EMRO

HEALTH SYSTEM PROFILE

KUWAIT

Regional Health Systems Observatory
World Health Organization

2006

Contents

List of Tables

FOREWORD

Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning. As the countries examine their health systems in greater depth to adjust to new demands, the number and complexities of problems identified increases. Some health systems fail to provide the essential services and some are creaking under the strain of inefficient provision of services. A number of issues including governance in health, financing of health care, human resource imbalances, access and quality of health services, along with the impacts of reforms in other areas of the economies significantly affect the ability of health systems to deliver.

Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation, can strengthen the scientific foundations of health policy at international and national levels. Comparison of performance across countries and over time can provide important insights into policies that improve performance and those that do not.

The WHO regional office for Eastern Mediterranean has taken an initiative to develop a Regional Health Systems Observatory, whose main purpose is to contribute to the improvement of health system performance and outcomes in the countries of the EM region, in terms of better health, fair financing and responsiveness of health systems. This will be achieved through the following closely inter-related functions: (i) *Descriptive function* that provides for an easily accessible database, that is constantly updated; (ii) *Analytical function* that draws lessons from success and failures and that can assist policy makers in the formulation of strategies; (iii) *Prescriptive function* that brings forward recommendations to policy makers; (iv) *Monitoring function* that focuses on aspects that can be improved; and (v) *Capacity building function* that aims to develop partnerships and share knowledge across the region.

One of the principal instruments for achieving the above objective is the development of health system profile of each of the member states. The EMRO Health Systems Profiles are country-based reports that provide a description and analysis of the health system and of reform initiatives in the respective countries. The profiles seek to provide comparative information to support policy-makers and analysts in the development of health systems in EMR. The profiles can be used to learn about various approaches to the organization, financing and delivery of health services; describe the process, content, and implementation of health care reform programs; highlight challenges and areas that require more in-depth analysis; and provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries. These profiles have been produced by country public health experts in collaboration with the Division of Health Systems & Services Development, WHO, EMRO based on standardized templates, comprehensive guidelines and a glossary of terms developed to help compile the profiles.

A real challenge in the development of these health system profiles has been the wide variation in the availability of data on all aspects of health systems. The profiles are based on the most authentic sources of information available, which have been cited for ease of reference. For maintaining consistency and comparability in the sources of

information, efforts have been made to use as a first source, the information published and available from a national source such as Ministries of Health, Finance, Labor, Welfare; National Statistics Organizations or reports of national surveys. In case information is not available from these sources then unpublished information from official sources or information published in unofficial sources are used. As a last resort, country-specific information published by international agencies and research papers published in international and local journals are used. Since health systems are dynamic and ever changing, any additional information is welcome, which after proper verification, can be put up on the website of the Regional Observatory as this is an ongoing initiative and these profiles will be updated on regular intervals. The profiles along with summaries, template, guidelines and glossary of terms are available on the EMRO HSO website at www.who.int.healthobservatory

It is hoped the member states, international agencies, academia and other stakeholders would use the information available in these profiles and actively participate to make this initiative a success. I would like to acknowledge the efforts undertaken by the Division of Health Systems and Services Development in this regard that shall has the potential to improve the performance of health systems in the Eastern Mediterranean Region.

Regional Director

Eastern Mediterranean Region

World Health Organization

1 EXECUTIVE SUMMARY

Kuwait occupies the northwestern corner of the Gulf. It is bound in the east by the Gulf and in the southwest by Saudi Arabia and in the north and the east Republic of Iraq, with a total land area of 17818 square kilometers. The climate is intensely hot summer with short cool winter.

The 2003 estimates showed total population to be 2,484,334 of national and non-national (nationals constitutes about 37% of the total population estimate). The population growth is estimated to be 3.36% in 2004. The population is distributed in 6 governorates with highest density in Hawelli (686,421 persons which represent 27.6% of the total population). Kuwait is nearly completely urbanized with 97% of its population living in urban area, with universal access to safe water and sanitation.

Kuwait is a small, rich, relatively open economy with proven crude oil reserves of about 98 billion barrels: 10% of world reserves. Petroleum accounts for nearly half of GDP, 95% of export revenues, and 80% of government income. Kuwait's climate limits agricultural development. Consequently, with the exception of fish, it depends almost wholly on food imports. In 2003 the GDP per capita estimated to be $18,100.

Kuwait is a country with small number of population, which gives good opportunity for employment. The labor force accounted to 1.3 million in which 80% of them are non-Kuwaitis. Unemployment was estimated to be 7% in 2002; these are mainly for short period of time.

Great emphasis has been placed on education as a means for economic development. Based on WHO/EMRO Country Statistical Profiles for 2003 the adult literacy rate was 91%. The female literacy rate was reported 89% that year. Primary education is universal in which, it accounted for 100% as well as the secondary level for both male and female. With the high literacy rates in Kuwait, women have full participation in all aspects of socio-economic activities including public and private sectors. However, women have yet to be given the right to vote.

According to Ministry of Health, life expectancy for the Kuwaiti population (no available data for non-Kuwaiti) at birth is 78.7, for males77.8 and for females79.9 in 2003. The infant mortality rate is 9.4 in 2003, and under-five mortality rate 11.8 per 1000 for males and 10.9 per 1000 for females.

Maternal mortality per 100 000 live births was 9.1 in 2003. Crud birth rate 17.7 per 1000, while crud death rate 1.8 per1000, and the total fertility rate in 2003 accounted to 2.2.Total population access to health services were 100% in 2003. There was no urban–rural gap since over 95% of the population is urban.

Food is available in abundance and is affordable to all sections of the population. However, there is evidence of under-nourishment, and some studies have reported a significant evidence of anaemia, especially among young girls. Overweight and obesity are significant health risk factors in Kuwait with a high prevalence especially among the Kuwaiti element of the population.

Substantial epidemiological transition happened in regards of infectious and communicable diseases. This is could be attributed to socioeconomic development, and rapidly changing lifestyles. There were no reported cases of cholera, diphtheria, polio and tetanus in 2000. The number of malaria reported cases was 233 in 2001. There

were a total of 111 of reported cases of tuberculosis in 2001. The cumulative reported (to WHO) number of AIDS cases by the end of 2004 is 87 and that of HIV cases is 1019.

With the decrease in the incidence of communicable diseases and the increase in life expectancy, the burden of disease has shifted towards non-communicable diseases and injuries. Trends are showing steady increases in the incidence of coronary heart disease, cancer and accidents and injuries (mainly road traffic accidents). In addition to this many risk of ill health are showing alarmingly high prevalence; for example, diabetes, obesity, dislipidemia and physical inactivity. Various national groups and communities have been set up to tackle these problems. We anticipate that specific targets with plan of actions to achieve target will produced. Mental disorders also represent a major public health problem and in particular among non-Kuwaiti. The extent of somatization is not known, but it is expected to be high in such a mixed population.

In 2003 the percentage of infants immunized against DPT was 98%, polio 98% and measles was 99% with 100% vaccination coverage against HBV. These high coverage rates could be attributed to the efforts of the MOH in reaching mothers, better provision of knowledge and improved awareness of the public on diseases.

Both public and private sectors provide health and medical care, with primary health care being provided by the public sector. All Kuwaitis have access to primary health care services. There are 74 PHC throughout the state across 6 health regions that provide polyclinic services. According to the Ministry of Health data, antenatal care is provided to 100% of pregnant females, trained health personnel attend all births and around 98% of the children were fully vaccinated. In 2003, the manpower rates per 10 000 population were 19 for medical doctors, 3 for dentists, 2.6 for pharmacists, 40 for nurses and mid wives, 21 for hospital beds and 3 for PHC units.

Kuwait is still relying and will continue to rely for many years to come on non-Kuwaiti health professionals to support the expanding health system. The variation in quality is huge and a system of recruitment to minimize variation is urgently needed. It will take sometime before such a variation could be overcome.

Secondary care is provided through six regional hospitals with 2500 bed capacity. In addition to this these are 9 specialist hospitals including maternity, infectious diseases, mental health and cancer hospitals bringing the total beds available to 4575, with total bed occupancy around 60 percent. These hospitals consume the largest proportion of the public health budget, despite moderate bed occupancy and high pressure on primary care services.

Despite the substantial improvement in health, the focus is still on programs of expanding hospital services in both public and private sector. This is a costly in the long term. The priority should be focused on reducing ill health and the burden of diseases through programs that secure the health of the whole population. This can not be achieved without shifting resources from curative to public health activities including prevention of chronic diseases and reducing the risks of ill health.

Kuwait does not depend on external assistance for the financing of its health sector. Kuwait is a net donor of funds for supporting the health sector of other Islamic countries in the Region.

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2000	2002
Human Development Index:	-	0.813	0.837	0.844
Literacy Total:	81.51	86.51	89.81	90.90
Female Literacy to total literacy:	72.08	79.40	84.30	85.90
Women % of Workforce	17.7	21.3	24.6	25.64
Primary School enrollment	70.89	71.32	-	-
% Female Primary school pupils	48.37	48.93	-	-
%Urban Population	94.92	95.53	96.01	96.17

Source: [a]Eastern Mediterranean Regional Office Database: reports from member states

Almost all of the population of Kuwait are Muslims, half being Sunni Muslims and a third Shi'ite Muslim. There are small Christian, Hindu and Parsi communities, as well as other Muslim groups. Roman Catholic, Church of England, Armenian, Greek, Coptic and Syrian Orthodox churches cater for the expatriate communities.

On the eve of the Iraqi invasion, the United Nations Development Program placed Kuwait at the top of its annual human development index with a life expectancy of 73.4 years, an adult literacy rate of 73 percent, and a real per capita gross domestic product of US$15,984.

Kuwait has put large funds into its educational system, and it is also of high standard. The general level of education among the population is high, and this applies to both sexes. Education is free and compulsory for all. Kuwait has one university, with 15,500 students, the Kuwait University. Around 2,000 Kuwaitis study abroad. Kuwait's level of illiteracy is seriously addressed by the government, and there are centers for schooling of adults, attended by about 2% of the total population.

Great emphasis has been placed on education as a means for economic development. Based on WHO/EMRO Country Statistical Profiles for 2003 the adult literacy rate was 91%. The female literacy rate was reported 89% that year. Primary education is universal in which, it accounted for 100% as well as the secondary level for both male and female. With the high literacy rates in Kuwait, women have full participation in all aspects of socio-economic activities including public and private sectors. However, women have yet to be given the right to vote.

2.2 Economy

Key economic trends, policies and reforms

Kuwait is a small, rich, relatively open economy with proven crude oil reserves of about 98 billion barrels: 10% of world reserves. Petroleum accounts for nearly half of GDP, 95% of export revenues, and 80% of government income. Kuwait's climate limits

agricultural development. Consequently, with the exception of fish, it depends almost wholly on food imports. In 2003 the GDP per capita estimated to be $18,100.

With its vast reserves of oil and massive overseas investments, Kuwait's economy has strong fundamentals that are the envy of many. Even in times of sluggish growth, the continual trade and government revenue surpluses mean that there is enough liquidity to ensure economic activity, although the fact that Government plays such a large role in the country's economic activity is also one of its structural deficiencies. Oil accounts for 95% of Government revenues, 91% of export earnings and 50% of GDP.

However, with the oil markets at their current levels, and the removal of the former Iraqi regime, confidence, private investment and activity have returned to the Kuwaiti economy with real vigour. During 2003, the Kuwaiti economy recorded one of its best years, which is continuing throughout 2004. GDP grew by 4.6%, the budget surplus equalled 18% of GDP, the stock market rose by over 80%, private companies are awash with profits and there is also a construction boom.[1]

Kuwait is a country with small number of population, which gives good opportunity for employment. The labor force accounted to 1.3 million in which 80% of them are non-Kuwaitis. Unemployment was estimated to be 7% in 2002; these are mainly for short period of time.

There are few other sources of income for Kuwait than petroleum production, and income from the country's investments abroad. The foreign investments come from a fund that is based upon 10% of oil revenues. Industries of Kuwait are connected to petroleum, and Kuwait is refining its oil. Agriculture and food production is limited, and make up less than 2% of GNP. Fishing is becoming more and more important, and is at the level of 9,000 tons annually. The infrastructure in the eastern part of Kuwait is well developed, and comprise 4,700 km of roads, and an international airport near Kuwait City.

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2002
GNI per Capita (Atlas method)current US$	-	18,200	16,280	16,340
GNI per capita(PPP) Current International	-	20,110	$18,720	17,870
GDP per Capita	-	14,738	12,586	11,598
GDP annual growth %	-	-2.18	-0.08	-3.28
Unemployment %	-	-	0.8	7
External Debt as % of GDP*	-	43.8 (98)	23.9	37.1
Trade deficit:	-	-	-	-

Source: *Economist intelligence unit limited 2004, Country profile 2004

Table 2-3 Major Imports and Exports

Major Exports:	Oil and refined products, fertilizers
Major Imports	Food, construction materials, vehicles and parts, clothing

Source: CIA factbook: http://www.cia.gov/cia/publications/factbook/geos/ku.html

2.3 Geography and Climate

Kuwait is located at the far northwestern corner of the Persian Gulf, known locally as the Arabian Gulf. The land area is about 17,818 square kilometers. Shaped roughly like a triangle, Kuwait borders the gulf to the east, with 195 kilometers of coast. Kuwait includes within its territory nine gulf islands, two of which, Bubiyan (the largest) and Warbah, are largely uninhabited but strategically important. The island of Faylakah, at the mouth of Kuwait Bay, is densely inhabited. To the south and west, Kuwait shares a long border of 250 kilometers with Saudi Arabia. The third side of the triangle is the 240 kilometers of historically contested border to the north and west that Kuwait shares with Iraq.

Kuwait has a desert climate, hot and dry. Rainfall varies from seventy-five to 150 millimeters a year across the country; actual rainfall has ranged from twenty-five millimeters a year to as much as 325 millimeters. In summer, average daily high temperatures range from 42° C to 46° C; the highest recorded temperature is 51.5° C. By November summer is over, and colder winter weather sets in, dropping temperatures to as low as 3° C at night; daytime temperature is in the upper 20s C range.

The land was formed in a recent geologic era. In the south, limestone rises in a long, north-oriented dome that lies beneath the surface. It is within and below this formation that the principal oil fields, Kuwait's most important natural resource, are located. In the west and north, layers of sand, gravel, silt, and clay overlie the limestone to a depth of more than 210 meters.

The bulk of the Kuwaiti population lives in the coastal capital of the city of Kuwait. Smaller populations inhabit the nearby city of Al Jahrah, smaller desert and coastal towns, and, prior to the Persian Gulf War, some of the several nearby gulf islands, notably Faylakah. [2]

Map of Kuwait

2.4 Political/ Administrative Structure

Basic political /administrative structure and any recent reforms

Kuwait is a hereditary emirate and the ruling emir comes from the descendants of Mubarak al-Sabah. The current emir is Sheikh Jabr al-Ahmed al-Jabr al-Sabah, who succeeded his uncle in December 1977. The emir appointed Sheikh Saad Abdullah al-Salem al-Sabah as his crown prince and prime minister; however, the position was, for the first time in Kuwaiti history, separated in July 2003, when the emir's half-brother and long-serving foreign minister, Sheikh Sabah al-Ahmed al-Jabr al-Sabah, became prime minister. Members of the ruling family hold key cabinet posts, including the defense, interior and information portfolios. Laws passed by emiri decree must subsequently be ratified by the National Assembly (parliament). Parliament can also initiate legislation. The make-up of the cabinet is at the emir's discretion, although members are appointed by the prime minister. At least one elected member of parliament must be included in the government. The 15-member cabinet formed in July 2003 included six members of the ruling family.

The first National Assembly was elected in 1963; it is supposed to sit for four year terms. However, the emir has dissolved the Assembly on three occasions (1976-82, 1986-92 and 1999). In the 1999 case, this was done entirely constitutionally and elections were held shortly afterwards. A campaign to allow women to vote and stand for office has so far failed to win sufficient parliamentary support. Cabinet members automatically become members of the Assembly, unless they have already been elected, making a total of 64 entitled to vote in the present parliament. In recent years the Assembly has been pressing the government for greater transparency in financial matters. Members have demanded a greater role in oil policy and more oversight of defense contracts. Relations have been strained by MPs' insistence on their right to question ministers, most recently in July 2002.

The constitution provides for judicial independence by stating that "judges shall not be subject to any authority". It also states that sharia (Islamic law) is "a main source of legislation". In practice, all judges are appointed by the emir and those who have Kuwaiti citizenship become judges for life. Some noncitizens are also appointed as judges on the pardon or commute all sentences.[3]

Key political events/reforms

The Kuwaiti Constitution was promulgated on November 16, 1962, but several articles have been suspended by the Emir over the years. The Constitution declares that Kuwait is a sovereign Arab state, ruled by an Emir heir to Mubarak as Sabah (died 1915). The Emir has executive power, exercising this through the Council of Ministers. The Emir appoints the Prime Minister, and appoints and dismisses ministers on the recommendation of the Prime Minister. The Prime Minister is usually the Crown Prince. The most important positions in the government, like foreign affairs, defence, interior, finance and oil are filled with members from the ruling Sabah clan.

The Emir also formulates laws, but all laws will have to be national assembly, Majlis. The legal system was codified in 1960, and there are strong traces of influence from Sharia. Even if it is liberal in some fields, as for women's position in the social context, it is marked by much conservatism in other fields, like control of moral behaviour. The Emir is also in charge of establishing public institutions.

The judicial system is divided into two categories, the constitutional court and the ordinary courts. The two lowest ordinary courts are the Traffic Court and Summary Court. Above the Summary Court is the Court of First Instance, then Court of Appeal and highest the Court of Cassation.

Kuwait is divided into 5 governorates, Al Ahmadi (313,000 inhabitants, Farwaniya (498,000 inhabitants), Hawalli (496,000 inhabitants), Al Jahra (252,000 inhabitants) and Kuwait Capital (305,000 inhabitants) (all 1998 estimates). 3 of these are governed by members from the Sabah clan.

Individual freedom is guaranteed to all Kuwaitis. All arrests, punishment or exile shall be imposed within the rulers of law. All Kuwaitis have the freedom of movement and can live where they chose inside the country.

Freedom of opinion and expression is free and full within the boundaries of the law. The Emir can under certain circumstances suppress the freedom of the press, but in general Kuwait is acknowledged for one of the freest presses in the Muslim world. There are still limitations on democracy, but Kuwait has a developed level of freedom of speech. Kuwait is still very much marked by the control exercised by the hereditary Emir, who is a sole ruler even if there is a government with ministers.

Trade unions are permitted, and private ownership of companies is allowed. The national assembly has 50 members, and of the time being only 13% of the population has the right to vote. Only literate natural-born Kuwaiti male citizens above the age of 21 can vote, with the exception of servicemen and police. Candidates to the Majlis must be above the age of 30 and literate. Members are elected for a period of 4 years. The Majlis can be dissolved by the Emir, something that has happned twice. New elections must be held within 2 months of the dissolution. In the meantime, the Emir rules by decree. The consequence of Kuwaiti politics is that the power distribution between the Emir and the Majlis has been under constant testing. In the elections for the Majlis in 1999, 20 seats were won by Islamist candidates, 14 by liberals, 12 by pro-Government candidates and 4 by independent candidates. [4]

3 HEALTH STATUS AND DEMOGRAPHICS

3.1 Health Status Indicators

According to Ministry of Health, life expectancy for the Kuwaiti population (no available data for non-Kuwaiti) at birth is 78.7, for males 77.8 and for females 79.9 in 2003. The infant mortality rate is 9.4 in 2003, and under-five mortality rate 11.8 per 1000 for males and 10.9 per 1000 for females.

Maternal mortality per 100 000 live births was 9.1 in 2003. Crud birth rate 17.7 per 1000, while crud death rate 1.8 per1000, and the total fertility rate in 2003 accounted to 2.2.Total population access to health services were 100% in 2003. There was no urban–rural gap since over 95% of the population is urban.

In 2003 the percentage of infants immunized against DPT was 98%, polio 98% and measles was 99% with 100% vaccination coverage against HBV. These high coverage rates could be attributed to the efforts of the MOH in reaching mothers, better provision of knowledge and improved awareness of the public on diseases.

Food is available in abundance and is affordable to all sections of the population. However, there is evidence of under-nourishment, and some studies have reported a significant evidence of anaemia, especially among young girls. Overweight and obesity are significant health risk factors in Kuwait with a high prevalence especially among the Kuwaiti element of the population.

Table 3-1 Indicators of Health status

Indicators	1990	1995	2000	2002	2003
Life Expectancy at Birth:	74.88	74.2	76.8	78.4	78.7
HALE:	-	-	65.1	67	-
Infant Mortality Rate:	12.1	10.9	9.1	9.6	9.4
Probability of dying before 5th birthday/1000:	16	14	11.8	11.4	11.4
Maternal Mortality Ratio:	-	7.3	9.6	6.9	9.1
Percent Normal birth weight babies*	95.8	94.1	92.5	92	92.2
Prevalence of stunting/wasting*	-	-	-	3/24	

Source: http://www.who.int/countries/kwt/en/index.html
* UNICEF

Table 3-2 Indicators of Health status by Gender and by urban rural

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	73.2	78.9
HALE:	-	-	67.4	66.6
Infant Mortality Rate:	-	-	9.8	8.9

Probability of dying before 5th birthday/1000:	-	-	11.7	10.8
Maternal Mortality Ratio:	-	-		
Percent Normal birth weight babies:				
Prevalence of stunting/wasting:	-	-	-	-

Source: The world health report 2005

Substantial epidemiological transition happened in regards of infectious and communicable diseases. This is could be attributed to socioeconomic development, and rapidly changing lifestyles. There were no reported cases of cholera, diphtheria, polio and tetanus in 2000. The number of malaria reported cases was 233 in 2001. There were a total of 111 of reported cases of tuberculosis in 2001. The cumulative reported (to WHO) number of AIDS cases by the end of 2004 is 87 and that of HIV cases is 1019. Hetro-sexual transmission represents the most prevalent mode of transmission (65%).

With the decrease in the incidence of communicable diseases and the increase in life expectancy, the burden of disease has shifted towards non-communicable diseases and injuries. Trends are showing steady increases in the incidence of coronary heart disease, cancer and accidents and injuries (mainly road traffic accidents). In addition to this many risk of ill health are showing alarmingly high prevalence; for example, diabetes, obesity, dislipidemia and physical inactivity. Various national groups and communities have been set up to tackle these problems. We anticipate that specific targets with plan of actions to achieve target will produced. Mental disorders also represent a major public health problem and in particular among non-Kuwaiti. The extent of somatization is not known, but it is expected to be high in such a mixed population.

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality	Morbidity/Disability
1.	Diseases of the circulatory system	Single spontaneous delivery
2.	Accidents and injuries	Other complications of pregnancy and delivery
3.	Neoplasms	Other symptoms sings & abnormal clinical & laboratory find
4.	Perinatal causes	Other pregnancies with abortive outcome
5.	Diseases of the respiratory system	Other aneamias
6.	Congenital deformities and pregnancy and birth complications	Other ischemic heart diseases
7.	Endocrine gland and assimilation diseases	Other maternal care related to fetus and delivery prob.
8.	Contagious and parasitic diseases	Chromic disease of tonsils and adenoids
9.	Urinary and reproductive system diseases	Pneumonia
10.	Digestive systems diseases	Diabetes

Source: Country profile 2001 http://www.emro.who.int/mnh/whd/CountryProfile-KUW.htm

Kuwait Institute for Studies and Research, Kuwait and Social Development, (Kuwait 1995),

3.2 Demography

Demographic patterns and trends

The 2003 estimates showed total population to be 2,484,334 of national and non-national (nationals constitutes about 37% of the total population estimate). The population growth is estimated to be 3.36% in 2004.

The population is distributed in 6 governorates with highest density in Hawelli (686,421 persons which represent 27.6% of the total population). Kuwait is nearly completely urbanized with 97% of its population living in urban area, with universal access to safe water and sanitation.

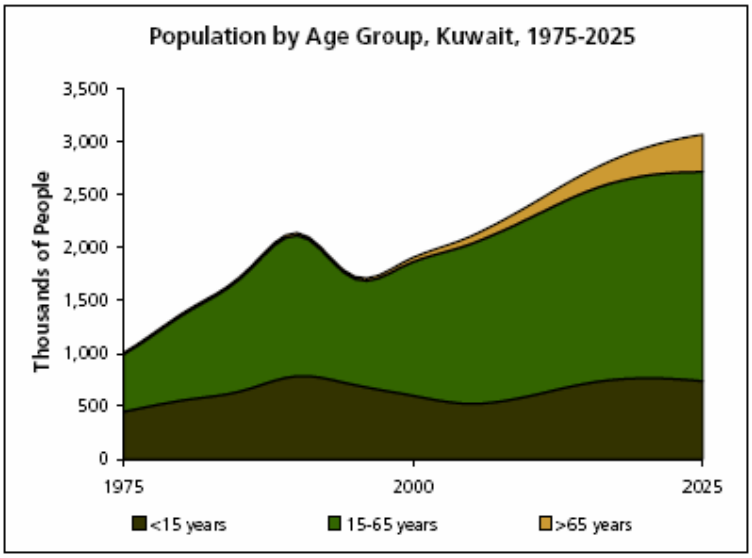


Table 3-4 Demographic indicators

Indicators	1990	1995	2000	2002	2003
Crude Birth Rate per 1000 pop	24.8	25.9	19.7	20.1	17.7
Crude Death Rate per 1000 pop	2.4	2.4	2.2	2.7	1.8
Population Growth Rate %	3.6	6.9	3.8	2.3	5.1
Dependency Ratio %	0.6	0.6	0.5	0.51	34
% Population <15 years	36.6	41.4	25.8	24.8	23.7
Total Fertility Rate:	3.4	2.9	2.6	2.5	2.2

Source: http://www.who.int/countries/kwt/en/index.html

Table 3-5 Demographic indicators by Gender and Urban rural

Indicators	Urban	Rural	Male	Female
Crude Birth Rate:	17.7		14.8	22.2
Crude Death Rate:	1.8		1.9	1.6
Population Growth Rate:	5.1		6.1	3.7
Dependency Ratio:	34		27.3	46
% Population <15 years	23.7		20	29.6
Total Fertility Rate:	2.2			2.2

Source:

It is projected that the population of the Kuwaitis over the age of 60 years will increase to 8% of the population by the year 2030 and to 25% by the year 2050. The prevalence of chronic disease therefore will be on the increase in particular, cancers, coronary heart diseases (angina, myocardial infarction, arrhythmias and heart failure) and disorders of mental health.

Kuwaiti nationals have been a minority of the population since the influx of foreign labor for oil-based development began in the 1960s. Many immigrants left after the Iraqi invasion, notably the substantial Palestinian community, which used to number around 450,000 and exited in large numbers after the ruling Al Sabah family were restored to power in Kuwait. Unlike their predecessors, most new immigrants are not accompanied by their families and dependants. According to the Public Authority for Civil Information (PACI), the rate of increase in the expatriate population slowed markedly in 1998, and in 1999 and 2000 Kuwait's expatriate population declined at the rate of 2.8% and 4.7% respectively. The fall in 1999 was the first time there had been a net expatriate withdrawal since liberation in 1991. This largely reflected the decline in oil revenues in 1998, which impacted on private sector demand and domestic investment levels in 1999, in turn leading to a decrease in demand for foreign labour that was felt the following two years as well. However, in 2002 and 2003 the foreign population resumed rates of growth in keeping with the post–war period. This was particularly marked in 2002, when the increase reached 6.6%; and in 2003 it rose by only slightly less (6.2%). The influx of expatriate workers reflected strong growth in the private sector, where the demand for low-income expatriate labour increased in construction and the retail economy specifically.

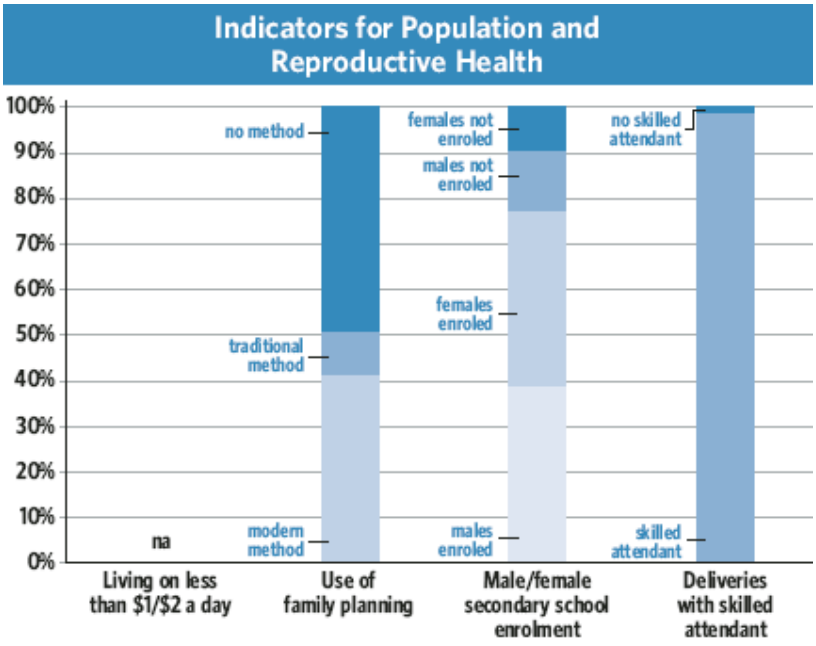
Figures from PACI for end-2002 show Kuwaitis accounting for 37% of the population, down from 38.1% in 2000. (By comparison, expatriates constitute an estimated 70% and 80% of the populations of Qatar and the UAE respectively, and in relatively resource-poor Oman expatriate workers represented only 26.3% of the overall population in 2001.) This demographic shift towards non-national Kuwaitis occurred despite continuing high rates of growth in the indigenous population during the second half of the 1990s, with the population rising by 3.8% in 1995 and by 3.3% in 2003.

PACI has not produced a breakdown of the size of the respective national populations among non-Kuwaitis for some years. However, according to a Kuwaiti newspaper, Al Watan, as of end-1999 the non-Kuwaiti Arab population was 38.5% of the total non-Kuwaiti population, making Arabs the second-largest ethnic group among non-Kuwaitis, after south Asians. Among the Arab group, Egyptians, at 19% of the overall non-Kuwaiti total, were by far the biggest. However, the largest non-Kuwaiti national group was Indians, at 19.8% of the total; Bangladeshis, Pakistanis and Sri Lankans comprised

10.9%, 7% and 6.9% of the total non-Kuwaiti population respectively. The total population of south Asian workers was 44.7% of the total non-Kuwaiti population. Local sources suggest that these proportions have remained at around the same level since end-1999, with south Asians and Arabs representing about 45% and 40% of the overall total respectively.

High rates of growth in the indigenous population are reflected in the fact that, according to the latest PACI data, some 42.2% of Kuwaiti nationals were aged under 15 as of end-2001. Some 69.8% of the Kuwaiti population were under 30, with the likely consequence that strong population growth in the national population will continue for at least the medium term. The total population at end-December 2003 was, according to PACI, 2.48m.

Population distribution: Cheap land and subsidized housing mean that Kuwaitis move frequently. New neighborhoods are continually being developed, while established ones become less popular. This pattern results in large swings in population between the various governorates in the country. However, the country is small and over 90% of the Kuwaiti population lives within a 500-sq km area bounded by Jahra, Kuwait City, Ahmadi and Fahahil. [5]



Public Expenditures on Health and Education

Health		Primary & Secondary Education	
% of GDP	Per capita ($US)*	% of GDP	Per student ($US)
2.90	417.45	3.11	2740.69

* *Commission on Macroeconomics and Health (2001) estimates that $30-40 per capita per year is the minimum required for essential health interventions in low-income countries. Much of this expenditure requires public funding particularly to provide services for the poor.*

Source: Country Profiles for Population and Reproductive Health, Policy Developments and Indicators 2005, produced jointly by UNFPA and Population Reference Bureau

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

Kuwait achievements are so far relatively comparable to average European standards of health and health care. This high level of health status and good standards and accessible health care services was achieved through the generous welfare system and education attainments developed since independence in 1961. Great strides have been made in health, since 1910 in which, curative health services were provided by American missionaries, till the time being.[6] One of the largest ministries in Kuwait, the Ministry of Health was established in 1936. However, the history of healthcare in Kuwait is much older - dating back to the first years of the twentieth century when the ruler, Shaykh Mubarak Al Sabah the Great, invited doctors from the Arabian Mission of the Dutch Reformed Church in the United States to establish a clinic. By 1911 the group had organized a hospital for men and in 1919 a small hospital for women. In 1934 the thirty-four-bed Olcott Memorial Hospital opened. Between 1909 and 1946, Kuwait experienced gradual, albeit limited, improvement in health conditions. General mortality stood between twenty and twenty-five per 1,000 population and infant mortality between 100 and 125 per 1,000 live births.

After the government began receiving oil revenues, it expanded the health care system, beginning with the opening of the Amiri Hospital in 1949. The Kuwait Oil Company (KOC) also opened some small health facilities. By 1950 general mortality had fallen to between seventeen and twenty-three per 1,000 population and infant mortality to between eighty and 100 per 1,000 live births.

In the 1950s, the government introduced a comprehensive health care system offering free services to the entire population. Free health care was so extensive that it even included veterinary medicine. Expenditures on health ranked third in the national budget, after public works and education. As with education, the system relied heavily on foreigners. Most of the physicians were foreigners, particularly Egyptians. Critics charged the designers of the system with paying undue attention to acquiring the most modern and expensive medical equipment, without regard to the country's health priorities, and favoring treatment over prevention. Nonetheless, improvements in available health care and in public health were dramatic. The number of doctors grew from 362 in 1962 to 2,641 in 1988. The doctor-to-patient ratio improved from one to 1,200 to one to 600. Infant and child mortality rates dropped dramatically; in 1990 the infant mortality rate was fifteen per 1,000 live births. Life expectancy increased ten years in the postindependence years, putting Kuwait at a level comparable to most industrialized countries. In 1990 life expectancy for males was seventy-two years and for females seventy-six years. [7]

4.2 Public Health Care System

Organizational structure of public system

The public health system in Kuwait is organized into two tiers; central MOH and regional health offices.

Central MOH:

The Ministry of Health (MOH), located in the Capital region is responsible for planning, financing, resource allocation, regulation, monitoring and evaluation as well as health care service delivery. The Ministry of Health is the third largest public-sector employer after the ministries of education and interior. During the Iraqi invasion, most medical facilities were devastated and reduced to shambles. One of the Government's primary tasks after liberation was to bring health care system back on rails in the shortest possible time.[8]

The Ministry of Health operates through an administrative and a technical workforce and has an extensive central organizational structure, headed by the Minister. (MOH organizational chart is attached as annex 1). The Minister of Health is assisted by the Undersecretary and twelve Assistant Undersecretaries. Central departments under the direct supervision of the Undersecretary include; Technical department, legal advisor, planning and follow up, public relations, treatment abroad, medical council and department of medical services. The Secretary General, Kuwait institute of medical specialization report directly to the Minister.

The Assistant Under-Secretaries are administratively responsible for public health affairs, dental health, health services, blood transfusion and laboratories, nutrition and drug control, drugs and medical supplies, financial affairs, administrative affairs, legal affairs, quality control affairs, and newly established health regions and private health services & licensing department. The MOH overall structure therefore consists of twelve functional divisions embracing 42 central departments and offices at the central level. A ministerial council, headed by the minister with Under Secretary and Assistant under Secretaries as its members, meets on a weekly basis to discuss all issues related to the health system. The health regions are represented by the newly appointed Assistant Under secretary of health regions.

Currently, the Ministry of health is in the process of revising its organizational structure. Few new departments have been added, like department of health regions, central department of medial services and private health services and licensing department. Few other departments have been either abolished or merged with others. Earlier eight departments along with all the health regions were reporting directly to the undersecretary. Recently, through a ministerial declaration, two separate departments have been created, including a department of health regions, therefore shifting some authority from the under secretary to the newly appointed assistant under secretaries.

Generally the organizational structure of the ministry is heavy at the top with some evidence of duplication of roles and responsibilities between different departments. In addition, there is a significant variation in distribution of responsibilities among assistant under secretaries. The number of departments supervised by them varies from one to eight departments leading to overburden in some cases. Roles and functions of each department is clearly defined in the ministerial decrees issued at the time of establishing new departments although in practice there is some overlap and duplication of work. There is a need to organize the structure of MOH with a view to minimize the overlap among various tasks and functions and with clear and equitable sharing of departmental responsibilities.

There is good working relationship and coordination between different departments in the ministry, evident by number of committees that meet regularly to discuss and resolves issues of mutual interest. The council of assistant under secretaries that meet on weekly basis is another forum to improve coordination between various departments. Likewise, the links with other ministries including ministries of planning and finance are

well established and smooth. Recently established council of undersecretaries facilitates this process. However, there seems to be a gap between the central departments in Ministry of health and the health regions in terms of coordination, communication, technical supervision and information sharing.

Administrative and financial rules and procedures in MOH are written down, clearly defined and available. Job descriptions of all the staff are developed at the time of creation of new positions and these are available within the ministry but not widely distributed and most of the staff is not aware of their existence. There is good system of performance evaluation of staff. Performance of all staff is assessed on annual basis by the respective supervisor and graded based on defined criteria into excellent, good or weak. There is a separate budget allocated for excellent performing staff, which gets a bonus based on the recommendation of supervisor. Sometimes promotions are also based on performance in addition to other considerations like certificates from continuing medical education department. Weak performers are recommended for refresher training and other administrative action if required. There are examples of actions taken, including termination from service, for the staff found guilty of negligence.

Despite the computerization initiative, the communication processes are still based on traditional paper based exchanges and all official correspondence and documents are maintained as hard copies. There is no inter-departmental networking in place at the ministry or its related departments. There is no central login-based intranet for access to ministry documents, training materials, or other resources to facilitate efficient communication.

Health regions:

Through a ministerial decree issues in 1984, Kuwait was divided into 6 health areas/regions namely Capital, Hawali, Ahmadi, Jahra, Farwania and Al Suabah. Another ministerial decree issued in 1998 revised the roles and responsibilities of health regions and central departments in MOH. The Health region is considered a nearly independent decentralized administrative unit. It is responsible for all executive affairs in the area according to the responsibilities assigned to it in terms of specialized health services as well as administrative, financial, engineering services. The Health Area offers health services assigned to it according to the laws and the policies of the Ministry of health and internal work systems in the area. The main duties of the area include: 1) implementing action plan of the ministry to ensure provision of health services to the residents of the area; 2) Offering different levels and types of health care; 3) Implementing training for medical, technical and administrative cadres; and 4) Establishing and implementing a comprehensive computerized system of health information in the area. The population in the regions range from 175,493 in Mubarak region to 687,805 in Farwania region.

A health region is headed by the Director of Health region, who reports to the under secretary of health. Recently a new position of assistant under secretary of health regions is being created. The Area Director is responsible for all the health services in the region according to the technical, administrative and financial authority delegated to him through the ministerial decree. Each health region office supervises and manages at least one general hospital and a number of primary health centres and specialized clinics. In addition to specialized clinics in other 5 regions, most of specialized hospitals are located in Sabah region. The regional health office also supervises private health sector. The policies, plans and programs of the MOH are implemented through this structure. Organizational chart of Health region is attached at annex 2.

Departments of health planning and information, legal research, allied health services and engineering affairs report directly to the Area director. The Area director is assisted by the Administrative and financial affairs inspector, head of primary health care services, head of general health services, head of dental services and Hospital director. There is a hospital board of director responsible for oversight of all matter related to regional hospital. Hospital director is assisted by a deputy hospital director with responsibilities of carrying out any task delegated by the Hospital Director, replacing him in his absence and participating in Quality Committees and following up on the decisions of the board of directors of the hospital.

At the regional level, a board of directors has been established with main responsibilities of accrediting the programs and executive plans submitted by the Area Director and approving mid-term and annual reports; suggesting and accrediting policies of the area; establishing committees, approvals of annual budget for the area and revising accounts; follow up on training and continuing education plan and encouraging scientific research; following up performance evaluation of technical staff; studying proposals related to health education and interacting with the governmental and non- governmental authorities; and identifying problems, suggesting suitable solutions, while ensuring that all the citizens are satisfied with the health services provided.

Primary health care is delivered through a series of health centres, with general or family health clinics, maternal and child care clinics, diabetic clinics, dental clinics, and preventive care clinics, school health services, ambulance services and police health services are also available.

Secondary health care is provided through six general hospitals. Tertiary health care is provided through a number of national specialised hospitals and clinics. The regionalisation of the health care delivery system is now complete so that each of the six general hospitals, along with a number of health centres which refer to it, constitutes a health region. The regionalisation of the health system, which covers six health regions, has resulted in more efficient delivery of health services.

The health system is based on three levels of health care delivery: primary, secondary and tertiary health care.

Primary Health Centres

There are 72 primary health centres spread over the country. The services offered by them include general practitioner services and childcare, family medicine, maternity care, diabetes patient care, dentistry, preventive medical care, nursing care and pharmaceuticals.

Secondary Health Centres

Secondary healthcare services are provided by the six major hospitals: Sabah hospital, Amiri hospital, Adan hospital, Farwaniya hospital, Mubarak Al-Kabeer hospital and Jahra hospital.

The structure of each one of this hospital include a general hospital, a health centre, specialised clinics and dispensaries. The policy of each hospital is to provide the best possible healthcare to all citizens and residents.

Specialised Health Centres

The specialised healthcare service centres in Kuwait include the following:

1. Obstetrics (delivery) hospital: for maternity

2. Chest hospital: for pulmonary ailments

3. Psychiatric hospital: for mental disorders
4. Ibn Sina hospital: for neurosurgery
5. Razi hospital: for burns
6. Kuwait Center for Allergies: for allergies
7. Kuwait Cancer Control Center: for cancer diagnosis and treatment
8. Hearing Impairments Center: for disorders connected with hearing
9. Hamed Al-Essa Transplant Center: for organ transplants
10. Sulaibikhat hospital: for physiotherapy and rehabilitation

Key organizational changes over last 5 years in the public system, and consequences

With the issuance of the Law of Health insurance of the expatriates in 1999, which was supplied in the year 2000, a position was introduced under the title of Health insurance department, and in March 2006 another position was introduced under the title of Assistant undersecretary for health care. Also new entities were introduced and others were merged.

Planned organizational reforms

A comprehensive study of the organizational structure of the Ministry of Health is being performed to cope with the requirements of developing health services.

4.3 Private Health Care System

Modern, for-profit

Despite the comprehensive services provided by the Ministry of health, private hospitals and clinics thrive in Kuwait. Private sector providers focus on curative services, and have little role in preventive interventions. There are 5 private hospitals in Kuwait with a total bed capacity of 427. Total number of doctors in these hospitals is 254 and number of nurses 707. In 2004, total number of outpatient visits in private hospitals was 798,985 (compared to 1.75 million in public sector hospitals). Data is not available on exact number of private clinics. Most of the private hospitals and clinics are concentrated in central and commercial areas like Farwania, Hawalli and the capital region and provide secondary and tertiary curative care. MOH is regulating the construction of new private hospitals to be built in other regions to ensure that they are equally distributed. Private health services are generally perceived to be of better quality and mainly accessed and utilized by the better-off Kuwaiti population.

Modern, not-for-profit

Oil companies' hospitals include

- Ahmadi Hospital
- Texaco Hospital
- Kuwait National Petroleum Company (KNPC) hospital

Traditional

It has not been licensed in the private sector yet, and hence it is not applicable.

Key changes in private sector organization

The government is encouraging the private sector to increase its role in service provision and to invest in the health sector through continuing policy of granting licenses with quality control over the services provided. Public practitioners are allowed to practice in the private sector in addition to their work in public facilities. Recently, the Ministry of Health has approved applications of 35 private companies to set up private hospitals in Kuwait. A decision is also taken, allowing cooperative societies, private hospitals and Kuwaiti doctors to open private clinics for general practice in residential areas. A new department of private sector and licensing has recently been established in Ministry of health and there are plans to establish Health insurance hospitals and privatization of some of the public health care services (e.g. medical laboratory, radiology, nuclear medicine and nursing).

Public/private interactions (Institutional)

Some medical cases are being transformed from the private sector to the government sector.

Public/private interactions (Individual)

None

Planned changes to private sector organization

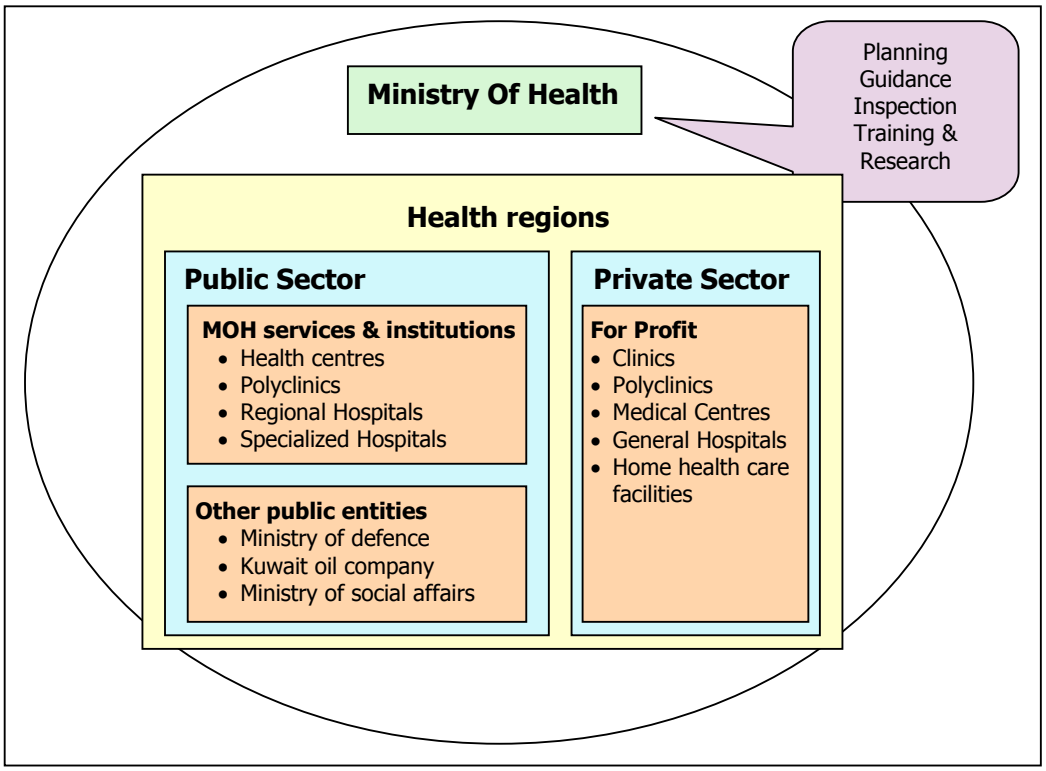
Encouraging the private sector to invest in the health sector via continuing the policy of facilitating granting licenses to health entities with quality control over the services provided.

4.4 Overall Health Care System

Brief description of current overall structure

Kuwait has one of the most modern health care infrastructures in the region. The health system consists of both public and private sectors. More than 80% of all health services are provided by the public sector, mainly by the Ministry of health. Other than MOH, Ministry of defence and Kuwait Oil Company have separate hospitals for their employees. Ministry of social affairs through its hospital provide health services to the handicapped and elderly. Private sector is small but rapidly expanding.

Figure1. Kuwait National health System



At present, the healthcare network in Kuwait is the best in the Gulf region and among the finest in the world. Kuwaitis receive medical services at government clinics and hospitals free of charge. Public healthcare is maintained by an intricate network of primary and secondary health centres and specialised hospitals and research institutions.

There are 72 primary health centres spread over the country. The services offered by them include general practitioner services and childcare, family medicine, maternity care, diabetes patient care, dentistry, preventive medical care, nursing care and pharmaceuticals.

Secondary healthcare services are provided by six major hospitals: Sabah hospital, Amiri hospital, Adan hospital, Farwaniya hospital, Mubarak Al-Kabeer hospital and Jahra hospital. The structure of each one of this hospital include a general hospital, a health centre, specialised clinics and dispensaries.[9]

Despite the excellent comprehensive services provided by the public health service, private hospitals and clinics thrive in Kuwait. The MPH regulates standards and the fees they may charge. The private hospitals and clinics have their own pharmacies. Most of them are general hospitals with some specialist departments. Some have limited equipment, such as ICUs, or specialists and refer patients to government hospitals for special procedures.

Private clinics are usually staffed by doctors of a particular specialty. There are several private dentists and dental clinics providing services to international standards. Orthodontics is only available to expatriates through these dentists and clinics. The Ministry of Health has approved the applications of 35 private companies to set up private hospitals in Kuwait. A decision is also issued allowing cooperative societies, private hospitals and Kuwaiti doctors to open private clinics for general practice in residential areas.

Provision of health services:

The Public Sector

1. The Ministry of Health:-

Rendering health services is based on:

- The health areas that include sequence of service rendering. There are six health areas as follows: Capital, Hawally, Farwaniaya, Ahmadi, Jahra, Sabah Specialized Health Area.
- The three levels that guarantee the comprehension of the rendered services, as the residential areas are being served by a group of health centers (that represent the first level of service- Primary Health care) from which transfer takes place to six general hospitals (area hospital) one for each area (representing the second level of service- secondary health care), and then from there to the group of specialized hospitals and medical centers affiliated to Sabah specialized health care area representing the third level of service- triple health care service).
- Free health care provision for citizens and through subscription to the health insurance service for expatriate with the fees of one Kuwaiti Dinar for visiting the health centre, and two Kuwaiti Dinars for visiting clinics of hospitals and specialized health center for dental services, in addition to some additional fees fro some particular services. These fees do not include diabetes injections, bandages and vaccination in the primary health care centers.

2. Other Government Entities:

- Ministry of Defense (Military Hospital)
- Ministry of Social Affairs
- Kuwait Petroleum Corporation (Ahmadi Hospital) health services for staff of the oil sector.

The Private Sector:

- Through private clinics, clinics, medical centers and general hospitals.

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy and trends in stated priorities

Ever since its independence in 1961, the leaders of Kuwait planned for it to become a welfare state, and in effect Kuwaiti citizens enjoyed one of the most comprehensive welfare systems in the world. The health plan, as part of the total socio-economic development plan and health policy, is based on three principles: maintenance and promotion of health in the people; improvement of physical, mental and social well-being of the people; and reducing morbidity, disability and mortality as much as possible. In this respect, health goals have been defined as long-term and medium or short-term.

The health system is based on three levels of health care delivery: primary, secondary and tertiary health care. Primary health care is delivered through a series of health centers, with general or family health clinics, maternal and child care clinics, diabetic clinics, dental clinics, and preventive care clinics, school health services, ambulance services and police health services are also available. Secondary health care is provided through six general hospitals. Tertiary health care is provided through a number of national specialized hospitals and clinics. The regionalization of the health care delivery system is now complete so that each of the six general hospitals, along with a number of health centers which refer to it, constitutes a health region. The regionalization of the health system, which covers six health regions, has resulted in more efficient delivery of health services.

The Ministry of Health is responsible for the establishment and functioning of the health care network.

The implementation of health strategies has had an effective impact on the health status of the population, as can be seen from the decrease in mortality indicators and the increase in life expectancy, as well as the decline in incidence of infectious diseases. Kuwait has, in fact, become the welfare state it was designed to be, as it overcame successfully, through its planning after liberation, the negative impacts of the Gulf War on health facilities, health status and environment.[10]

Out of the government obligation to render health care to both the citizens and the expatriates, and based on the liabilities of the Ministry of Health in this concern, the general guidelines of the health policies in the State of Kuwait were set as follows:-

1) Health plan is an integral part of the general development plan of the State of Kuwait.
2) The health care level should cope with the society values and should satisfy the needs of its individuals
3) Facilitation of health care rendering and upgrading its level to match the highest technical standards
4) Priority should be given to the needs of special groups of the citizens as the handicapped, the elderly people, mothers and children
5) Encouraging popular and social participation in forming the health policies and rendering health services

6) Development of health administration to render health care with the highest standards of efficiency and effectiveness
7) Development of the human resources working in the health sector
8) Governmental monitoring and supervision of the health services rendered by the private sector
9) Application of the technical standards for rendering health services in the required level
10) Continuous co-operation with Arab and international entities.

In this concern, these policies were translated into programs and procedures that resulted in the modern structure of the health services in the State of Kuwait and in the support and development of the methods of operation in the health sector, in addition to setting health programs that achieve the required goals within the scope of comprehensive development plans.

Formal policy and planning structures, and scope of responsibilities

The department of planning and follow up in the Ministry of Health prepares health plans based on the direction and within the framework of the general plan of the government as prepared by the Ministry of Planning, which is approved by the council of Ministers and authorized by the nationals.

Analysis of plans

- The eighties phase was distinguished by the health plans aiming at establishing and expanding different health services.
- The first phase of the nineties was distinguished with the re-habilitation of the health services after the liberation from the Iraqi invasion.
- the second phase of the nineties to date is distinguished with the health services that aim at supporting the health economic and enhancing the level of services provided

5.2 Decentralization: Key characteristics of principal types

Within MOH: e.g. to district teams, central or district boards

In order to improve the efficiency, effectiveness and quality of services, Ministry of health, Kuwait carried out a number of studies in various areas. The findings of the studies highlighted the need to change the current, highly centralized model of service delivery. Based on the findings and to ensure that all population of Kuwait have access to best possible service and to improve the overall performance of health system, MOH decided on decentralization. A Ministerial decree (No. 188) was issued in 1984 to establish health areas/regions. Each region to be responsible for providing comprehensive health services to the residents of its area.

As a first step, MOH established a health area committee with responsibilities of identifying the health areas, studying the services provided, assessing essential steps needed to establish a health area and establishing an organizational structure for the area and identifying its relation with the departments and centralized authorities in the ministry. The committee carried out a detailed study to establish scientific grounds for dividing the country into health areas and identify needed capacity; define role of the health areas; establish rules and procedures for the health area; define relationship

between health area and the centralized authorities according to the concept of decentralization in establishment, and centralization in planning and guidance while avoiding duplication of work; and to identify necessary steps needed to establish health areas. The study was based on MOH organization chart, existing system of work in the MOH and relationships between technical and administrative centralized authorities. Based on the work and recommendations of the committee, Kuwait was divided into six health areas.

Key Duties and functions of the Health Areas defined by the committee included; implementing health plan of the ministry; identifying and studying the health problems; providing comprehensive health care at different levels and types; developing a updating database of organizations, individuals, costs; and technical and administrative training for the staff

- **Responsibilities of health areas:**

Most administrative and technical procedures, earlier carried out by the centralized authority, were delegated to health areas, specifically: technical and administrative procedures; supervision of staff; investigating complaints and suggesting action; transfers within the area; performance evaluation of staff; approval of leaves; suggesting promotions, raises and other bonuses/benefits, and other administrative, technical and executive affairs which was carried out by the centralized authority.

- **Main Responsibilities of Technical Centralized Authorities after establishing Health Areas:**

1. **Planning**; Suggesting general policy for services, and preparing plans and necessary programs and submitting them to the ministry for approval; collaborating with concerned authorities in developing job titles, job descriptions, and organization structures; setting technical performance standards in health services according to international standards and local needs; suggesting mechanisms to improve technical performance of staff and preparing budget for human resources for new projects.
2. **Guidance**: Regular supervision of the ministry units to assess the standards of performance, and sending reports to the concerned area director and head of the concerned centralized authority; studying technical reports and statistics of health areas to ensure best services are provided and publishing scientific and technical periodicals.
3. **Rectifying**: Rectifying the technical work in the units of the ministry and suggesting ways and means to improve it.
4. **Training and Scientific Research**: Developing training programs for staff in all departments, and suggesting post-graduate programs; encouraging scientific research in the field of technical services, and developing necessary programs in coordination with department of the health research.
5. **Appointments, Transfers, Bonuses**: Compiling all the needs of the health areas according to the approved budget; advertising for the required staff and identifying qualifications and conditions required; establishing a committee to interview candidates; following up on procedures related to hiring in coordination with the concerned authorities; distributing new appointees to the health areas and transfers of staff from one health area to another after the approval of the officials of both areas.

Through a ministerial decree (No. 310), issued in 1998, roles and responsibilities of the health areas, area director and other officials were revised and more clearly defined. It

was decided that health areas would come under the direct supervision of the under secretary. The responsibilities of board of directors for the health areas were also revised and a separate decree was issued for the Al-Sabah Specialized Medical Area. The Health Area is now considered a nearly independent decentralized administrative unit. It is responsible for all executive affairs in the area according to the responsibilities assigned to it in terms of specialized health services as well as administrative, financial, engineering service. The revised duties of the area include: 1) implementing action plan of the ministry to ensure provision of health services for the residents of the area; 2) Offering different levels and types of Health care; 3) Implementing training for medical, technical and administrative cadres; and 4) Establishing and implementing a comprehensive computerized system of health information in the area.

The Area Director is responsible for all the health services in the area according to the technical, administrative and financial authority delegated to him through the ministerial decree. His main duties include:

1- Developing a program and executive health plans for the area.
2- Establishing temporary committees and teams to implement and follow-up
3- Recruiting, firing, internal transfers (within the health area), internal delegations of duties, in accordance with laws and regulations for the health area in coordination with administrative and the financial affairs departments in Ministry of health.
4- Implementing disciplinary actions after investigating and verifying the fact according to the laws and the administrative regulations of the health area.
5- Preparing budget plan for the area according to the systems followed by the ministry, and implementing the budget according to the accredited systems
6- Supervising the activities of the area funds, and submitting a detailed financial statement in accordance with the financial regulations.
7- Continuous coordination with the board of directors and training & education committees to improve educational and technical level of the staff of the area.
8- Direct communication with different departments of ministry, national authorities, and the public cooperation, without adding any financial or intellectual commitments to the ministry, without prior approval.

Head of the Primary Health Care Services, Head of the General Health Services, and the Head of Dental Services in addition to being incharge of their respective areas have the responsibilities of; implementing policy of the Ministry and health plan of the area; assessing performance of staff; Daily follow–up on services provided to ensure patient safety; Annual needs assessment of manpower, drugs, equipment, engineering services and the health facilities; Suggesting staff transfers; approving leaves; suggesting monetary and non–monetary benefits for the staff; supervising technical and training activities and continuous education programs; strengthening Health promotion programs; implementing emergency health plan; and ensuring that the citizens are satisfied with the services. Administrative, Financial and Service Affairs Inspector supervises all administrative, financial and service affairs in the area and coordinates administrative work between the different health centres in the area. The Hospital Director assisted by Deputy Hospital director reports to Area Director and is responsible for supervising all the technical, administrative, financial activities in the hospital. The director is also accountable to the board of directors of hospital for ensuring quality of health service.

Since the Health Area is considered a decentralized authority, it implements all the duties assigned without any interference from centralized authorities which has the main responsibilities of planning, guidance and inspection over the area, without going into the executive issues. There is direct communication between the Area director and the

under-secretary, and the director has the authority to call the assistant undersecretaries, and centralized authorities in the ministry and other governmental authorities, while informing the undersecretary and not bearing the ministry any financial obligations.

A board of health areas was established with the Undersecretary as president of the board and Assistant under secretary for Health Care and Health Area Directors as its members. Main functions of board include; strengthening relationships between health areas and coordinating work between them and centralized authorities in the ministry; establishing long-term work plans for expanding health services; identifying problems, finding suitable solutions, and taking action; reviewing performance standards and their feasibility; and reviewing administrative and financial regulations. The Board meets at least once every 2 months, and whenever the need arises based on an invitation form the head of the board. Decisions are made by the votes of the majority. The board could delegate some activities to small committees within the board of directors.

- **Administrative Regulations of the Health Area:** The Area Director is delegated to approve the appointments of all the staff nominated in the Health Area. Doctors are appointed by the approval of the specialized medical departments, concerned head of the Department and the Area Director. Similarly Health Technicians and other staff are appointed by the approval of the concerned technical committees, concerned head of the Department, head of the sector and the Area Director. In all cases the Administrative Affairs Department in the ministry has the final authority for procedures of appointments. Area director has the authority to transfer staff within the region, while the powers to transfer staff from one area to another are with Administrative affairs authority after approval of concerned area directors. Transfer outside the ministry needs approval from the undersecretary. Area director has complete authority for granting leaves within the area. For investigation of a technical mistake he needs to refer to the MOH. For promotions and raises, the area director sends his nominations to the Administrative Affairs authority for approvals according to the rules and regulations. The area director also has the authority to give bonuses and approve termination and renewal of contracts. The approval has to be sent to the Administrative Affairs authority in the MOH.
- **Financial Regulation of the Health Area:** According to the ministerial decree, the health area is an administrative unit that has the financial authority regarding expenditures and income through two separate bank accounts maintained in the local banks. The funds are under the supervision and the inspection of the Authority of Financial Affairs in the ministry. The Area Director is responsible for all the activities related to the funds. A "Public Money Account" is used for transfer of funds from the ministry according to the approved budget of the area. The Authority of Financial Affairs deposits an instalment at the beginning of the fiscal year, which is balanced out throughout the year. A separate "Other Activities Account" is maintained where donations accepted by the area board and income from approved activities is deposited. The expenses from the Public Money account is limited only to purchasing and maintenance of furniture & equipment, stationery, urgent simple medical equipment, agricultural, interior/exterior design, hiring of temporary staff and health awareness activities. The health area can not purchase anything that is in stock and if it is in the contract of the ministry. Funds can also be used for special national occasions, gifts and purchasing incentive gifts for the excellent performing staff. The Area board must approve any other expense. Any purchases of more than 5000KD requires approval from the Authority of Financial Affairs and payment is made from the general budget of the ministry. In all cases, estimates should be from registered companies, and the receipts should be detailed. All Expenses should be in

coordination with the Authority of Financial Affairs. Authority of Financial Affairs inspects and settles the accounts on monthly basis. It must be provided with bank statements, statements of all financial resources, and receipts. At the end of the fiscal year, the Authority of Financial Affairs performs an audit of the financial statements and expenditures.

Kuwait's experience with decentralization is mixed. According to the MOH, the new health region system has allowed better planning, management and more efficient use of resources, which resulted in more efficient delivery of health services. However, there are serious concerns about its impact due to the limited powers delegated to health areas. The authority delegated to manage health work force in the regions is variable. The Directors of health areas have the authority to transfer staff (within the region), approve leaves, conduct performance evaluation, reward well-performing staff, nominate for continuing education and approvals of termination and renewal of contracts; they can not recruit, penalize or dismiss the staff. They do not have the authority to be flexible with salaries to attract qualified staff, especially nurses. For promotions and raise in salaries, the area director sends his nominations to the Administrative Affairs authority in MOH for approval, in accordance with rules and regulations.

Health regions develop annual plans and send their requirements regarding staff and other resources to the MOH, however the funds and human resources received are often not based on the needs. Packages of health services and standards of care are defined by the MOH in consultation with the regions. Decisions about construction of new hospitals and facilities are also combined. Continuing education and health information system is highly centralized. There is duplication of efforts in data collection and compilation and limited capacity at regional level to analyze and use data collected from hospitals and health facilities. Strengthening of health information system and capacity development in the area of strategic and operational planning in the regions will be essential for the success of decentralization.

Fiscally, the system remains highly centralized and health areas rely almost entirely on government financing. There are restrictions on use of revenue generated through user fee, donations and other approved sources. Budgets are prepared by the health areas, mostly on incremental basis and submitted to the MOH. Once approved an instalment of funds is deposited in the designated local bank at the beginning of the fiscal year, which is balanced out throughout the year. Authority of Financial Affairs in MOH inspects and settles the accounts on monthly basis. According to the regional director, budget is allocated for all regions and they are not aware of the amount allocated to their region. Each time they need funds, regions have to give justifications. There is no flexibility between line items without the approval of the MOH. Regional directors have the powers to disburse up to KD 5000 ?? in accordance with the approved budget. They are required to make payment of more than 100 KD through cheques and any donations received by the area must be notified to the Authority of Financial Affairs. There are restrictions and conditions for purchase of simple medical equipment. Medicines and other supplies are also procured centrally and then distributed to the regional facilities. During discussions some concern was raised regarding the misuse of resources if the procurement is decentralized and regions are given more financial powers.

The regions are not empowered to authorize autonomous status to hospitals or launch insurance plans. They have the authority to contract out maintenance, cleaning and catering services to private companies. There are no regulations and means of enforcement to regulate the private health facilities based on the existing norms and standards. The regulatory functions are limited to registration and licensing. There are

no mechanisms for monitoring and supervision and enforcement of measures in the event of non-compliance.

The health areas have well developed organizational structures with departments of administration & finance, planning & information, legal research and engineering affairs with laid out operational policies and procedures. Directors and managers are highly qualified and experienced. However, there seems to be a limited capacity in health system management. Coordination with central departments is weak and health information system needs strengthening to support the decentralization process. There is also a lack of clarity among regions as well as central departments about the rules and regulations regarding decentralization and the extent of financial and administrative authority.

Generally there are concerns among regions that overall health system is still highly centralized; resources allocated to the regions are not enough and not based on their needs; there is duplication of work and limited coordination between MOH and regions; administrative and especially financial regulations are too restrictive; staff is appointed in the regions without their consent or consultation; and they do not have enough authority to efficiently mange the affairs of the regions.

The current level of transfer of authority and responsibility in the decentralized system can be explained on the basis of the decision space model,[1] which gives the range and extent of independence in decision making allowed by the Central MOH to the health regions. Table 1 provides a quick mapping of the current decision space available to the Health regions in Kuwait.

Table1. Level of Decentralization:

Health system functions	**Level of Government**	
Finance	**Central**	**Regional**
Revenue generation	++	+
Budgeting, resource allocation	++	++
Power of expenditure	+++	+
Line item flexibility	+++	-
Income from fee and contracts	+++	-
Information and Planning		
Prepare annual plans	+++	++
Health information systems design	+++	-
Data collection, processing, and analysis	+++	+
Dissemination of information to stakeholders	+++	+
Service organization		
Hospital autonomy	-	-
Managing insurance schemes	+++	-
Defining service packages	+++	-
Setting norms, standards, regulations	+++	-
Monitoring, oversight of service providers	+	++
Contracts with private providers	+++	++
Human resources		
Recruit staff	+++	+
Dismiss staff	++	-
Reward staff	++	++

[1] Bossert T. (1998) Analyzing the Decentralization of Decision Space in Developing Countries: Decision Space, Innovation and Performance. *Soc Sci Med*; **47**(10):1513-27.

Penalize staff	+++	-
Determine salaries & benefits	+++	-
Transfer staff	++	++
Performance evaluation	+	+++
Continuing education	++	+
Procurement and Logistics		
New equipment	+++	+
Drugs & supplies	+++	-
Repair and maintenance contracts	+	++

Key: +++ Full authority; ++ Moderate; + Limited; - None

State or local governments

Not applicable

Greater public hospital autonomy

Not applicable

Private Service providers, through contracts

- The experience of finalizing some non-medical services, security, cleaning, transport and alimentation
- The experience of privatization of some health services:
  1. x-ray and medical laboratories in Adan Hospital
  2. Nursing services in Adan and Mubarak Al-Kabeer HospitalMain problems and benefits to date: commentary

Integration of Services

- There is a continuous expansion in the experience of expanding the capacities of health areas
- Privatization experience is being evaluated.

5.3 Health Information Systems

Kuwait has a complex health information system. A lot of good quality data is generated on morbidity, mortality, vital health statistics and utilization from all levels of health care delivery. Detailed statistics are available for primary, secondary and specialized care. However, there are separate systems of data collection for primary health care facilities and secondary & tertiary health care hospitals and separate reporting systems for preventive and curative care. Other than regional offices, there are 3 central departments involved in data collection and management namely, department of statistics and medical record (collects data from public and private hospitals), public health department (concerned only with preventive services data), Primary health care department (receives data on OPD from PHC centers). Various health Programs generate their on reports which are not part of the routine information system. In addition, Central Information System Department deals with computerization, networking and developing software programs.

The department of statistics and medical record is the main department responsible for management of information including data and statistics exchange and publications within the ministry of Health. It undertakes compilation, statistical analysis and reporting of health data in the country. The data is collected through its offices in the health regions, which is compiled and analyzed on monthly basis. It regularly publishes quarterly and annual health statistics reports. The department has health registration, Medical records and health statistics sections. All the births and deaths in the country are registered. For each newborn a separate file is prepared and maintained in the catchment area health facility. In addition to this, all the people entering Kuwait are also registered. The department shares the responsibility of registration of expatriate workers with Legal department in Ministry of health. Medical records section is responsible mainly for all the records of country's hospitals and clinics. It collects data, develop formats for reporting and conduct trainings of staff in filling the forms and reports. Statistics department is concerned with data analysis. The department of statistics and medical record is mainly responsible for data collection from hospitals. Data from Primary health care centers and Preventive services is reported separately to the respective departments and then it reaches the department of medical records and statistics, where all the data is compiled and reports are generated on quarterly and annual basis. These reports are disseminated to MOH, regional health offices and sometimes to the hospitals and clinics.

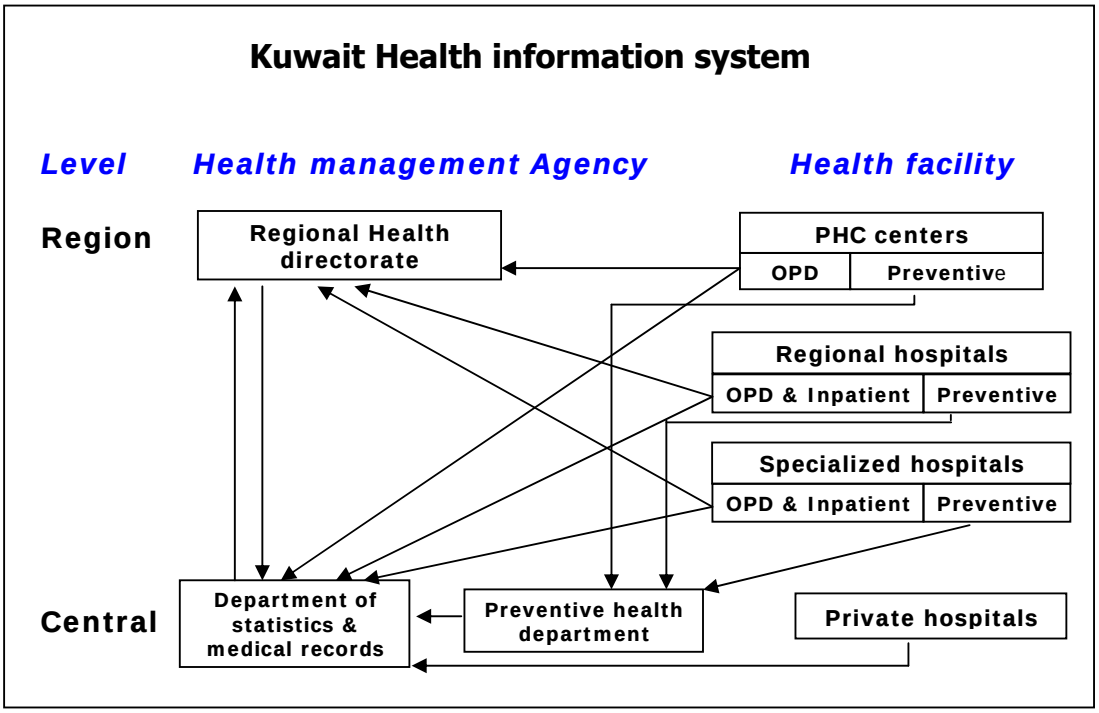
Information system department in MOH is responsible for computerization of PHC centres, secondary hospitals, birth and death registration, wireless networking and developing a database. Three subdivisions of the department include System development, operations and technical support. System development subdivision has different sections on projects, programming and follow up. Operations sub division is responsible for planning of operations, implementation and statistics, and image processing. Technical support subdivision is responsible for operating systems, database and training sections. The department has computerized all the primary health care centres. When a patient visits a clinic, his ID card is entered in the computer and his data can be retrieved from the server. The doctor examines the patient and enters the patient's information including diagnosis that is linked with the pharmacy for collection of medicines. The birth and death registration system has also been computerized and currently the department is in the process of computerization of regional and specialized hospitals, wireless networking and developing a health and demographic database.

The department of public health in Ministry of health is mainly responsible for prevention of diseases. It has 4 divisions. 1) Disease control division responsible for prevention and control of communicable and non communicable diseases, environmental sanitation, food handler's services and epidemic control. 2) Port and border division, which enforces international health regulations and also responsible for screening of expatriates for communicable diseases, HIV/AIDS, TB and hepatitis. 3) Public health laboratory with sections on microbiology, hemo-chemistry virology and malaria control and 4) Rodent and insect control division. The public health department receives data on preventive services directly from the health centres and hospitals and it issues a detailed weekly report that includes EPI, disease surveillance and other preventive activities. The information is also sent to the department of statistics and medical records.

The flow of data is quite intricate. From Primary health care centres, patient record and outpatient data is entered in the computers by the statistical clerks and reported manually to department of statistics and medical records and copies sent to regional health directorate. The outpatient data include, new and follow up cases, nationality and morbidity along with personal information of each patient. Data on preventive services

goes directly to the central department public health. From secondary and tertiary care levels, number of outpatients and detailed inpatient data is reported to department of statistics and medical records as well as to the regional health office, while preventive services data flows separately to the public health department. Each regional and specialized hospital has a statistical unit within a medical records department which is responsible for collecting morbidity and inpatient data. Administratively, the unit belongs to the region. Outpatient clinics and operation theatres have their separate data collection and reporting system. In all, a hospital sends 8 different reports (forms) to the department of statistics and medical records through regional office every month. They send weekly reports to the director of the hospital. Hospitals also generate their own detailed annual reports.

Figure3. Health information system organization and flow of information



The regional tier between the facilities and central departments is not well established. Although the data from PHC centers and hospitals is sent to the regional health offices, there seems to be limited capacity and facilities at the regional level for analysis and the main responsibility for compilation and analysis still lies with the central department of statistics and medical records. Regional offices receive the data, compile and send it to the central department of statistics and medical records, which also receive data directly from hospitals. Regional health offices produce their own reports. Ministry of health is planning to integrate the data flow by actively involving the regional offices and to have all data from facilities go first to regional offices and then to the central department.

There is no law or regulation that requires private health sector to report data. According to the MOH, almost all the private hospitals report on a regular basis based on an official letter from the ministry. Collection of data from private clinics is still an issue but the Ministry is now working to resolve this issue and to ensure that data is received from all private facilities. Same forms are used as in the public sector and the private sector report on inpatients and number of outpatients.

Data reporting is almost 100% from public facilities. Timeliness of data is also not an issue as most of the hospitals and centres send their reports within the designated time (report for previous months is sent before 10th of next month). However, sometimes there are delays in getting morbidity data from facilities and from private sector. Operational policies and specific guidelines for data collection and reporting are available and used in training of staff.

The quality and completeness of data is good. There are several mechanisms to verify and validate the data from health facilities. The error rate is less than 5% and if the information is found to be incorrect or incomplete, it is sent back to the concerned facility. Monthly meetings are held with the staff of statistical departments in hospitals to discuss and resolve issues related to information system. Regular training workshops and refresher courses are also organized for the staff in how to fill in the forms and to improve the data quality.

Data is analyzed on most of the internationally comparable indicators with a strong focus on curative care. Preventive services data is not part of the routine health information system and it is not reported in annual statistical report. Comparative analysis is conducted between hospitals and health facilities as well as between regions. Data is also analyzed overtime to see the trends. There are no specific guidelines for analysis of data. The statistics section decides on what analysis to be done based on their understanding of importance. All raw data is kept with this section and it can be analyzed differently or in more detail upon requests. The feedback is provided to the facilities and hospitals in the form of compiled quarterly and annual reports to inform them of their performance. These reports are also sent to the regional offices and most of the departments in the ministry of health. According to the MOH officials, the information generated is used for decision making, planning, budgeting and research. MOH health plans are also developed based on the information from routine information system. There are other examples of changes in plans and decisions based on these reports e.g. expansion of services or building new hospitals.

The information system is computerized only at the primary health care level and some of the hospitals and specialized clinics. Data is entered in the computers but the reports are sent manually and again entered in the computers in the department of statistics and medical records for compilation and analysis, which is very time consuming and labour intensive. There is a strong need to computerize the system at all levels and to develop an integrated health information system, covering both curative and preventive service from all levels of care.

5.4 Health Systems Research

Priorities of Health Research

- Applied research aiming at management and prevention of common diseases in Kuwait.
- Applied research affecting the health of larger strata of the population.
- Basic health research that serves the developmental strategies of the country, in particular those with industrial and economic applications.
- Field surveys aiming at determination of magnitude of common diseases in Kuwait in order to assist health administration to set preventive and management plans for such diseases.

- Research aiming at evaluation of existing health systems and procedures, and testing new health systems and protocols.
- Multidisciplinary research involving health sciences and other disciplines like social, environmental and safety.
- Promote health and health education in relation to leading causes of death in Kuwait, and health behaviour and lifestyle.
- Thus research priorities in Kuwait can clearly define the health problems and evaluated the appropriate service, the providers of such a service and evaluate those who make use of it, along with enhancing the ways of supporting the continuity of financing and improving it in a way that ensures the patients safety and consolidates health with its comprehensive concept, by setting the right health strategies.
- Research priorities concentrate on fighting the main reasons of diseases and death: diabetic mellites – heart diseases due to arteries – embolism – tumors- genetic diseases – contagious diseases – accidents – psychological diseases- overweight – mouth and dental health – osteopsathysosis – protection against diseases.

Research Units

- Kuwait Institute for medical specialization health systems researches unit
- The planning and follow-up department health systems researches unit
- Statistics and Medical Records department
- Food and Catering department

5.5 Accountability Mechanisms

- A system for cost accounting was introduced in the Ministry since the seventies
- The system depends on dividing the work centers and service centers in the ministry to cost centers (Treatment Prevention services)
- The theory of used power is applied to health services as it is considered suitable for the work circumstances from the practical point of view due to its being connected with the size of activity with disqualification of the non-used power.
- Analysis takes place on several levels :
    1. Compiling Level: Treatment activity centers, prevention, assisting medicine, general services, financial, administrative, etc.
    2. Analytical Level: clinics, wards, x-ray, laboratories, alimentation, transport, general services and management.

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2002
Total health expenditure/capita,	-	-	537	552
Total health expenditure as % of GDP	-	-	3.9	3.8
Investment Expenditure on Health	-	-	-	-
Public sector % of total health expenditure	-	-	78	75.2

Source: http://www.who.int/countries/kwt/en/index.html
The world health report 2005

Table 6-2 Sources of finance, by percent

Source	1990	1995	2001	2002
General Government	-	-	78.1	75.2
Central Ministry of Finance	-	-	78.1	-
State/Provincial Public Firms Funds	-	-	-	-
Local	-	-	-	-
Social Security	-	-	0	-
Private	-	-	21.2	24.8
Private Social Insurance	-	-	-	-
Other Private Insurance	-	-	-	5.7
Out of Pocket	-	-	21.2	94.3
Non profit Institutions	-	-	-	-
Private firms and corporations	-	-	-	-
External sources (donors)	-	-	-	-

Source: http://www.who.int/countries/kwt/en/index.html

The government spent 6.7% of its 2002/03 budget on health services, a significant rise in value terms on the previous year, when it represented 6.3% of a smaller overall outturn. Concerns about spiraling healthcare costs have been addressed through the introduction of a law requiring expatriates to pay for the use of public hospitals and clinics. The introduction of healthcare charges made a noticeable impact on actual revenue received during the first nine months of the 2001/02 fiscal year. Income from health services almost trebled to KD26.5m (US$86.3m) during this period from KD9.4m during the corresponding months of 2000/01. The Ministry of Health is the third largest public-sector employer after the ministries of education and interior, but only half of its

28,000 staff are Kuwaiti. The ratio of doctors and nurses per head of the population is higher in Kuwait than in other Gulf countries, according to data for the numbers of Kuwaiti staff provided in the latest *Statistical Abstract* published by the Ministry of Planning.[5]

Trends in financing sources

- The cost of health service was increased during the recent years due to increase in the cost of labor, medical equipment and medicine, in addition to the increase of population and the increase of prices in general.
- Expatriates visits were relatively controlled via the application of visiting fees
- Financial revenue was achieved via the application of the visiting fees and the health insurance system on expatriates.

Trends in health expenditures by category:

PROGRAMS	92/93	%	96/97	%	99/2000	%
The program of the ministry head office	13,250,341	5.5	13,783,817	5.3	15,870,095	5.9
Program of preventive health & environment protection	13,214,213	5.5	11,560,790	4.5	9,666,006	3.6
Program of the first case and public hospitals	138,940,518	58.5	144,998,778	55.9	142,288,247	53.3
Program of hospitals and specialized health centers	50,743,727	21.2	67,338,928	25.9	77,317,994	29.0
Program of the assistance technical services	14,933,152	6.2	14,400,750	5.5	13,377,173	5.0
Program of health researches, education and training	1,313,148	0.5	1,134,183	0.4	1,092,004	0.4
Program of public services	73,448,852	3.0	6,374,559	2.5	7,404,478	2.8
Total	**2397433951**	**100**	**259591805**	**100**	**267015997**	**100**

*Values in Kuwaiti Dinars

- During the time course of preparing the study the total cost of the health service increased, despite the fact that the increase during the first period is larger than that of the second period.
- A relative decrease in spending on the general health programs and primary health care program took place compared to the relatively high cost of hospitals and programs.

6.2 Tax-based Financing

Levels of contribution, trends, population coverage, entitlement

Not applicable

Key issues and concerns

Not applicable

6.3 Insurance

The government's policy of health insurance became effective in 1999 and was implemented on both citizens and expatriates based on the ministry's intention to establish hospitals for those covered by this health insurance. The ministry's aim was to lease out these hospitals on contract basis to provide expatriates with medical facilities. Kuwait's residents were to receive treatment at these specially designated insurance and private hospitals. This was planned with the aim of decreasing the pressure on government hospitals and giving them an opportunity to provide better health services for those not covered by the health insurance system,

From 10th April, 2000 health insurance was made mandatory for expatriates. No residence is renewed unless the premium for health insurance is paid and the renewal period is also linked to the period of health insurance coverage. Expatriates holding health insurance from local private insurance companies will be allowed to renew their residence for the period of validity of the insurance. However, for holders of private insurance, the Ministry will charge KD 4 for each visit to health clinic besides the one dinar charge. They will also have to pay for medicine, laboratory tests and radiology scans. Visit to the outpatient clinic will cost KD 6, stay at public hospital KD 10 per day, KD 80 per day at an intensive care unit and KD 5 per day for stay at a psychiatric hospital. Expatriates covered by private insurance companies will also have to pay KD 10 per visit to a birth registration clinic. The charge for normal delivery is KD 200 inclusive of a three day stay at a hospital. Any overstay will cost KD.10 per day.

Insurance coverage exempts expatriates from paying daily inpatient charges when they receive medical treatment in hospitals, in addition to exemption from charges of medical operations, pharmaceuticals, and laboratory analysis and X-ray. They also receive 50% subsidy on specialised tests and analysis such as CT-Scan, Nuclear Magnetic Resonance, Sonar and hormonal analysis.

The Health Ministry intends to review the procedures of implementing its policy of health insurance, Collection of charges against this health insurance and the procedures of collecting the outstanding amounts from the insurance companies which have been accumulating for the past five years will also be reviewed. [11]

The law of Health Insurance No.1 of 1999 applies only on expatriates. All expatriates are registered under the protection of governmental or private sector health insurance.

Private Medical Insurance

Medical insurance, from companies such as Expacare, BUPA and ARIG, can be bought in Kuwait. Local group insurance often requires a minimum of 15 persons, with an annual premium of about KD75 per person for a cover of KD 5,000 for both inpatient and outpatient treatment with an excess of 20%. For individuals there are some local medical insurance schemes (about KD125 per year) but the cover provided, the exclusions and age limits sometimes leave a lot to be desired.

Table 6-3 Population coverage by source

Source of Coverage	1990	1995	2000	2002
Social Insurance	-	-	-	-
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	--	-
Uninsured/Uncovered	-	-	-	-

Trends in insurance coverage

New plans for Insurance coverage for expatriate workers are being finalized.

Social insurance programs: trends, eligibility, benefits, contributions

The health insurance set out in law covers the following basic health services:

- The medical examination and the necessary treatment in clinics of general practitioners and specialists
- Laboratory and radiological investigations
- Surgical operation excluding plastic surgery.
- Treatment medicines and hospitalization expense to ordinary and emergency cases
- Ordinary dental treatment

Private insurance programs: trends, eligibility, benefits, contributions

Same as above

6.4 Out-of-Pocket Payments

(Direct Payments) Public sector formal user fees: scope, scale, issues and concerns

- Governmental health services are free for citizens.
- Expatriates pay the amount of K.D 1 upon visiting primary health care centers
- Expatriates pay the amount of K.D 2 upon visiting the clinics of general hospitals and specialized hospitals

- There are some symbolic fees on some examinations
- Expatriates pay annual health insurance fee of K.D 50 for labour, K.D 40 for wife, K.D 30 for children up to 18 yeas old and K.D 5 for housemaids and non-nationals.

(Direct Payments) Private sector user fees: scope, scale, type of provider involved, issues and concerns

Average individual spending on health care services is about K.D. 2.250

Public sector informal payments: scope, scale, issues and concerns

Not applicable

Cost Sharing

Token fees have been established at the Public facilities to discourage frivolous use of health facilities.

Via health insurance for the expatriates

6.5 External Sources of Finance

Kuwait does not depend on external assistance for the financing of its health sector. Kuwait is a net donor of funds for supporting the health sector of other Islamic countries in the Region.

6.6 Provider Payment Mechanisms

Hospital payment: methods and any recent changes; consequences and current key issues/concerns

Governmental health services are financed through the governmental budget.

Payment to health care personnel: methods and any recent changes; consequences and current issues/concerns

Salaries of the staff working in governmental health services are paid through the governmental.

7 HUMAN RESOURCES

7.1 Human resources availability and creation

Table 7-1 Health care personnel

Personnel per 100 000 pop	1994	1995	2000	2002	2003
Physicians	1.41	1.87	1.6	1.6	1.9
Dentists	0.18	0.28	0.30	0.30	0.3
Pharmacists	N.A	0.26	0.33	0.26	0.21
Nurses midwives	4.39	5.0	4.1	4.1	4
Paramedical staff	N.A	2.0	2.9	2.8	2.8
Community Health Workers	N.A	-	-	-	-
Others	N.A	3.1	4.3	3.5	3.4

Source: [a]Eastern Mediterranean Regional Office Database: reports from member states

Trends in skill mix, turnover and distribution and key current human resource issues and concerns

In 2003, the manpower rates per 10 000 population were 19 for medical doctors, 3 for dentists, 2.6 for pharmacists, 40 for nurses and mid wives, 21 for hospital beds and 3 for PHC units. Table 1 gives the breakdown of health human resource in Kuwait, and its distribution by Kuwait and non-Kuwait population.

During the study period the rates of medical doctors, dentists and supporting medical services increased, while there was a relative decrease in the rates of nursing staff and other human resources.

Table 1: Health Human Resource Profile in Kuwait - 2003

Cadre	Kuwaitis	Non-Kuwaitis	Total
Physicians	1718 (40%)	2537 (60%)	4255
Pharmacists	152 (29%)	380 (71%)	532
Managers	6622 (91%)	669 (9%)	7291
Technicians	4245 (62%)	2650 (38%)	6895
Nurses	984 (11%)	8013 (89%)	8997
Support Staff	511 (69%)	229 (31%)	740
Ancillary staff	82 (11%)	693 (89%)	775
Total	14314 (49%)	15171 (51%)	29485

Source: Ministry of Health Kuwait

Kuwait has ratios of health professionals to population higher than the regional average in all categories except for pharmacies. There is an excellent national system of Continuing Professional Development (CPD) for all categories of health workforce.

Table 7-2 Human Resource Training Institutions for Health

	Current		Planned		
Type of Institution*	**Number of Institutions**	***Capacity**	**Number of Institutions**	**Capacity**	**Target Year**
Medical Schools	1		1		
- B.M.B. Ch		72		125	2025
- Masters/PhD		8		15	2025
Postgraduate training institutions	1	300	1	600	2025
Schools of Dentistry	1	24	1	40	2025
Schools of Pharmacy	1	38	1	35	2025
Nursing Schools	1	360	1	360	2007
- Nursing institute	1	420	1	750	2007
- Nursing college					
Midwifery Schools	0		0		
Paramedical Training Institutes	1	120	1	360	2025
Schools of Public Health	0		0		

Source:

Information regarding the paramedical training programs in this table pertains only to the Faculty of Allied Health Sciences at the Health Sciences Center (HSC). The Public Authority for Applied Education and Training also has a paramedical training program, but capacity and planned capacity fro their training program, is not available for HSC. PAAET should provide the information from their program, and it should be added to the 'Paramedical Training Institutes' information in this table for the final submitted document (i.e. the final document should list "2" institution, with the combined capacity from both.

Accreditation, Registration Mechanisms for HR Institutions

Faculty of Medicine:

- Registration from the World Health Organization since 1978
- Planning registration with the World Federation for Medical Education
- Self-Evaluation Process and External Review by Harvard Medical, International, completed and approved 2004/2005.

Faculty of Dentistry

- The faculty will undergo an assessment process with the Association of Dental Education in Europe (ADEE). The Assessment group will also include member of the American Dental Education Association (ADEA) in November 2005.
- Preliminary discussions is on with American Dental Associations for an accreditation visit as soon as it begins oversees accreditation program

Faculty of Pharmacy

- The faculty is currently undergoing a self-evaluation process for the B.Pharm through the ACPE (USA)

Faculty of Allied Health Sciences

- The four departments in the Faculty are currently preparing the documentation for accreditation of their program. Accreditation of two programs is expected within the next 1- 2 years. Two departments may opt for benchmarking their programs.

Kuwait Institute for Medical Specialization (KIMS)

- Self-evaluation of the training programs have been undertaken by the institution
- Review the postgraduate training programs by external reviewer
- Evaluation of the postgraduate training programs and the MPC Program (for CME/CPD) by WHO expert have been completed
- MPC Program of KIMS has been granted substantive recognition by Royal College of Physicians and Surgeons of Canada and recognized by The Royal College of Pathologists, UK.

7.2 Human resources policy and reforms over last 10 years

Kuwait is still relaying and will continue to relay for many years to come on non-Kuwaiti health professionals to support the expanding health system. The variation in quality is huge and a system of recruitment to minimize variation is urgently needed. It will take sometime before such a variation could be overcome.

Faculty of Medicine:

- The faculty of Medicine works closely with Kuwait institute of Medical Specialization and the Ministry of Health in determining the human resource needs of Kuwait with respect with the number of graduating physicians each year.
- The number of medical graduates from the faculty of Medicine has averaged around 70 graduates per year over the past 10 years.
- The faculty of Medicine consists of over 170 faculty members, and has a specific policy of increasing the percentage of Kuwaiti faculty members
- Currently the Kuwaitis comprise 47% of all faculty members and 76% of all clinical faculty members

Faculty of Dentistry

- The faculty plans to graduate an average of 24 students per year until the training facilities permit an annual intake of 40 students.
- The faculty is new and therefore the human resources needs for training has been largely expatriates

- Increase in the number of Kuwaiti faculty staff has been planned as follows:
  - Transfer of qualified Kuwaiti dental specialists from the Ministry of Health to the faculty as academic staff
  - Introduction of Kuwait University Scholarship scheme for the Faculty of Dentistry to train qualified Kuwaitis abroad in different Dental specialties.

Faculty of Pharmacy

- No information on HR policy and past reforms was provided by the faculty of Pharmacy

Faculty of Allied Health Sciences

- Faculty of Allied Health Sciences works closely with the Ministry of Health in determining the human resource needs of Kuwait with respect to the number of graduating professionals in each of the Allied Health professions each year.
- The faculty is moving towards Kuwaitisation of its teaching staff, and now has 41 Kuwaiti Assistant and Associate professors
- The average number of gradates from the Faculty of Allied Health Sciences over the past 10 years is 60 graduates per year.

Kuwait Institute for Medical Specialization (KIMS)

- Change of overall policy to ensure that the postgraduate training is offered to prospective trainees on the basis of health care specialty needs of the country instead of the individual trainee's preference of specialty.
- The new postgraduate training programs have been established so that training is now offered in nearly all the specialties of medicine, with training opportunities made available locally or abroad, in collaboration with internationally recognized postgraduate training institutions
- Acceptance of the need for a formal scheme for continuing education for health professionals and the establishment of the MPC Program which now covers physicians, dentists and pharmacists, and which could be expanded to benefit other categories in due course
- Establishment of close links with other countries in the GCC region and the formation of GCC Committee for Postgraduate Training, with the aim of collaboration among training institutions and optimization of the resources.

7.3 Planned reforms

Faculty of Medicine

- Given the increasing population of Kuwait and the trends towards Kuwaitization of the physician workforce in Kuwait, the medical school is planning to increase the size of the graduating class to 125 per year by 2025
- A new campus for the faculty of Medicine, complete with an affiliated teaching hospital under the direction of the faculty of Medicine, is planned to become operational in 2015
- Although there are no schools of Public Health in Kuwait, the Faculty of Medicine is planning to introduce a Masters of Public Health Program within the next two years. The program has been approved by the University, but is awaiting recruitment of two or more essential faculty members before the program can be implemented.

- Curriculum reforms for the Medical School planned for the 2005 – 2010 period include:
  - Restructuring of teaching into a system-based curriculum and increased case-triggered learning
  - Phased integration of basic science teaching and clinical teaching
  - Insertion of Evidence-based Medicine skills teaching and practice into the curriculum.

Faculty of Dentistry

- Increase in the number of graduating dental practitioners; the faculty plans to increase the annual graduating dental practitioners to 40 as soon as necessary faculty become available.
- Permanent Clinical Facilities: the faculty plans to have a permanent clinical facility for the student education, clinical practice of faculty and research as part of the Teaching Hospital Complex of the Health Sciences Centre by 2015.
- Postgraduate Dental programs: the faculty plans to provide postgraduate dental education in all fields of Dental specialization from 2010.
- Curriculum reform: in line with the planned curriculum reform by the Faculty of Medicine , the faculty will be embarking on restructuring of the undergraduate's dental curriculum,
- Continuing Dental education: the faculty plans to intensify its role in providing avenues for continuing dental education in Kuwait and to serve as resource center for knowledge and skills development for all dental practitioners in Kuwait.
- Outreach community Service: the faculty plans to provide outreach dental services and education to the Community especially for the disadvantaged and underserved population of the country.

Faculty of Pharmacy

- Kuwaitization Policies will be more rigorously applied, to achieve total kuwaitization of pharmacists working in MOH by 2018.
- The new campus will allow for better clinical training and more expanded integrated facilities in the new campus by 2025.
- Curriculum reforms will be on the agenda after the ACPE evaluation of the B. Pharm Programme. Pharm D. and Post-graduate programmes may be started in the next 5 years, when the faculty reaches its critical mass of tutors and facilities and curriculum review.

Faculty of Allied Health Sciences

- The faculty is moving towards a teaching staff comprised only of Ph.D holders
- The faculty is planning to increase the number of graduates from each program in order to fulfils the aim of providing a Kuwaiti workforce of Allied Health professionals for the MOH, and for the private sector hospitals at a later stage.
- Two new undergraduate programmes in Speech Therapy and Occupational therapy will be established when the needed resources are available. The faculty plans to propose the establishment of additional programmes in the mid-term.

- The Faculty plans to establish Master's programmes in addition to a Master's in Medical Laboratory Sciences which has already been approved. Specific Diplomas and Ph.D programmes shall also be established.

Kuwait Institute for Medical Specialization (KIMS)

- An extensive study on the health workforce needs of Kuwait has been completed so that the data could be used as the basis for planning for undergraduate as well as postgraduate training in the fields of medicine, dentistry and nursing. (details available at www.kims.org.kw)
- The MPC program, which at present covers physicians, dentists and pharmacists will be expanded to other health to other health professionals
- The measures already taken by KIMS to get health professionals to use online learning will be expanded so that this form of learning will constitute a major component of the learning media available to the practitioner. The format of the MPC Program is being reviewed with the aim of encouraging reflective practice and rewarding it within the scheme.
- Measures will be taken to enhance quality assurance in postgraduate medical education
- Implementation of training will be reviewed to ensure that the guidelines for postgraduate training and continuing education recommended by the World Federation for Medical Education would constitute the basis fro training as applicable.
- Specialty training for health professionals will be expanded to include newer specialists that are being recognized as playing a significant role in the delivery of Health care services.
- Cooperation and collaboration with postgraduate training institutions and CMECPD authorities in the other GCC countries will be promoted by providing guidance in establishing CME programs where relevant and by sharing the extensive collection of education planning materials that have been published by KIMS during the past five years.

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

Table 8-1 Service Delivery Data and Trends

TOTAL (percentages)	1990	1995	2000	2002
Population with access to health services	100	100	100	100
Married women (15-49) using contraceptives	-	-	50*	-
Pregnant women attended by trained personnel	-	99	100	100
Deliveries attended by trained personnel	99	100	100	100
Infants attended by trained personnel (doctor/nurse/midwife)	100	100	100	100
Infants immunized with BCG****	-	0	0	0
Infants immunized with DPT3	76	100	98	98
Infants immunized with Hepatitis B3	-	94	100	100
Infants fully immunized (measles)	63	98	99	99
Population with access to safe drinking water*	100	100	100	100
Population with adequate excreta disposal facilities***	100	100	100	100

*Source: **Country profiles for population and reproductive health. Policy developments and indicators 2003

URBAN (percentages)	1990	1995	2000	2002
Population with access to health services	100	100	100	100
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	98	100	100
Deliveries attended by trained personnel	-	100	100	100
Infants attended by trained personnel	100	100	100	100
Infants immunized with BCG	-	0	0	0
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	100	100	100	100
Population with adequate excreta disposal facilities	100	100	100	100

Source:

RURAL (percentages)	1990	1995	2000	2002
Population with access to health services	100	100	100	100
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	100	100	100
Deliveries attended by trained personnel	-	98	100	100
Infants attended by trained personnel	100	100	100	100
Infants immunized with BCG	-	0	0	0
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	100	100	100	100
Population with adequate excreta disposal facilities	100	100	100	100

Source:

Access and coverage

Access to primary care:

Owing to the small size of the country and the resources available, access to health care is universal.

There is 100% access to P.H care. In each area in Kuwait, there is a health center.

Access to secondary care:

Same is true for secondary care

There is 100% access to secondary care. In each region in Kuwait, there is a general hospital.

8.2 Package of Services for Health Care

Complete package is available for health care that includes;

- Preventive and promotive services
  - Health education and nutrition
  - Vaccination
  - Growth and Development follow-up
- Curative Services at:
  - Primary health care level
  - Secondary health care level
  - Tertiary health care level.

8.3 Primary Health Care

Infrastructure for Primary Health Care

Primary health care is delivered through a series of health centers, with general or family health clinics, maternal and child care clinics, diabetic clinics, dental clinics, and preventive care clinics, school health services, ambulance services and police health services are also available. Foreign residents are entitled to treatment here. The clinics deal with preliminary examinations and routine matters and where necessary, patients are referred to hospital specialists.

There are 72 primary health centres spread over the country. The services offered by them include general practitioner services and childcare, family medicine, maternity care, diabetes patient care, dentistry, preventive medical care, nursing care and pharmaceuticals.

Settings and models of provision

Primary health care is provided through the health centers preventive & curative services are provided to all population, Kuwaitis & non-Kuwaitis, to all age groups with special care to mothers and children.

Public/private, modern/traditional balance of provision

Public-private ownership mix;

At present we don't have this system.

Public Sector:

About 97% of PH care services are provided by Government, in a modern way of provision.

Primary care delivery settings and principal providers of services; new models of provision over last 10 years

In addition to the general practice services some health centers have mini clinics for chronic diseases and for health promotion, also some health centers (10%) have applied the family doctor system.

Public sector: Package of Services at PHC facilities

All items of the PHC are provided to the population mostly by the MOH, other items e.g. supply of safe water, basic sanitation are provided by other ministries in collaboration with the MoH.

Private sector: range of services, trends

There are many private clinics and hospitals in Kuwait. The Government monitors them, ensures a high standard and regulates the fees charged. Most private hospitals have their own pharmacies. Most private hospitals are also general hospitals with some specialty departments.

Despite the excellent comprehensive services provided by the public health service, private hospitals and clinics thrive in Kuwait. The MPH regulates standards and the fees they may charge. The private hospitals and clinics have their own pharmacies. Most of them are general hospitals with some specialist departments. Some have limited

equipment, such as ICUs, or specialists and refer patients to government hospitals for special procedures.

Private clinics are usually staffed by doctors of a particular specialty. There are several private dentists and dental clinics providing services to international standards. Orthodontics is only available to expatriates through these dentists and clinics.

The Ministry of Health has approved the applications of 35 private companies to set up private hospitals in Kuwait. A decision is also issued allowing cooperative societies, private hospitals and Kuwaiti doctors to open private clinics for general practice in residential areas.

Small number of private clinics are provided only curative services by family doctors or by general practitioners

Referral systems and their performance

There is a referral system from primary health care to secondary health care but we still have problems with the feedback from hospitals to the primary health care centers.

Utilization: patterns and trends

About 97% of the population is using Government health centers. 3% seek the treatment directly from hospitals and specialized centers, private and governmental.

Current issues/concerns with primary care services

- A variety of disease pattern due to presence of persons from different parts of the world.
- To introduce geriatric services at PHC level, and establish mini clinics for Chronic health problems and for preventive & promotive services e.g. well baby clinic- breast feeding clinics and no smoking clinics.

Planned reforms to delivery of primary care services

To provide all the health centers with maternal care, diabetic clinic, and laboratory and mini clinics for chronic health problems.

8.4 Non personal Services: Preventive/Promotive Care

- **Availability:** available
- **Affordability:** free
- **Accessibility:** accessible and acceptable

Organization of preventive care services for individuals

Department of General Health – The Central Administration for Primary Health Care and Health Education Department are the entities concerned with the preventive services in the MOH.

Environmental health

The Public Authority for environment is concerned with environment health.

Environment - current issues:

Limited natural fresh water resources; some of world's largest and most sophisticated desalination facilities provide much of the water; air and water pollution; desertification

Environment - international agreements:

Party to: Climate Change, Desertification, Environmental Modification, Hazardous Wastes, Law of the Sea, Nuclear Test Ban, and Ozone Layer Protection signed, but not ratified: Biodiversity, Endangered Species, Marine Dumping.

The Environment Public Authority (EPA) was established in 1995. This law was, later, amended in 1996. According to this amendment, the authority consists of the High Council, which defines EPA's aims and objectives and policy. It is headed by the First Deputy Prime Minister and the Foreign minister and has the following members:

- The Minister for Health
- The Minister for Planning
- The Minister for Oil
- The Minister for Commerce and Industry
- The Minister for Communications
- The Municipality Chief
- The Chairman - the Director General of the Public Authority for the Agriculture Affairs and Fish Resources

The High Council of the EPA also includes, for four renewable years, three qualified and experienced individuals in the field of environment protection and the Director General is the rapportteur of the council.

The responsibilities of the EPA are to:

- Prepare and apply public policy for the protection of environment and prepare strategies and action plans to achieve sustainable development.
- Prepare and supervise the execution of the complete action plan relating to the protection of the environment.
- Control the activities, procedures and practices concerned with the protection of the environment.
- Identify pollutants and specify environmental criteria and standards and prepare regulation and systems for the protection of the environment
- Prepare and participate in directing and supporting environmental researches and studies.
- Identify the problems resulting from environmental pollution and deterioration with the assistance of the state agencies.
- Study and review the ratification or accession of the regional or international conventions related to environmental protection.
- Prepare an integral action plan for training citizens on the means and ways of environmental protection
- Study environmental reports submitted to it relating to environmental conditions of the country.

The EPA has recently promulgated a 10-year strategy aimed at protecting Kuwait's environment, and addressing specific concerns about the atmosphere, water resources,

environment preservation, education and awareness as well as industry and power. The strategy includes many laws aimed at protecting and maintaining buildings, heritage and archaeological sites. Old mosques and historical buildings are being renovated. It also provides a safe environmental framework to protect and preserve components of the infrastructure and the urban environment. The strategy also includes education and awareness programs on environment protection and preservation.[8]

Health education/promotion, and key current themes

The Health Education Section is responsible for education & promotion. The focus for this section is fighting chronic diseases, through changing attitudes and behaviors related to unhealthy lifestyle. Thus, promoting healthy diet and exercise to adopt a healthy life style.

Changes in delivery approaches over last 10 years

A program for health enhancement was recently introduced including 12 subsidiary programs that aim at fighting the most important causes for morbidity and mortality in the State of Kuwait.

Current key issues and concerns

See previous item

Planned changes

See above

8.5 Secondary/Tertiary Care

Secondary care is provided through six regional hospitals with 2500 bed capacity, each serving about 300 000 people. In addition to this these are 9 tertiary care (specialist hospitals) including maternity, infectious diseases, mental health and cancer hospitals bringing the total beds available to 4575, with total bed occupancy around 60 percent. These hospitals consume the largest proportion of the public health budget, despite moderate bed occupancy and high pressure on primary care services.

The regionalization of the health care delivery system is now complete so that each of the six general hospitals, along with a number of health centres which refer to it, constitutes a health region. This new health region system has allowed better community involvement and better planning through identification of local health problems. It has also allowed for better management and more efficient use of resources. The regionalization of the health system, which covers six health regions, has also resulted in more efficient delivery of health services. Regional directors of health are involved in the planning process as well as in itemization of the budget and recruiting of human resources. They are responsible for annually reporting on the activities of their regions[12].

Public Hospitals

Kuwait is divided into five Health Regions. Each region has a general hospital -- the Amiri Hospital in Kuwait City, Jahra Hospital in Jahra, Farwaniyah Hospital in Farwaniyah, Mubarak Al-Kabir Hospital in Jabriya, and Adan Hospital in Fahaheel. Each general hospital provides an outpatient service and a 24-hour emergency service.

Kuwait also has several specialty hospitals, covering a range of specializations from chest and heart diseases to neurosurgery, pediatrics, obstetrics and gynecology, burns, cancers, radiology, nephrology, infectious diseases, ophthalmology, physiotherapy, and psychiatry.

Dental Clinics

The main public dental clinic is behind the Amiri Hospital in Kuwait City. There are many other public dental clinics throughout the country; most of which are attached to local medical clinics.

Maternity Care

Many of the general hospitals run by the Government have maternity wards. The government-run Al-Sabah Maternity Hospital in west Shuwaikh, is probably one of the best maternity hospitals in the world, providing a comprehensive range of ante-natal, delivery and post-natal care. The Al-Sabah Maternity Hospital is equipped with state-of-the-art technology, including more than 100 ICUs, and a highly trained and dedicated staff.

There are also several private hospitals offering maternity care. All maternity hospitals, public or private, require a couple's marriage certificate for their records.

Blood Banks

The blood bank is situated in Jabriya. Equipped with the latest technology, it supplies blood to public and private hospitals in Kuwait. Donors are always welcome. Relatives of those undergoing operations are requested to make donations in order to maintain supplies.

Opticians

Sight tests are usually free and prices for prescription lenses are fairly reasonable. Common corrective lenses are available from stock and new glasses can be delivered within 48 hours. Persons with complicated prescriptions may have to wait several weeks, as the ground lens must be imported from abroad.

Hospital visiting hours vary and are normally restricted to the afternoon. The number of visitors to a patient allowed during visiting hours is not usually limited, though sometimes when things get extremely crowded only two visitors at a time are allowed in together.

Health Care Charges

Kuwaitis receive medical services at government clinics and hospitals free of charge. Before 1994 expatriates were entitled to free medical services but now they must pay for certain procedures as well as prosthetic items.

Neither Kuwaitis nor expatriates are charged for medications obtained from pharmacies in public hospitals and clinics on prescription from a hospital doctor, provided the patient's civil ID card number is shown on the prescription. However a doctor may no longer provide about 80 expensive drugs for expatriates, though an expatriate patient can always ask the doctor for a prescription and then buy the medicine himself.

Table 8-2 Inpatient use and performance

	1990	1995	2000	2003	2004
Hospital Beds/1,000	-	2.6	2.2	2.1	2
Admissions/1000	-	9.9	8.1	7.1	8.1
Average LOS (days)	-	5.4	5.3	5.3	-
Occupancy Rate (%)	-	67.6	67.2	65.5	-

Public/private distribution of hospital beds

The government sector provides 90% of the available beds (4575) in 15 hospitals whereas the private sector is limited to 559 beds in 7 hospitals.

Key issues and concerns in Secondary/Tertiary care

- Rehabilitation of general and specialized hospitals is taking place.
- New departments were introduced for medical causality (emergency)
- A computer program is under application for connection with the primary health care centers and other utilities in the Ministry.
- Programs are under the application for developing performance and health quality control in hospitals.

Reforms introduced over last 10 years, and effects

Refer to previous item

Planned reforms

Refer to previous item

8.6 Long-Term Care

8.7 Pharmaceuticals

Percentage of purchase from the local & regional (gulf area) companies to the total purchase price of medicines 9.3% while the percentage of purchase from foreign companies to the total purchase price of medicine will be 90.7%

8.8 Technology

Trends in supply, distribution of essential equipment

The needs of the utilities of the MOH for medical equipments are being provided via the purchasing system and maintenance contracts with the agent companies

Effectiveness of controls on new technology

Periodical upgrading of the medical equipment takes place via following-up the new issues in the field

Reforms over the last 10 years, and results

A study of the renting with maintenance system for medical equipment instead of purchase and maintenance.

Current issues and concerns

The national program for upgrading medical equipment is being carried out.

Planned reforms

The national program for upgrading medical equipment is being carried out.

9 HEALTH SYSTEM REFORMS

9.1 Summary of Recent and planned reforms

Currently there is a special interest in:

- Continuity of financial and technical support via the application of economics of health and privatization.
- Maintaining health gains and development of services
- Re-habilitation of health services and upgrading medical equipment
- Introducing a comprehensive system for health information
- Caring for the quality of health services

Determinants and Objectives

1. Structuring health system for guaranteeing comprehensive coverage of all citizens with a high quality service
2. Development of different levels of health services (preventive, treatment, rehabilitative)
3. supporting infra-structure of health organizations
4. upgrading the level of technical and professional performance of medical and technical cadres
5. Enhancement of health economics concerning service cost and finding other revenue generating resources for the budget.
6. Interest in the general health in the society
7. Developing emergency medical services to reach the highest possible level.
8. Providing modern technologies
9. Establishing an information center equipped with a network that covers all hospitals and is connected to primary health care centers
10. Providing effective and safe medicine for citizens
11. Development of private health sector
12. Aiding researching of supporting health systems to help decision
13. Makers identify points of strength and weaknesses as well as the problems and opinions of service providers and beneficiaries, taking procedure and setting suitable plans and programs.

Chronology and main features of key reforms

The referred to goals were embodied in the program of work plan of the Ministry for the period from 1999 till 2010

Process of Implementation; approaches, issues, concerns

Program included in the program and work plan of the ministry till the year 2010.

1. The National Program for Hospitals Qualification:- includes the construction works, amendments, comprehensive maintenance and increasing the number of beds
2. The National Program for Qualifying Primary Health Care Centers: includes renewal of the building of primary health care centers.
3. Program of Expansion in Health Utilities: Execution of new projects for a number of health centers and a public hospital.
4. Charity Projects Program: Establishing health utilities from the charity donations of individuals and organizations
5. Accreditation and Quality Control Program:- aims at the continuous development of provided health care services pursuant to official standard.
6. Program of Developing Working Force: aims at upgrading the level of staff working in the technical and administrative fields via increasing the rates of trainings, programs, symposium, conferences, in addition to the continuous medical learning programs.
7. Health Insurance Program: Aims at expansion in the system of health insurance of the expatriates via establishing three health insurance hospitals
8. Program of Encouraging the Private sector:- aims at continuing to encourage the private health sector and increasing its share in the health development of the country
9. Information Program: aims at establishing the unified electronic medical file of the patient by introducing the computer system to all the primary health care centers, general and specialized hospitals as well as the other utilities of the MOH.
10. The National Program for upgrading medical Equipment: aims at replacement of all the medical equipment with other developed and modern ones
11. Health Enhancement Program: Aims at limiting risks of non-infectious chronic diseases like diabetes, cardiac diseases, cancer, in addition to enhancing positive health behaviors.
12. Primary Health Care Program: aims at developing the Primary Health Care services
13. Getting Rid of Medical Waste program: aims at getting rid of the medical waste by a modern scientific way methods which prevent environmental pollution and protect the human health
14. The Emergency Medical Program aims at developing emergency medical services via increasing the number of ambulance cares by adding new developed ones, together with increasing the ambulance centers to cover all the areas, upgrading the communication system in addition to introducing a helicopter ambulance service to the field of medical emergencies

Progress with Implementation:

A good achievement percentage was achieved during the previous period and the other executive programs are being completed

Process of Monitoring and Evaluation of Reforms

Currently, execution is being followed-up by the MOH in addition to an annual follow-up by the Ministry Of Planning, the council of Ministers and the National Assembly.

Future Reforms

The program is continuous until 2010

Results/ Effects

The program is expected to be a new step towards improvement of the service, in addition to the continuity of the financial and technical support of the service.

10 ANNEXES

1. Organizational chart, Ministry of Health
2. Organizational chart Health areas (except AlSabah area)
3. Organizational chart, AlSabah specialized health area

11 REFERENCES

[1] UK Trade and Investment Site: https://www.uktradeinvest.gov.uk/ukti/appmanager/ukti/middleeast?_nfpb=true&portlet_17_933_actionOverride=/pub/portlets/advancedGeneric/displayDetail&portlet_17_933pathToItem=%2FBEA+Repository%2F327%2F226155

[2] Kuwait country profile Library of congress: http://lcweb2.loc.gov/frd/cs/kwtoc.html

[3] Country profile Kuwait: Economic Intelligence Unit

[4] http://lexicorient.com/e.o/kuwait_3.htm

[5] Country profile 2004The Economist Intelligence Unit Limited 2004.

[6] WHO, 2004. Country Cooperation Strategy for WHO and the State of Kuwait 2005 – 2009

[7] http://www.country-data.com/cgi-bin/query/r-7585.html

[8] http://www.kuwait-info.com/sidepages/health_over.asp

[9] Kuwait Information: http://www.kuwait-info.com/

[10] Country profile Kuwait 2001 http://www.emro.who.int/mnh/whd/CountryProfile-KUW.htm

[11] http://www.arabtimesonline.com/arabtimes/kuwait/Viewdet.asp?ID=5437&cat=a

[12] http://www.indiansinkuwait.com/kinfo163.asp

The Regional Health Systems Observatory is an undertaking of the WHO Regional Office for the Eastern Mediterranean. The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health systems in the EMR. Its primary goal is to contribute to the improvement of health system performance and outcomes, in terms of better health, fair financing and responsiveness of health systems. The aim of this initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health systems and to serve as repository of information on health systems.

This document is part of a series of in-depth health systems profiles, produced and updated by the Observatory using standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

World Health Organization

Regional Office for the Eastern Mediterranean
Abdel Razek El Sanhouri Street,
PO Box 7608, Nasr City, Cairo 11371, Egypt
Phone: +202-6702535, Fax: +202-6702492
URL: www.emro.who.int