mortality ratio for the Region in 2001 was as high as 330 per 100 000 live births, while over 60% of infant deaths occur in the neonatal period in most countries. Foodborne diseases are also on the rise and represent a major public health challenge. The rapid change in lifestyles in many countries is having a clear impact in terms of stress and mental health-related conditions.

The health system, including governance, quality assurance, service delivery, health regulation, and medical technologies and medicine, needs major strengthening in almost all countries. Health financing is a major emerging issue in the Region. In lower income countries most health expenses are borne by people. The middle-income countries have a mix of private and public sector. In these countries, in some instances, there is a surplus of trained human resources, such as physicians. In high-income countries the major share of health expenditure is borne by governments. The health information system in almost all countries needs to be strengthened. The nursing picture is rather gloomy, both in terms of adequate numbers in poor countries and career structure.

In light of the above situation, the Regional Office has identified certain priority areas for its collaboration with Member States. These were spelled out in the programme budget for the period 2004–2005 which was endorsed by the Regional Committee for the Eastern Mediterranean at its Forty-ninth session held in October 2002 (EM/RC/49/R.2). The priorities include the following:

Health protection and promotion

- ❖ Promotion and development of healthy lifestyles through programmes such as the Tobacco Free Initiative, healthy communities, villages and cities, action-oriented school health activities, health of special groups and health education.
- ❖ Strengthening of national and regional initiatives to improve nutritional status through raising awareness of individuals and the community and control of micronutrient deficiencies.
- ❖ Integration of health promotion aspects with clinical approaches at all levels of the health care system, such as in the example of the regional initiatives to integrate at the primary health care level maternal, child and adolescent health, prevention and control of noncommunicable diseases and mental health activities.
- ❖ Promotion and strengthening of environmental health initiatives, particularly those relating to water safety and security, environmental health impact assessment, food safety and healthy environments for children and development of intersectoral activities in this respect.

Community development

- ❖ Addressing the underlying determinants of health and poverty as essential to ensuring sustainable development and sustained health improvements in the long term. Community-based initiatives such as basic development needs (BDN), healthy cities, healthy villages and

women in health and development are among the priorities adopted by countries. In all these initiatives special emphasis is given to strengthening and enhancing the role of women as major stakeholders in achieving and sustaining the desired health and development goals.

- ❖ Efforts to facilitate achievement of the Millennium Development Goals, aiming to halve the number of people living in absolute poverty by the year 2015. This will include the development of various policies and plans such as Poverty Reduction Strategy Papers, to create supportive political, physical and economic conditions for all segments of the population to produce a positive impact on the overall quality of life. Concerted efforts are being made to make health systems better oriented to the needs of the poor by giving greater attention to promoting health throughout the life span, and reducing inequities in health status.

Disease control

- ❖ Improvement of epidemiological profiles using quantitative methods, such as burden of disease assessment and forecasting techniques. Efforts should be made to strengthen national and regional capabilities in epidemiology and national information systems through developing national and subnational registries for priority health problems. Efforts should also be made to benefit from epidemiological research studies in designing health policies and strategies. Priority diseases that are

the main contributors to the disease burden and at the same time are amenable to intervention strategies will be identified.

- ❖ An integrated approach in communicable disease control programmes through ensuring political commitment, integrating cross-cutting control activities, scaling-up disease-specific control activities, and developing synergy of managerial processes.
 - ▶ Essential packages of services for prevention and control of priority diseases and indicators to monitor and evaluate these programmes will be developed.
 - ▶ Integration of cross-cutting control activities will cover at least communicable disease surveillance, epidemic preparedness and response including developing early warning and surveillance systems, infection control and containment of antimicrobial resistance, integrated human resource development, health education and advocacy, and operational research.
 - ▶ Scaling-up of disease-specific activities includes immunization programmes, tuberculosis control, malaria control, HIV/AIDS/STD prevention and control, elimination and eradication of specific diseases.
- ❖ Immunization programmes maintained and strengthened, with particular focus on countries that have lower immunization coverage and problems in certification of poliomyelitis

eradication. The Regional Office will pursue its policy aimed at achieving self-sufficiency in vaccine production.

- ❖ Integrated management in control of noncommunicable diseases. Particularly attention will be paid to quality assurance programmes and to emerging needs, such as palliative care for cancer patients and health of the elderly.

Health systems and services development

- ❖ Promotion of a culture of strategic thinking in decision-making, using evidence-based policies and strategies, and development of important components of the stewardship function, such as regulation, public-private mix management, coordination, etc.
- ❖ Strengthening decentralization of health systems through capacity-building and technical expertise, and supporting district health systems through institutionalization of the district team problem-solving approach and development of sustainable management through national management effectiveness programmes.
- ❖ Improving quality in health service delivery through implementation of a programme of continuous quality improvement based on quality standards for individuals, departments and organizations against which performance will be measured.

- ❖ Support to accreditation initiatives, such as multidisciplinary assessments of health care functions, organizations and networks, as an important approach for improving the quality of health care structures.
- ❖ Enhancing national information systems in order to provide necessary data on spending on health, particularly on private services, making use of household expenditure and utilization surveys and national health accounts analysis.
- ❖ Testing of the WHO framework and tools for health system performance assessment and development of an observatory in the Regional Office to assess, manage and monitor health sector reforms.
- ❖ Development and decentralization of laboratory activities, health imaging technology, blood safety and blood transfusion.
- ❖ Strengthening of the essential drugs programme and ensuring use of essential drugs lists by most countries while promoting rational drug use and traditional medicine.
- ❖ Improvement of coordination for human resources development and promotion of continuing education for health personnel at the various levels of the system. Efforts will focus on developing innovative approaches for human resources development, including community-oriented health personnel education.

Section

6

Strategic Agenda: Priorities Jointly Agreed
for WHO Cooperation in and with Qatar

Section 6. Strategic Agenda: Priorities Jointly Agreed for WHO Cooperation in and with Qatar

6.1 National health priorities

Consultations between the WHO team and different health managers and stakeholders concluded that technical support should cover the following areas:

- ❖ supporting appropriate policies and interventions aimed at assessing and improving quality and overall performance of the national health system (public and private);
- ❖ building national capacity on policy formulation and health strategic planning;
- ❖ strengthening of the institutional capabilities of the public health sector through the empowerment of the four functions of the health system: governance, resource generation, health care financing and health service provision;
- ❖ optimal management of human resources for health and professional career development and introducing home health care;
- ❖ clearer definition of the relationship between the three levels of the health system;
- ❖ strengthening disease surveillance and control;
- ❖ reducing deaths and disability related to noncommunicable diseases and road traffic injuries;
- ❖ strengthening national health information system, establishment of

disease specific national registries; and support widespread e-health applications;

- ❖ support for healthy lifestyle and safe community programmes;
- ❖ support for food safety and nutritional values programmes through research and the establishment of a database;

The following strategic directions take into account the findings of the CCS mission and try to propose the way forward to achieve a viable, credible and accountable national health system with the partnership of the WHO.

6.2 Strategic directions

6.2.1 Governance and institutional development

As discussed in this report, the role of the Government is to exercise effective oversight which becomes increasingly important as it considers shifting from direct service provision to a role dominated by policy formulation and priority-setting. It also covers assessment of needs for health service population-based interventions; financing; regulation of providers and insurers; guidance of the system and how it works through research, as well as provision of information; quality enhancement activities; coordination of all stakeholders/sectors involved in health delivery; and careful use of financial subsidies.

To attain that with effective implementation there is a need for institutional development through ensuring

clarity of roles, functions and responsibilities of the Ministry of Health and key actors in the arena of health in Qatar. WHO will provide technical support in convening a consensus meeting of Ministry of Health and other partners to review themes and specific health system issues (e.g. privatization, health insurance, national health accounts, and decentralization).

A national health “forum” for better governance and reorganization of the health sector is required to ensure effective coordination among the different national institutions including the Qatar Foundation, the Hamad Medical Corporation, the Planning Council and the Ministry of Health.

To ensure top level political support, a steering group chaired by the Minister of Health should be constituted to review roles, functions and structures, lines of accountability and coordination/collaboration among the main players/partners/actors in health.

There is a need to develop a sector-wide normative national framework on health service activities and standards, while also determining responsibility and resources for assessment of performance, inspection and enforcement, monitoring practice procedures to ensure compliance and sanctions to enforce compliance.

6.2.2 Attainment of better health and quality of life

The PHC centres have played an important role in providing essential care and achieving high coverage based on the PHC approach. Now that the burden of disease is shifting to noncommunicable diseases

and injuries, responsibility for health should be shared between individuals, communities, health professionals, health services and Government. Health services need to move increasingly in a health promotion direction, beyond the responsibility of providing clinical and curative services alone. This requires a new way of delivering care, changing the organization of health services to refocus on the total needs of the individual and the family. More outreach activities and home health care are needed, for example, to cater for the health of the elderly.

Adoption of a disease management approach which would allow segmentation of patients into acute, chronic and co-morbid at this stage. This management approach should shift sooner or later to preventative care (such as screening) and more community surveys to assess care seeking behavioural patterns. This new environment requires policy changes and new health planning processes. In addition the training and terms of reference of the health facilities and health workers should be revisited to enable them to cope with new utilization patterns and community needs.

6.2.3 Human resources development

At present there is no information on the workload (type, time and spatial distribution) national human resources development plans will need to address:

- ❖ Needs assessment studies for future human resources requirements and the current workload from both geographic and speciality perspectives.

- ❖ Long-term strategic planning for human resources development as part of the national policy and strategic planning functions taking into account that the bulk of the workforce is expatriate;
- ❖ Plan and organize licensure, re-licensure schemes, professional regulatory and accreditation bodies of health;
- ❖ Building team work and emphasizing continuous on-the-job training and evidence-based practice.

6.2.4 Redesigning the health care system

The organization of health care is divided among the Ministry of Health and the Hamad Medical Corporation with the understanding that the Ministry of Health’s role is mainly normative, regulatory, and in policy-setting and coordination. As yet these functions are not fully operational. Time is needed to develop the capacity of the Ministry of Health to undertake such a huge task. In the short and intermediate term the following eight domains are essential in improving the performance of the national health care system:

1. Applying evidence to health care delivery. Efforts should include analysis and synthesis of the practice of evidence-based medicine, delineation of specific management and practice guidelines, identification of best practices in the design of care processes.
2. Review of relations and interaction between levels of care. The starting point is ensuring the catchment population and gate keeping practice. At the same time ensure availability of high quality

services at the local level, reviewing the organization and delivery of secondary care and the role acute hospitals play and introducing referral protocols for transfers between primary, secondary and tertiary care. Feedback to PHC centres is required and cases registered at the Hamad Medical Corporation should be advised to follow up care at the PHCC level. This will ensure credibility of PHC centres and a better use of resources.

3. Public–private mix. This is an emerging issue which has to be addressed for the establishment of a close relationship between the two sectors to build mutual respect and a common aim of providing high quality care that meets the national health priorities.

4. New managerial culture. User satisfaction should be at the heart of health care delivery. A new attitudinal and organizational culture should prevail based on information and knowledge sharing clear lines of accountability and communication and harmony in the relationship between the different levels of care and leadership development. The anticipated role of the Hamad Medical Corporation as the main public provider and referral setting in a new era encouraging privatization as well as launching insurance schemes has to be reviewed to ensure continuity of care and equitable access.

5. Family Practice Programme. This programme needs establishing to promote the role of family health care as being a pillar of health service provision. The need for quality personal and public health care is emphasized. The PHC centres

are now in a position to play important roles in comprehensive family practice. To achieve such a programme, the staff should have administrative and financial skills in addition to good communication and clinical skills.

6. Effective and efficient emergency care. A utilization pattern review of emergency services is important from a cost point of view, as well as the delivery of care to those who really need it. The triage system should be strengthened.

7. Continuous quality and performance improvement. Efforts are under way to launch a national quality improvement programme at the Hamad Medical Corporation. Also the Hamad Medical Corporation is in the preparatory stages for accreditation in collaboration with Joint Commission International. The PHC centres are to follow with preliminary activities, such as surveying missions and assessing capacities of the PHCCs. A quality culture is essential at the PHC level. The potential is high to form quality teams, standards of care and standard operating procedures, guidelines and auditing systems.

8. Drugs and health technologies account for a substantial proportion of health care costs. A national database covering all major medical equipment and their location should be developed along with a maintenance and support plan as the first steps towards making policy options for technology importation, standardization, maintenance and utilization.

6.2.5 Health care financing

Health care financing is a priority system issue especially with the moves of the Government towards health insurance schemes starting with the expatriate population. Equity also is a major concern. Health care financing is also being considered by decision-makers and planners to rationalize use and management of financial resources. There are several scenarios in process which need WHO technical support and partnership. The Ministry of Health leadership role in health care financing thus may be enhanced.

- ❖ As a first step, rigorous examination of financing alternatives should be considered and their implications on equitable access and utilization of services, especially in the promotive and preventive services.
- ❖ The role and relations of the Ministry of Health with different stakeholders in implementing the different options of the financing schemes should be clarified.
- ❖ A multistage long-term plan will be needed to gradually implement the agreed scenario for health care financing and social protection, which at the same time aligns payment policies with quality improvement.
- ❖ Studies on national health accounts and cost packages of services at the different levels of health care should be launched.
- ❖ Improvement of financial management will be needed through capacity-building in hospital management to increase efficiency and improve

performance, in addition to increasing the awareness of staff and the wider population of the costs of providing health care and the opportunity cost of inappropriate use of health service resources;

6.2.6 Development of a national health information and communication system

The current status of data collection, analysis and use of information at health care facilities requires restructuring and mainstreaming. A national strategy for data coding, collection, documentation, validation and dissemination should be developed especially for activities at the PHC centre level.

- ❖ Systems and procedures are needed for the development and maintenance of health records, clinical information and medical documentation according to international standards and which will support both clinical practice and administration and finance in addition to research, such as burden of disease studies.
- ❖ A central information body should be created to coordinate, collect and report on national health data sets.
- ❖ e-health is an enabling factor for health services at local and national levels. This should be translated into infrastructure development at the PHC centre level. A starting point is needs assessment of e-health development to ensure evidence-based practice. In addition, there is a need to introduce laws, regulations, legislation and codes of conduct to support e-health

activities. These may include personal data collection, access rights, privacy, confidentiality and others. Pilot projects for telemedicine can be introduced in selected PHC centres.

- ❖ The electronic health record (EHR) is one important measure for effective service in Qatar. This can be a continuation of the computerization system of medical records in the Hamad Medical Corporation.

6.2.7 Reducing the burden of disease

Noncommunicable diseases and injuries dominate patterns of morbidity and mortality. The main causes of death as reported by nationals are cardiovascular diseases, road traffic injuries, diabetes and cancer. However, sexually transmitted infections, hepatitis B and C and tuberculosis have been reported to be of public health importance in recent years. Their incidence has increased due to prevailing risk conditions. The department for Infectious Diseases Control has identified sexually transmitted infections, HIV/AIDS and tuberculosis as important areas for its work during the coming years, in addition to surveillance of other communicable diseases. Concerted efforts are to be made to ensure coordination of efforts in surveillance and screening of HIV/AIDS and reporting. There is a need to orientate relevant health workers, such as gynaecology and obstetrics specialists, dermatologists and private practitioners especially in referring suspected cases. Special attention should be given to reporting sexually transmitted infections

cases by all practitioners. The infection control department will develop standard operating procedures and guidelines on screening, reporting and referring suspected cases of sexually transmitted infections, including HIV/AIDS.

There is a need to have a national technical committee for HIV/AIDS to orchestrate the different actors in the control activities of HIV/AIDS. This committee will be viable and effective due to the presence of competent experts in Qatar. At a later stage a national intersectoral committee will need to be established. Apparently the steering committee will only be realized and operational if the technical committee starts as soon as possible.

Mapping of diseases and health facilities should be used as a tool for better planning, decision-making and proper utilization of resources. Such mapping will eventually lead to integrated national strategies for control of common diseases (communicable and noncommunicable diseases) at the health centre level.

Several national registration programmes to know the magnitude of morbidity, disability and mortality from noncommunicable diseases and

communicable diseases are already in place. This will allow better planning in the reduction of the burden of disease and provision of effective continuous care at all levels and mapping of major causes of morbidity, disability and mortality in each catchment area. Accordingly, a national workplan will be developed to provide required resources and technical support, monitor progress and ensure timely and quality performance of all health centres.

Conduct of burden of disease surveys is an essential step to guide health policies and cost-effective decision-making in controlling the three major categories of the burden of disease i.e. noncommunicable diseases (including maternal and mental disorders), communicable diseases and injuries. A committee has been formed chaired by Assistant Secretary of Health to steer a burden of disease survey, which is also being conducted in other GCC countries.

Political commitment and support for strengthening surveillance and epidemic preparedness and outbreak management in Qatar will be augmented.

Section

7

Implementing the Strategic Agenda: Implications for WHO Secretariat, Follow-up and Next Steps at Each Level

Recognizing the fact that limited financial input is available to CCS based plans through the Joint Programme Review and Planning Mission process, the allocation of funds from national resources is a prerequisite for successful implementation of the strategy. A possible mechanism for joint implementation is that of Funds-in-Trust, where WHO is the executing agency, allowing national financial resources to be managed through WHO as a support to countries. The following are requisite.

7.1 Periodic backstopping by the Regional Office and headquarters staff

Capitalizing on and making use of the expertise that exists in the Organization constitutes a cost-effective method for rapid response to needs by the country. Backstopping may be planned at regular intervals or upon request for assistance. The knowledge of WHO staff may be utilized for planning, evaluation, advisory services, training and capacity- building in the country. The country may make use of WHO as a knowledge broker in health care system development and disease control.

7.2 WHO leadership for CCS implementation with international technical cooperation

There is a central role for WHO as a catalyst and broker for streamlining activities in the country for the implementation of CCS. WHO, as a leader in international health and as a prime

partner in health system development in Qatar, can be strengthened through the development of a roster of interested parties nationally, regionally and internationally. Assumption of a leadership role is a natural development which it has to rise to. In the case of Qatar, WHO should be in a position to identify partners, coordinate efforts and participate in the provision of technical support for implementation of the strategic directions of the CCS. WHO's position of leadership puts it in the unique position of knowing who is doing what and in which area in the country and of being able to work with the Government in the distribution of roles and maximization of resource utilization.

7.3 Mutual understanding by WHO and the Government to work with other main partners in health

The role of the central Government in facilitating the implementation of the CCS plans can be strengthened through collaboration with WHO to work directly with other partners. This type of work may include coordination of strategic planning for health care delivery, the effects of General Agreement on Trade in Services (GATS) and Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) on organization and performance of the national health services, training of health workers, disease survey and epidemiology, household surveys, etc.

7.4 Strengthening the Qatar Desk Office

Availability of core technical capacity at the Qatar Desk Office is a prerequisite for efficient and timely implementation of the CCS, in addition to the need for periodic missions by WHO staff on specific technical areas.



Annexes:

Annex 1

Participants in the CCS mission to Qatar

WHO team

Dr Ahmad Abdellatif, Qatar Desk Officer,
Coordinator of Health System and
Regional Adviser/Health Care Delivery

Dr Sayed Jaffar Hussain, Medical Officer/
Healthy Lifestyle Promotion

National team

Dr Khalifa Al Jabir, Assistant Under-
Secretary for Technical Affairs

Annex 2

List of people met

Ahmed Al Ibrahim, Director of Preventive Medicine Department

Dr Ahmed Al Mulla, Head of Noncommunicable Diseases

Dr Essam M. El Sawaf, Head of Occupational and Environmental Health Secretariat

Dr Syed F. Shah, Head of Communicable Disease Control And Prevention

Dr Zubaida Al-Suwaidi, Clinical Scientist Head of tuberculosis laboratory

Dr Yousuf Almaslamani, Acting Chairman Emergency Department, Hamad Hospital

Dr Salih Almarri, Director of Primary Health Care

Dr Khamis Alsulite, Planning Officer

