

MEMOR

HEALTH SYSTEM PROFILE

Q A T A R



Regional Health Systems Observatory
World Health Organization

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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 have 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

Qatar forms one of the newer emirates in the Arabian Peninsula. After domination by Persians for thousands of years and more recently by Bahrain, by the Ottoman Turks, and by the British, Qatar became an independent state on September 3, 1971. Unlike most nearby emirates, Qatar declined to become part of either the United Arab Emirates or of Saudi Arabia. Qatar occupies 11,493 square kilometers on a peninsula that extends approximately 160 kilometers north into the Persian Gulf from the Arabian Peninsula. Qatar's total population, including expatriates, has grown quickly, from 70 000 in the late 1960s to 724 000 by 2003. Of that total only about 30% are Qatari nationals. The remainders are expatriates, mostly from India and Pakistan.

Qatar is ranked 47th in the 2004 Human Development Report, with an HDI value of 0.833. The Qatari government has invested heavily in education since the 1970s and, according to government statistics, literacy had reached 88% by 2000. The figure is close to the average for the Gulf, although rates are higher in Qatar for women than elsewhere in the region.

Qataris' wealth and standard of living compare well with those of Western European nations. Qatar has the highest GDP per capita in the developing world (\$39,607 as of 2005). Qatar is also one of the two least taxed sovereign states in the world with no income tax. The growth rate of the Qatari economy has fluctuated dramatically over the past several years, reflecting the country's vulnerability to oil price fluctuations. Despite diversification efforts, the economy remains heavily dependent on oil (and gas). In 1975, after the quadrupling of oil prices had fed through into the economy, oil accounted for 71.9% of GDP. Falling oil prices in the late 1990s resulted in the oil and gas sector's share falling below 50%, but it rose again in the following three years, as oil prices rose and gas output increased. In 2002 the contribution of the oil and gas sector to nominal GDP reached over 59%. The importance of natural gas to the Qatari economy has been rising. Qatar has the world's third largest gas reserves, after Russia and Iran. In energy terms, these reserves are equivalent to over 150bn barrels of oil and are expected to last more than 300 years at the current and anticipated rate of production.

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

The recent reforms introduced by the Emir towards political liberalization and democratization are widely supported by the Qatari people. The population has started to reap the benefits of the prosperity that has come with accelerated development of Qatar's gas riches, and have welcomed the efforts that the Emir has made to open up the political system. In March 1999, Qatar held its first ever nationwide election for a Central Municipal Council in which both men and women were allowed to vote and stand for office. In mid 1999, a constituent assembly was established to write a permanent constitution for the State, including provision for an elected parliament. The constitution was finally approved in a referendum in April 2003.

Over the past three decades Qatar has invested billions of riyals in developing its health services, which has resulted in significant improvements in the delivery of these services and in the health status of the population as reflected in all the health indicators. By

investing in primary health care the Ministry of Health has achieved a high status of health in Qatar in comparison with the developed countries. The Government in its strategic intent to be a regional centre of excellence for health care is reorganizing and developing the national health system.

The quality of health care in Qatar is high, even by the standards of the industrialized countries. Life expectancy has risen sharply as healthcare provision has improved, reaching 74 years in 2002, compared with 53 in 1960. The Infant, Child and Maternal Mortality rates are comparable to the industrialized countries. There are more than 1400 hospital beds and further specialist hospitals are planned. As Government income increased in the wake of the oil price boost, Qatar was able to provide free health care to all nationals and expatriates. However, rising costs and increased pressure on the budget led the Government in 1999 to require expatriates to purchase health cards. The costs are still low and do not come close to meeting the actual cost of health provision, but signal a shift in the policy of the Government. The country is currently actively pursuing an alternate system of health care financing through health insurance. This shift in the Government's attitude to the public provision of health care is reflected in the establishment of several new private hospitals.

Data from the Qatar Family Health Survey for 1998 and Vital Statistics indicate that the State of Qatar has achieved tangible progress in meeting the inter-national goals stated in the World Declaration and the national goals stated in the National Plan for Childhood for the year 1992. Infant mortality reduced from 12.6 per 1000 live births in 1990 to 10.3 per 1,000 live births in 1999. This success is due to the effectiveness of health programs and the implementation of preventive and therapeutic measures; the promotion of breast-feeding and the implementation of health services offered to mother and child as well as health education programs. Similarly, under-five mortality reduced from 16.3 per 1000 live births in 1990 to 12.7 in 1999. Improved water safety; improved hygiene within the home environment; the rising levels of education in the family; and the increase in health education programs, have been the main contributing factors. No poliomyelitis cases were registered during the 1990s. No neonatal tetanus cases were registered during the 1990s as all births occurred under proper medical supervision in medical institutions. No under-five deaths from measles were registered during the 1990s. Immunization coverage against major childhood diseases rose to 90% exceeding international targets.

Anemia is considered among the most widespread medical problems among pregnant women due to several factors, mainly close and successive pregnancies, as indicated by the Qatar Family Health Survey study for 1998. Prevalence of low birth weight was reduced to less than 10% during the 1990s. According to the Qatar Family Health Survey breast-feeding is not prevalent in Qatar. Exclusive breast-feeding rate reached 11.7%. In this context, a decree was issued for the formation of a breast-feeding committee and converting maternal and childhood care hospitals and health centers into baby-friendly initiatives.

During the 1990s over 99% of births occurred in public hospitals under advanced medical supervision. Only three maternal mortality cases were registered, one for each of the following years 1994, 1996 and 1997 when maternal mortality ratios were 9.3, 9.7, and 9.6 per 100,000 live births respectively. A standing committee was formed to monitor, register and report on maternal mortality and determine their causes. 92% of mothers who gave birth during the last three years received antenatal care by a physician or a specialized nurse. Concerning the use of contraceptives, 69% of married women or those who had been married used one contraceptive method or another, and 43% of the presently married women use contraceptives. The rate of contraceptive use

among women rose from 32% in 1987 to 43% in 1999. The total fertility rate dropped from 4.7 in 1990 to 3.2 in 1999. The total overall fertility rate for the last four years was close to 3.2. Access to and availability of maternal health care for pregnant women was maintained throughout the decade and reached 100%. The availability of maternal health care facilities includes hospitals, medical centers and private clinics. The rate of child-birth care has also reached 100% throughout the decade.

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

Qatar's total population, including expatriates, has grown quickly, from 70 000 in the late 1960s to 724 000 by 2003. Of that total only about 30% are Qatari nationals. The large number of single male expatriate workers has had a marked effect on the gender balance of the total population, with females making up only 34.4%, according to the most recent census, taken in 1997. Ninety per cent (90%) of the population lives in an urban setting, and the urban population is increasing at an average rate of 2% per year. The country is currently witnessing a relatively expansive growth in population partly because of the rapidly growing economy due to the booming petroleum industry and the resultant influx of expatriates in the development process, and partly because of a general increase in fertility and population growth rates.

The Ministry of Health is the statutory health authority in the country. It is responsible for the oversight of health system development. The organization of health care is divided among the Ministry of Health and the Hamad Medical Corporation with the understanding that the Ministry of Health's role is mainly normative, regulatory, and in policy-setting and coordination. As yet these functions are not fully operational.

Health services are currently structured as; Primary health care centers (Primary health care level through which basic curative and preventive health care is offered at 21 health centre); Specialized clinics in some health centres. Specialist care, such as diabetic care, is provided to those referred from primary health care centres and Specialized and teaching hospitals. Care is provided to those referred from specialized clinics to Hamad Medical Corporation.

The Qatari government has also encouraged the private sector to play a greater role in providing healthcare to the public. With private hospitals playing a vital role, the private health sector in the state of Qatar has developed considerably. In 2003, the private health sector included 23 health complexes, 131 dental clinics, 128 medical clinics and 2 general hospitals, in which 1294 doctors were employed.

The National Health Authority (NHA), which was established in 2005 aims at providing the medical preventive and treatment services and supervising over the provision of public health services at home and the medical treatment of Qatari nationals abroad. Besides, it regulates the marketing and manufacturing of drug in accordance with

international quality standards, within the frame work of the public policy of the State and in accordance with a national -laid strategy aimed at realizing the abovementioned objectives. It also supervises over Hamad Medical Corporation, Hamad Specialist and Educational Hospital, private medical facilities, laboratories, pharmacies, councils of auxiliary medical professions, hospitals, primary health care centres and other public medical treatment utilities.

The national health information system has consistently reported progress and achievement in attaining the PHC/Health for All goals and recently reported on status with regard to meeting the Millennium Development Goals (MDGs) on a regular basis. However, the current status of data collection, analysis and use of information at health care facilities requires restructuring and mainstreaming. The current system for monitoring the progress and effectiveness of health services is also inadequate. The methods used for collecting and analyzing information are not up-to-date, and communication between sectors providing health services is inadequate. Efforts are being made to establish a modern database of health indicators and to set up a specialized unit for monitoring and follow-up. Health system research has yet to be developed as an integral part of national health system development.

The main problem in Qatar has been the reliance on expatriate workers in the health sector, although a specific policy to encourage the local population is in place with various incentives. In regard to human resources planning, there are no clear plans to match needs with number and categories of health personnel. There is poor linkage between continuing medical education (CME) programmes and career development, and inadequate training in management.

Comprehensive health care, including preventive, curative and rehabilitative services are provided to all nationals free of charge by the public sector. Expatriates are provided with free preventive and emergency care. There is a health card system to obtain services, including subsidized drugs at PHC centers. Expatriates either pay QR 100 for a yearly entitlement or pay QR 30 for each visit to the PHC centers. The main public hospitals operate at high occupancy rate, but no information is available regarding unit costing, employment of staff and efficiency in the utilization of the resources. Primary health care aims to realize social development by adopting health programs that help citizens to become productive elements in society. The programs implemented by the Primary Health care include health awareness, maternity and childhood health care, immunization against childhood diseases, diagnosing and treating chronic diseases, providing medicinal drugs, healthy food and clean water and ambulance and medical emergency services.

The referral system among these levels is lax allowing direct access to tertiary care once a patient is registered and given a file. Such open access creates a burden on the tertiary level and could partially explain why the outpatient per capita visits to PHC centers are as low as 1.7.

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2000	2002
Human Development Index:	-	-	-	0.849*
Literacy Total:	77.03	79.25	74.7 ^a	89.2*
Female Literacy:	76.03	79.91	66.3 ^a	-
Women % of Workforce	11.3	12.8	15	16.36
Primary School enrollment	97.31	86.23	106.20	95*
% Female Primary school pupils	47.57	49.00	48.77	-
%Urban Population	89.29	90.44	91.48	91.83

Source: ^aEastern Mediterranean Regional Office Database: reports from member states

*UNDP <http://hdr.undp.org/statistics/data/countries.cfm?c=QAT>

Qatar is ranked 47th in the 2004 Human Development Report, with an HDI value of 0.833.¹ The Qatari government has invested heavily in education since the 1970s and, according to government statistics, literacy had reached 88% by 2000. The figure is close to the average for the Gulf, although rates are higher in Qatar for women than elsewhere in the region. However, literacy levels still lag behind those found in emerging markets such as South-east Asia.

Education in Qatar, including tertiary study, is free but not compulsory. According to Ministry of Planning data, there were 70,500 students in Qatari state schools in 2001 (as well as 8,462 university students), 54% of whom were at primary level. The country has 113 primary schools, 57 intermediate schools and 45 secondary schools. Qatar also has a low pupil/teacher ratio of 11 at primary level and 12 at intermediate and secondary levels, a result of the prosperity attained from high oil revenues. Qatar founded its own university in 1977, although many nationals still travel abroad for higher education. Private education is increasing in popularity, partly because the government is able to keep fees down by providing private schools with books, stationery, healthcare and water and electricity free of charge. According to the Ministry of Education, there were 47,362 students in private education in 2002.

Qatar is vigorously pursuing plans to increase the range and number of schools in the country. The government expects to spend US\$5bn over the next five years on the setting up of outposts of Western colleges outside Doha and another US\$2bn on the expansion of primary and secondary education facilities. Among Western university campuses already up and running at the "Education City" being developed to house such institutions are: Weill Cornell Medical College; Texas A & M University; Virginia Commonwealth University College of Fine Arts and Design; Rand Policy Institute; and Canada North Atlantic College of Technology. In consultation with the Rand Institute, the government is also changing the curricula at primary and higher secondary level to place more emphasis on English, Sciences and Mathematics, instead of Arabic and Religion. The Emir's wife, HH Sheikha Mouza bint Nasser al-Misnad, heads this educational

transformation drive herself. In line with the program of expanding education facilities in Qatar, the budgeted allocation for education and youth welfare increased from almost 10% of capital expenditure in fiscal year 2002/03 to over 15% in 2003/04. The scale of the increase is more apparent in absolute terms, which shows that expenditure more than doubled from QR418m (US\$115m) to QR961m, during the period. The money will be spent on completing 84 schools and improving existing education facilities, including those of the University of Qatar.²

2.2 Economy

Key economic trends, policies and reforms

In nominal terms, the growth rate of the Qatari economy has fluctuated dramatically over the past several years, reflecting the country's vulnerability to oil price fluctuations. Despite diversification efforts, the economy remains heavily dependent on oil (and gas). In 1975, after the quadrupling of oil prices had fed through into the economy, oil accounted for 71.9% of GDP. Falling oil prices in the late 1990s resulted in the oil and gas sector's share falling below 50%, but it rose again in the following three years, as oil prices rose and gas output increased. In 2002 the contribution of the oil and gas sector to nominal GDP reached over 59%. However, figures for the oil sector's direct contribution to GDP show only part of the picture, as government spending of oil revenue on infrastructure projects and civil service salaries determines the buoyancy of the small, local economy. Qatar's oil is produced from seven offshore fields and one onshore field.

The importance of natural gas to the Qatari economy has been rising. Qatar has the world's third largest gas reserves, after Russia and Iran. In energy terms, these reserves are equivalent to over 150bn barrels of oil and are expected to last more than 300 years at the current and anticipated rate of production. Crude oil is only expected to last around 20 years. Gas has become an increasingly important source of export revenue, and has also provided the fuel or feedstock for a string of petrochemicals projects.

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2002
GNI per Capita (Atlas method)current US\$				
GNI per capita(PPP) Current International				21500
GDP per Capita	15000		26880*	25545*
GDP annual growth %				8.8
Unemployment %				
External Debt as % of GDP				
Trade deficit:				

Source: Ministry of Foreign affairs QATAR website

Table 2-3 Major Imports and Exports

Major Exports:	petroleum products, fertilizers, steel
Major Imports	machinery and transport equipment, food, chemicals

Structure of the economy

Oil was discovered in Qatar in 1939, but development only got under way in 1949. Production reached a cyclical peak of 530,000 barrels a day (b/d) in 1973, with about half coming from offshore areas. Following the oil price slump of the mid-1980s, development slowed, but re-accelerated in the 1990s. Important discoveries have given new life to the sector, and reserves are now 15,200 million barrels, according to figures published by British Petroleum in June 2002. Qatar Petroleum (QP), the state energy firm, is aiming to raise production capacity to 1 million b/d. Qatar's production is constrained by OPEC policy, and as a result its quota currently stands at 562,000 b/d. Qatar has been pressing for an increase in its quota to reflect its large reserves and small production level. Two thirds of Qatari oil goes to Japan and more than 95 per cent to Far Eastern countries

The second element of Qatar's energy sector is natural gas. Qatar currently has the second largest gas reserves in the world after Russia, with proven reserves put at 900 trillion cubic feet (tcf). Following the development of the North Field, which extends from the north of Qatar into the Gulf and is the world's largest non-associated gas field, the first shipment of liquefied natural gas (LNG) took place in December 1996. LNG exports rose to 10.5 million tons in 2000, from 6.6 million tons in 1999. In May 2002, QP announced that combined sales including spot cargoes amounted to about 13 million tons in 2001. Qatar aims to increase production to 45 million tons by 2010, at which point Qatar will be the world's leading LNG supplier.

Gross Domestic Product

Qatar's GDP growth has been rapidly rising in recent years, averaging 14.7% over the past five years, with the increased export of LNG and related industries providing for the overall positive trend in GDP growth. Preliminary figures released by the Planning Council shows that nominal GDP grew by an estimated 8.8% in 2003 to reach QR 70.8 billion, compared to a marginal growth of 0.8% in 2002. In 2003, the Oil & Gas sector is estimated to have increased by 12.9% to reach QR 42.3 billion, while the Non-Oil sector is estimated to have increased by 3.2% to reach QR 28.5 billion.

Final GDP data for 2003 are anticipated to show an increase of 10.5% according to QNB estimates, compared to currently published figures by the Planning Council of 8.8% growth. For 2004, QNB forecasts a nominal GDP growth rate of 5.2%.

Gross Domestic Product at Current Prices by Economic Sectors (1999-2004)

QR (million)	2000	2001	2002	2003	2004 Preliminary
1. Oil & Gas Sector	39,065	36,812	40,717	50,551	64,365
2. Non-Oil Sector :	25,581	27,767	31,016	35,367	39,198
Agriculture & Fishing	241	240	181	200	202
Manufacturing	3,515	3,909	5,075	6,553	7,922

Electricity & Water	780	975	966	1,798	2,324
Building & Construction	2,330	2,938	3,593	4,654	5,414
Trade, Restaurants and Hotels	3,750	3,918	3,882	4,237	4,350
Transport and Communications	2,006	2,223	2,489	2,672	2,907
Finance, Insurance & Real Estate	4,703	5,116	5,723	6,276	6,910
Other Services	8,256	8,448	9,107	8,977	9,169
Total GDP	64,646	64,579	71,733	85,918	103,563
% Change	43.30%	-0.10%	11.10%	19.80%	20.50%
Total GDP (\$ Million)	17,760	17,741	19,707	23,604	28,451
GDP per capita (\$)	27,968	26,480	27,953	31,897	36,476

In 2003, the following factors contributed in the overall GDP trend:

- The price of Qatar's crude oil increased by 13.9% to \$27.9 p/b, from \$24.5 p/b in 2002, according to the Middle East Economic Survey (MEES).
- Qatar's crude oil production increased by 11.6% to 714,000 bpd, from 640,000 bpd in 2002, according to MEES.
- The Oil & Gas sector GDP increased by 12.9%, as compared to a rise by 1.9% in 2002.
- Higher LNG exports, which increased by 6.7% to reach 14.4 million tons, from 13.5 million tons in 2002.
- An improved performance from the Non-Oil sector, with a growth of 3.2%, as compared to a decline by 0.6% in 2002.

GDP Growth in Qatar:

Qatar's GDP growth in nominal terms averaged 13.5% over the past five years. In 2001, nominal GDP declined marginally by 1.8% to reach QR 58.8 billion (\$16.2 billion), as a result of a 12.9% decline in average crude oil prices to \$23.6 p/b, from \$27.1 p/b in 2000. Qatar's crude oil production also declined in 2001 to 681,000 bpd from 696,000 bpd in 2000, due to quota stipulations put in place by OPEC. In spite of the oil price and production fallback, Qatar has been able to stem the decline in GDP, with an effective economic diversification plan, that has seen natural gas and downstream industries gaining ground over crude oil. Natural gas and downstream industries will dominate industrial activities in the coming years and fuel a two-fold increase in GDP by 2005.

Strategy of Economic Development:

Qatar's abundant hydrocarbon wealth, reduction in external debt, and its strategy of economic development based on the diversification away from oil, has led to sovereign ratings upgrades in 2002, by leading credit rating agencies Standard & Poor's, Moody's and Capital Intelligence. These upgrades certify that the seeds of Qatar's resource development strategy has come to fruition and Qatar's image as an investment destination is set to strengthen further in the coming years.

2.3 Geography and Climate

Qatar occupies 11,493 km² ³ square kilometers on a peninsula that extends approximately 160 kilometers north into the Persian Gulf from the Arabian Peninsula. Varying in width between fifty-five and ninety kilometers, the land is mainly flat (the highest point is 103 meters) and rocky. Notable features include coastal salt pans, elevated limestone formations (the Dukhan anticline) along the west coast under which lies the Dukhan oil field, and massive sand dunes surrounding Khawr al Udayd, an inlet of the gulf in the southeast known to local English speakers as the Inland Sea.

The capital, Doha, is located on the central east coast on a sweeping (if shallow) harbor. Other ports include Umm Said, Al Khawr, and Al Wakrah. Only Doha and Umm Said are capable of handling commercial shipping, although a large port and a terminal for loading natural gas are planned at Ras Laffan, north of Al Khawr. Coral reefs and shallow coastal waters make navigation difficult in areas where channels have not been dredged. Doha is the capital of the country and the major administrative, commercial, and population center. The long summer (June through September) is characterized by intense heat and alternating dryness and humidity, with temperatures exceeding 55° C. Temperatures are moderate from November through May, although winter temperatures may fall to 17° C, which is relatively cool for the latitude. Rainfall is negligible, averaging 100 millimeters per year, confined to the winter months, and falling in brief, sometimes heavy storms that often flood the small ravines and the usually dry wadis. Sudden, violent dust storms occasionally descend on the peninsula, blotting out the sun, causing wind damage, and momentarily disrupting transport and other services. The scarcity of rainfall and the limited underground water, most of which has such a high mineral content that it is unsuitable for drinking or irrigation, restricted the population and the extent of agricultural and industrial development the country could support until desalination projects began. Although water continues to be provided from underground sources, most is obtained by desalination of seawater.

Map of Qatar



2.4 Political/ Administrative Structure

Basic political /administrative structure and any recent reforms

Qatar declared its independence in 1971 after the United Kingdom announced its withdrawal from the region. The highest authority is the Emir but the cabinet, which is appointed by the Emir, carries out the day-to-day administration. The constitution provides for a partially elected consultative assembly, the Advisory Council. The Emir is also obliged to rule in accordance with Islamic precepts, which include fairness, honesty, generosity, and mutual respect. Islamic religious and ethical values are applicable to both the ruler's personal life and his rule. Thus, the ruler must retain the support of the religious community, which often asserts itself in such areas as media censorship, education regulations, and the status of women.

The constitution also provides for a deputy ruler, who is to assume the post of prime minister. The prime minister is to formulate government programs and exercise final supervisory control over the financial and administrative affairs of the government.

The Council of Ministers, which resembles similar bodies in the West, forms the Emir's cabinet. The Council of Ministers is responsible collectively to the ruler, as is each minister individually. The Emir appoints and dismisses ministers (technically on the recommendation of the prime minister when that post is occupied by someone other than the Emir). Only native-born Qataris can become ministers, and the constitution prohibits the prime minister and other ministers from engaging in business or commercial activities while holding state office. According to the new constitution approved by a referendum on 29 April 2003, some powers are devolved to a 45-seat consultative assembly, two thirds of which will be elected.

The Qatari judicial system has two branches. Sharia (Islamic law) courts handle family, inheritance, and other civil matters, while other courts retain responsibility for criminal, commercial and national security matters. Sharia is the basis for all laws in Qatar. Cases are initially heard by a lower court, with the possibility of appeal to an appellate court. The judicial system is efficient, with most cases generally decided within months. Judges are appointed by Emir decree at the recommendation of the minister of justice or the minister of endowments and religious affairs. There are no state taxes on individuals, and the state subsidizes the prices of basic commodities to minimize the effects of inflation.

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

Key political events/reforms

In March 1999 Qatar held its first ever nationwide election for a Central Municipal Council, in which both men and women were allowed to vote and stand for office. In mid-1999 a Constituent Assembly was established to write a permanent constitution for the state, including provisions for an elected parliament.

A permanent constitution was approved by referendum on April 30, 2003 with 97% of the vote. The new constitution will bring vast changes to the electoral system once it is promulgated. In the new constitution the process of proposing legislation will be devolved to the Consultative Council from the Emir, two-thirds of whose 45 members will be elected, with the remainder appointed by the emir. As of March 2004, the previous system is still in place. The Emir appoints the Advisory Council, a 35-member body that serves for four-year terms, to assist and advise the government. The Council has no official legislative powers. Members of the Advisory Council are selected from among landowners, farmers, and businessmen. There are no political parties in Qatar.

The second elections to the Municipal Council took place on April 7, 2003. 78 candidates contested 29 seats. Four candidates, including one woman, stood unopposed, giving Qatar its first elected female official after her two competitors simultaneously dropped out of the race.

3 HEALTH STATUS AND DEMOGRAPHICS

3.1 Health Status Indicators

The quality of healthcare in Qatar is high, even by Western standards. Life expectancy has risen sharply as healthcare provision has improved, reaching 74 years in 2002, compared with 53 in 1960. The Infant, Child and Maternal Mortality rates are comparable to the industrialized countries. There are more than 1,400 hospital beds, and further specialist hospitals are planned. According to government figures, Qatar had 450 doctors in the public sector in 2000 and 1,475 nurses.

As Government income increased in the wake of the oil price boost, Qatar was able to provide free health care to all nationals and expatriates. However, rising costs and increased pressure on the budget led the Government in 1999 to require expatriates to purchase health cards. The costs are still low and do not come close to meeting the actual cost of health provision, but signal a shift in the policy of the Government. The country is currently actively pursuing an alternate system of health care financing through health insurance. This shift in the Government's attitude to the public provision of health care is reflected in the establishment of several new private hospitals.

Table 3-1 Indicators of Health status

Indicators	1990	1995	2000	2002
Life Expectancy at Birth: *	72.2	74.8	74.4	74.6
HALE:			61.2	
Infant Mortality Rate: *	19.0	10.6	11.7	8.7
Probability of dying before 5 th birthday/1000: *	25.0	12.7	13.1	10.2
Maternal Mortality Ratio: *		8.3	8.3	23.3
Percent Normal birth weight babies ^a	92	92	91	90
Prevalence of stunting/wasting ^a		8.1		

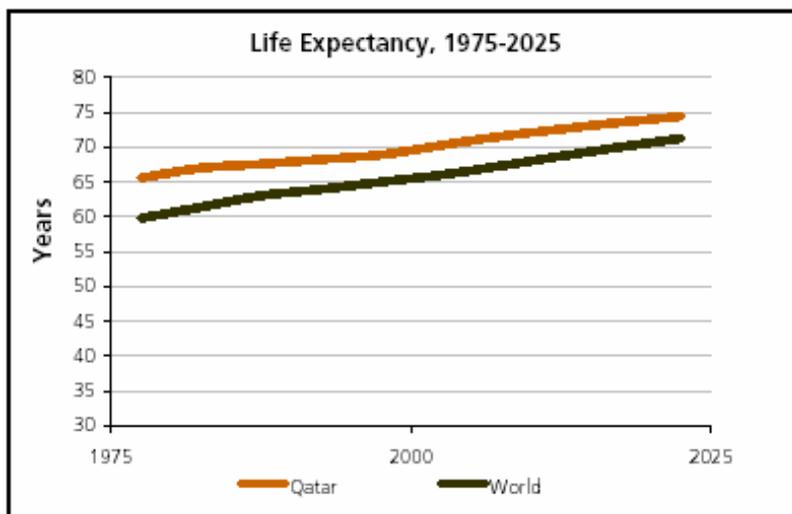
Source: ^aEastern Mediterranean Regional Office Database: reports from member states

*Annual health report 2003

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

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	74.4	74.7
HALE:	-	-	59.2	63.1
Infant Mortality Rate:				
Probability of dying before 5th birthday/1000:				
Maternal Mortality Ratio:				
Percent Normal birth weight babies:				

Prevalence of stunting/wasting: - - - -

Source: Annual health report 2003*Source:* Earth trends, country profile Qatar**Table 3-3 Top 10 causes of Mortality/Morbidity**

Rank	Mortality	*Morbidity/Disability
1.	Diseases of circulatory system	Chicken pox
2.	External causes of mortality	Viral hepatitis (C,B,A)
3.	Endocrine, nutritional and metabolic diseases	Streptococcal throat infection
4.	Neoplasms	Acute respiratory infections
5.	Congenital malformations, deformation and chromosomal abnormalities	Sexually transmitted diseases
6.	Conditions originating in perinatal period	Tuberculosis
7.	Diseases of respiratory system	Food poisoning
8.	Infectious and parasitic diseases	Diarrhea
9.	Diseases of digestive system	Scabies
10.	Diseases of genitourinary system	Mumps

Source: Annual health report 2003

* Infectious diseases reported to preventive health department 2003

Communicable diseases

The Department for Control of Communicable Diseases has identified the following priority areas: sexually transmitted infections including HIV/AIDS, hepatitis and prevention and control of tuberculosis and surveillance of communicable diseases. These priority areas are interrelated (except tuberculosis) as far as the mode of transmission is

concerned and are listed in order of priority according to the case-load.⁴ The reporting system is operational in all PHC centers.

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

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

Non-communicable diseases

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

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

The safety of food supplies is the responsibility of the Ministry of Health with over 1300 samples of food analysed annually. The food safety laboratory is the reference laboratory for the members of the GCC. Balanced nutrition is an important aspect of maintaining health throughout life. The database for the nutritional values of a typical Qatari diet is inadequate. Statistics show anaemia is a main cause of morbidity particularly in children and women of child-bearing age. Services for hypertension and diabetes are provided in PHC settings but protocols and algorithms need to be developed for general practitioners to effectively address the problem.

Safe drinking water and sanitation

Regarding safe drinking water, the whole population of Qatar has access to safe drinking water through water distribution network systems which is being constantly examined

and maintained. But in remote areas, where the network does not reach, water is delivered to communities by tankers. As for excreta disposal, most of the city areas are connected with public sewage piping system. In other city areas which are not connected with public sewage, septic tanks are used. Garbage collection and solid waste disposal are undertaken on regular basis by the Municipality. In general, the whole population has adequate facilities for excreta disposal.

Child health

Data from the Qatar Family Health Survey for 1998 and Vital Statistics indicate that the State of Qatar has achieved tangible progress in meeting the international goals stated in the World Declaration and the national goals stated in the National Plan for Childhood for the year 1992. These include:

Reducing infant mortality from 12.6 cases per 1000 live births in 1990 to 12.0 cases in 1996 and 10.3 cases per 1,000 live births in 1999. This success is due to the effectiveness of health programs and the implementation of preventive and therapeutic measures; the promotion of breast-feeding and the implementation of health services offered to mother and child as well as health education programs.

Reducing under-five mortality from 16.3 cases per 1000 live births in 1990 to 14.6 cases in 1996 and to 12.7 cases in 1999. This reduction can be attributed to the rise in the level of child and mother health care and to the expansion of preventive health and immunization programs to include all sectors of the population.

In addition, improved water safety; improved hygiene within the home environment; the rising levels of education in the family; and the increase in health education programs, have also been contributing factors. No poliomyelitis cases were registered during the 1990s. This is due to the effectiveness of the immunization programs.

No neonatal tetanus cases were registered during the 1990s as all births occurred under proper medical supervision in medical institutions. No under-five deaths from measles were registered during the 1990s due to the effectiveness of the immunization program.

Under-five measles cases declined from 132 cases in 1990 to 83 in 1995 and 28 cases in 1999 due to the effectiveness public health awareness and immunization programs. Immunization coverage against major childhood diseases (Diphtheria, Pertussis, Tetanus, Measles, Poliomyelitis, and Tuberculosis) rose to 90% exceeding international targets.

Diet and Nutrition

Anemia is considered among the most widespread medical problems among pregnant women due to several factors, mainly close and successive pregnancies, as indicated by the Qatar Family Health Survey study for 1998. Because no national figures on this indicator are available, this effort highlighted the need to prepare and execute a mechanism for collecting this information from the medical centers and hospitals which offer services and care to pregnant women, in order to understand the magnitude of this phenomenon, its causes, and remedies. Success was achieved in reducing low birth weight (below 2.5 kg) to less than 10% during the 1990s.

According to the Qatar Family Health Survey breast-feeding is not prevalent in Qatar. Exclusive breast-feeding rate reached 11.7%. In this context, a decree was issued for the formation of a breast-feeding committee and converting maternal and childhood care hospitals and health centers into baby-friendly initiatives.

Concerning measures adopted to improve the facilities available for infant care, Qatari law allows working mothers a sixty-day maternity leave, and provides them a daily one-hour leave for breast-feeding.

Family Planning and Health of Mothers

During the 1990s over 99% of births occurred in public hospitals under advanced medical supervision. Only three maternal mortality cases were registered, one for each of the following years 1994, 1996 and 1997 when maternal mortality ratios were 9.3, 9.7, and 9.6 per 100,000 live births respectively.

A standing committee was formed to monitor, register and report on maternal mortality and determine their causes. The committee is currently conducting a study on this issue. Under-five mortality rate declined from 16.3 to 12.7 cases per 1000 live births for males and females between 1990 and 1999, i.e. a decline of 22%. The same rate of decline was registered for females for the same period, from 14.5 to 12.1 deaths per 1000 births, i.e. a decline of 19%. For males the same rate of decline from 18 to 13.4 deaths per 1000 births, i.e. a decline of 34% during the same years. In both cases, the goals stated in the World Declaration were achieved.

The Qatar Family Health Survey indicates that 92% of mothers who gave birth during the last three years received antenatal care by a physician or a specialized nurse. As for the 8% of the women who did not receive antenatal care, 58% attributed the reason (according to the same study) to their own experience with pregnancy and antenatal care, while 24% of them attributed the reason to not having experienced any pregnancy-related health problems.

Generally speaking, HIV is rare in the State of Qatar. The conservative nature of the Qatari society, the teachings of Islam; the increased awareness about the disease, and the vigilance of health authorities, have all contributed to keeping the disease at bay and below the level of other countries with similar demographics and characteristics as Qatar. Moreover, the procedures adopted by the State concerning the influx of foreign labor and other visitors have been highly effective in curbing the disease. Concerning the use of contraceptives, 69% of married women or those who had been married used one contraceptive method or another, and 43% of the presently married women use contraceptives.

The rate of contraceptive use among women rose from 32% in 1987 to 43% in 1999, i.e. and increase of about 34%. The fertility rate for women (ages 15-19) dropped from 57 children per 1000 women in 1990 to 36 children in 1999, i.e. a decline of 36%. This decline is due to the rise in marriage age, which is attributed to the tendency of this age group to pursue further education and join the workforce.

The total fertility rate dropped from 4.7 in 1990 to 3.2 in 1999. The total overall fertility rate for the last four years was close to 3.2. Access to and availability of maternal health care for pregnant women was maintained throughout the decade and reached 100%. The availability of maternal health care facilities includes hospitals, medical centers and private clinics. The rate of child-birth care has also reached 100% throughout the decade.

3.2 Demography

Demographic patterns and trends

Qatar's total population, including expatriates, has grown quickly, from 70 000 in the late 1960s to 724 000 by 2003.⁵ Of that total only about 30% are Qatari nationals. The remainder is expatriates, mostly from India and Pakistan. The large number of single male expatriate workers has had a marked effect on the gender balance of the total population, with females making up only 34.4%, according to the most recent census, taken in 1997. Ninety per cent (90%) of the population lives in an urban setting, and the urban population is increasing at an average rate of 2% per year. It is projected that the population will reach close to 850 000 by 2010.⁶

Table 3-4 Demographic indicators

Indicators	1990	1995	2000	2002
Crude Birth Rate per 1000 pop**	24.66	21.2	19.5	19.8
Crude Death Rate per 100 pop	3.74	2.23	3.22	3.50
Population Growth Rate %*	4.21	1.00	3.48	2.1
Dependency Ratio %	0.42	0.40	0.37	0.35
% Population <15 years	28.66	26.73	26.50	24.92
Total Fertility Rate:**	-	3.1	3.2	3.4

Source: **Annual Health report 2003

* World Development Indicators database, August 2005

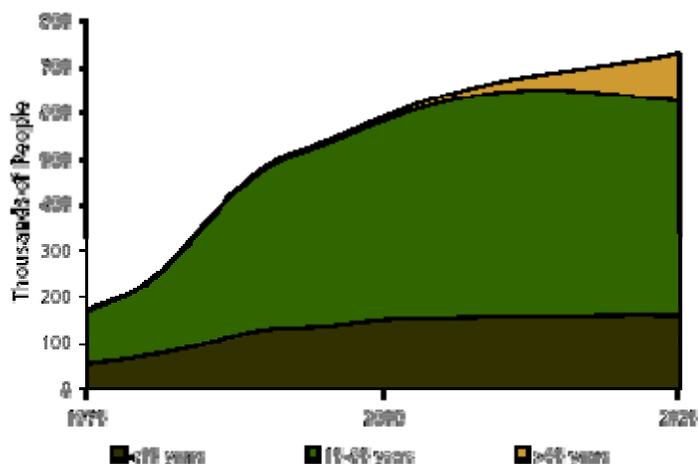
Table 3-5 Demographic indicators by Gender and Urban rural

Indicators	Urban	Rural	Male	Female
Crude Birth Rate:				
Crude Death Rate:				
Population Growth Rate:				
Dependency Ratio:				
% Population <15 years				
Total Fertility Rate:				

Source:

The country is currently witnessing a relatively expansive growth in population partly because of the rapidly growing economy due to the booming petroleum industry and the resultant influx of expatriates in the development process, and partly because of a general increase in fertility and population growth rates. The large number of single male expatriate workers has had a marked effect on the gender balance of the total population, with females making up only 34.4% of the total population.⁶

Population by Age Group, Qatar, 1975-2025



In 1998, when low world oil prices put a damper on the economy, the population of Qatar dropped by 5.3% as expatriates were made redundant. However, in 1999, the population shot up by 9.3%, probably as a result of increased investment in industrial projects and the consequent rise in demand for expatriate blue-collar labor. There was a slight fall in the total population in 2000, followed by increases of 2.9% and 3.9% respectively in 2001 and 2002, as the Government started to move ahead with a host of new construction projects. The population is disproportionately young, with the UN estimating that 27% of the total population is under the age of 15 (Figure 1).⁷

The main demographic challenge that affects the health situation and services in the country is the relatively large number of expatriates working in Qatar whose demands and utilization patterns for health services are distinct from the national population.

4 HEALTH SYSTEM ORGANIZATION

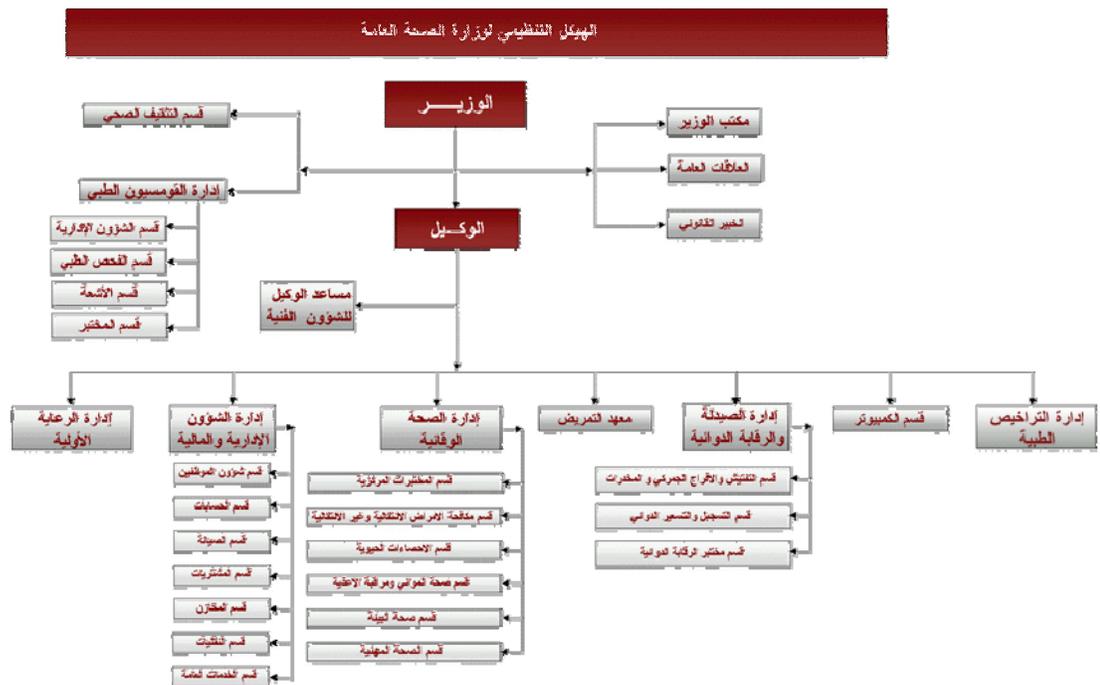
4.1 Brief History of the Health Care System

Before oil was discovered, health care consisted of traditional medicine: barbers performed circumcisions and other minor procedures, and herbalists dispensed natural remedies. A one-doctor "hospital" opened in Doha in 1945. In 1951 Shaykh Ali ibn Abd Allah agreed to a British doctor and a small staff. The first state hospital, Rumailah Hospital, opened in 1959 with 170 beds. A 165-bed maternity hospital was established in 1965.

The development of social services, including health care, accelerated after the accession in 1972 of Shaykh Khalifa ibn Hamad, who dramatically altered the allocation of oil revenues. This included transferring the ruler's 25 percent of oil revenues to the state budget. But the health budget suffered because of the downturns in oil revenues. In 1986, for example, there were cuts of 10 percent in clinic staff.

4.2 Public Health Care System

Organizational structure of public system



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

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

The organization of health care is divided among the Ministry of Health and the Hamad Medical Corporation with the understanding that the Ministry of Health's role is mainly normative, regulatory, and in policy-setting and coordination. As yet these functions are not fully operational.

The Medical Commission Department play a major role in controlling the infectious diseases through examining expatriates coming for employment and to visit Qatar. All the newcomers above the age of 12 years who wish to stay in the country for a period longer than one month are required to undergo examination and screening tests as recommended by GCC States. They are responsible for issuing medical fitness certificates to the people for employment. Also, they examine Qatari nationals for employment, obtaining government popular house, joining universities and educational institutes abroad.

Through the services of the Medical Commission Department, there is a total control over the import of deadly communicable diseases from other countries. In 2003, there was a computer link established between the Ministry of Interior and the Department of the Medical Commission in order to avoid the delay caused in providing medical certificates for newcomers. This computer link helped the Ministry of Interior and Medical Commission Department to exchange the required information of the new comers to the country to take appropriate action on issuing their residence permit. This has increased the efficiency of the system .

Although the Ministry of Public Health and Hamad Medical Corporation are primarily responsible for providing health care to all people in Qatar, the Ministry of Interior, Ministry of Defense, Sports Medicine Center, Q.G.P.C (3 clinics) and industrial sector clinics (3) also bear part of the responsibility for providing health services to their employees. All these PHC clinics are well-equipped and well-staffed to provide some of the specialized health care services. Sports Medicine Center provide sterling services for athletes and sportsmen by keeping them fit and helping them to keep the country's flag flying high in the international arenas.

Health services are currently structured as follows:

- Primary health care centres. Primary health care level through which basic curative and preventive health care is offered at 21 health centres.
- Specialized clinics in some health centres. Specialist care, such as diabetic care, is provided to those referred from primary health care centres.
- Specialized and teaching hospitals. Care is provided to those referred from specialized clinics to Hamad Medical Corporation.

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

Qatar's healthcare sector has come a long way since the country's first hospital opened its doors almost 50 years ago. Today, the industry boasts the most advanced medical equipment and highly qualified staff, a countrywide network of hospitals and healthcare centers, as well as a cardiology department that is referred to by outside specialists as "one of the best in the world". And according to a report from the general secretariat of the GCC ministers of health, Qatar enjoys the region's lowest maternal mortality rate.

Back in October 1957, Rumaillah Hospital opened as a 200-bed general hospital with ambulance services and a large outpatient facility. With the years, as the population's medical needs grew, the country decided that something had to be done and the Hamad Medical Corporation (HMC) was established to provide state-of-the-art diagnosis and treatment of diseases.

Since its establishment in October 1979, HMC has become Qatar's leading non-profit healthcare provider through its network of Primary Health Care Centers and four highly specialized hospitals in the capital, Doha.

At these HMC facilities, medical and dental treatment is free for Qatari's and heavily state-subsidized for expatriates. To use the facilities, residents and visitors are required to apply for a QR100/year (\$ 30) health card, which allows them to pay small charges for various tests and consultations as well as a nominal fee for inpatient care.⁸

In recent years, in addition to establishing new health centers, the following steps have been taken to reorient services towards primary health care:

- school health services have become the responsibility of the Ministry of Health and form part of the activities of the Directorate of Primary Health Care
- a new Division for Childhood Immunization has been established in the Ministry of Health to cover immunization against the six diseases of childhood targeted by the expanded programme on vaccination: diphtheria, measles, mumps, pertussis, poliomyelitis and tetanus
- health education has become part of health centres' activities; the necessary health promotion leaflets have been prepared for their use
- the licensing commission for private clinics has been reorganized in such a way that it enables the public sector to play a supervisory role over private sector activities, especially where primary health care services are delivered.

Recently, a planning committee, comprising representatives of the various departments of the Ministry of Health, as well as of hospitals, was established as a nucleus for a national planning committee for health development.

4.3 Private Health Care System

Modern, for-profit

With regard to the Private Sector health services, there is a growing number of private clinics and practitioners in Qatar. With a growing population and increasing costs, the Ministry of Public Health expects the private sector to lift some of the burden off its shoulders. So, it is the intention of the top health ministry officials to encourage the private sector facilities. In the private sector, there are close to 131 dental clinics, 128 medical clinics and 23 polyclinics that offer consultancy in different specialties. There are

two private hospitals with a capacity of 100 beds in which 1294 doctors were employed.⁹ and they are committed to excellence. These hospitals provide high quality medical care and patient services. Also, they provide the best in diagnostic and therapeutic services within an atmosphere of caring and concern of compassion. Licensing Committee in the Ministry of Public Health plays a major supervisory role over the private health sector activities.

The Qatari government has also encouraged the private sector to play a greater role in providing healthcare to the public. The country's first private hospital opened in late 1999, and private practices and clinics (both medical and dental) now offer a full range of medical services, from rheumatology and dermatology to reflexology and home nursing care. Laws governing private practice are strict, and licensing by the Ministry of Public Health - which oversees all health services in the country - is mandatory for all establishments and each of their medical and nursing staff. Private medical service facilities have expanded to represent 67% of all the country's health services providers, helping to ease the burden on HMC and the Primary Health Care Centers.⁸

Key changes in private sector organization

The ministry of Public Health encourages the establishment of private medical service facilities; so much so, now they represent 67% of all the country's health services providers. The council of ministers has issued a decision to allow the investment of GCC capitals in health services in the state of Qatar.

Planned changes to private sector organization

The ministry of public health is in the process privatizing the health sector by introducing health insurance service for non-Qataris. Planning is underway to implement this service in coordination with the concerned employers in the public and private sectors.

The ministry of public health supervises health insurance companies and decides the roles of private hospitals and clinics that are going to extend health insurance service.

4.4 Overall Health Care System

Brief description of current overall structure

Health sector has come a long way to provide the most advanced medical equipments and qualified cadres as well as expand the cover of health services all over the country through a wide network of hospitals and health centers. Health services in Qatar are discharged through a compact link chain from primary to intensive care and from health centers to major hospitals.

During the year 2003, there were 186 primary health care units including private clinics in Qatar for providing primary health care services and the ratio of PHC units was 2.6 units per 10,000 population while the ratio of hospital beds was 20.3 per 10,000 population.

The Preventive Health Department is responsible for fighting contagious diseases; carrying out vaccination, immunization and food and quarantine watch control; providing health education in the field of mother and child care and insuring environmental health and safety. A section for incommunicable diseases was set up comprising three units: tobacco control unit, chronic diseases and accidents control and statistics unit and nutrition unit. The Primary Health Services Department of Hamad Medical Corporation (HMC) supervises 23 primary health care centers, which are conveniently distributed

across the country. It provides various programs including health awareness; child and mother care; immunization against child diseases; diagnostic and treatment services of common and chronic diseases; medicines; nutritious food; clean water and ambulance and emergency services. The Ministry of Public Health is working to set up health centers on the highways such as al-Shamal, Dukhan, Abu Samra and Mesaieed highways, in collaboration with the ambulance and emergency health services centers, thus effectively stretching health care activity outside Doha. In the same context, a number of developments have been made including the inauguration of a child emergency unit in al-Wakrah health center and al-Matar health center; enlarging the parking lot of Madinat Khalifa health center; completing the emergency unit of al-Shaml health center and rehabilitating some other health centers. Two health centers are going to be opened for the first time in Doha central market and al-Kara'ana areas on the road to Abu Samra. Health Commission Department carries out medical checks on everybody entering the country for work or visit, and issues certificates of health fitness for such categories as those who are about to get married and who are applying for jobs, universities or public housing.

With private hospitals playing a vital role, the private health sector in the state of Qatar has developed considerably. In 2003, the private health sector included 23 health complexes, 131 dental clinics, 128 medical clinics and 2 general hospitals, in which 1294 doctors were employed.

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

The policy of the government is to provide best health care for all the residents in the country based on primary health care and a good referral system. While most medical services are free in Qatar for nationals, they are subsidized for the expatriate residents and visitors. A plan for starting a health insurance scheme for expatriates is underway. In addition, the policy of government to nationalize the health workforce is progressing. Therefore, training and developing the Qatari nationals in the health network is of high priority.¹⁰

The Master Plan Update (update for the health care master plan prepared by the Ministry of Public Health and Hamad Medical Corporation, 1994) noted that the health care system in Qatar was modeled on the Danish system, with strong focus on community-based local health services providing primary health care. The Master Plan noted that the system for primary health care centers was designed with catchment area populations averaging 11,000 persons. In addition, one of the emerging trends and philosophies in hospital planning in Qatar has been, and is expected to be, decentralization of secondary health care services from centralized locations in Doha to suburban and rural health care centers. Currently, the catchment areas population for health centers outside Doha average between 5,000- 20,000 and the health care centers in Doha have catchment areas averaging over 35,000.

Formal policy and planning structures, and scope of responsibilities

Currently, Qatar is preparing a detailed and comprehensive five-year health programme. It is also in the process of creating a National Council for Health and of restructuring the Ministry of Health in order to maximize effective coordination and reduce bureaucracy.

Health systems currently operate within an environment of rapid social, economic and technological change. Health systems are also under continuous scrutiny by planners, purchasers and users of the services. Most health managers and policy-makers now view as imperative measuring the impact, evaluation and control of the quality of services.

There is a lack of clarity between different stakeholders in carrying out health policy analysis, strategic health planning, priority-setting, formulation of national health targets and standards, coordination among the different health stakeholders, and monitoring and assessing performance of health system functions;

Analysis of plans

The policy of the government is to provide the best health care for all the residents in the country based on primary health care and a good referral system. While most medical services are free in Qatar for nationals, they are subsidized for the expatriate residents and visitors. A plan for starting a health insurance scheme for expatriates is underway. In addition, the policy of government to nationalize the health workforce is progressing. Therefore, training and developing the Qatari nationals in the health network is of high priority¹¹.

Key legal and other regulatory instruments and bodies: operation and any recent changes

The National Health Authority (NHA) was established in 2005. It aims at providing the medical preventive and treatment services and supervising the provision of public health services at home and the medical treatment of Qatari nationals abroad. Besides, it regulates the marketing and manufacturing of drugs in accordance with international quality standards, within the framework of the public policy of the State and in accordance with a national - strategy aimed at realizing the abovementioned objectives.

The National Health Authority also supervises Hamad Medical Corporation, Hamad Specialist and Educational Hospital, private medical facilities, laboratories, pharmacies, councils of auxiliary medical professions, hospitals, primary health care centres and other public medical treatment utilities. The National Health Authority undertakes the organization of the medical private sector and acts in coordination with the Health Insurance System to upgrade the level of health service and disseminate health education and awareness.

The National Health Authority comprises the following units:

- Department of Health Research.
- Department of Health Information Technology.
- Department of Health Care Financing
- Public Health Department.
- Quality Management.
- Planning and Evaluation Department.
- Department of Foreign Health Relations.
- Department of legal Affairs.
- Department of Administrative and Financial Affairs.

5.2 Decentralization: Key characteristics of principal types

One of the emerging trends and philosophies in hospital planning in Qatar has been, and is expected to be, the decentralization of secondary health care services from centralized locations in Doha to suburban and rural health care centers.

5.3 Health Information Systems

Organization, reporting relationships, timeliness

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

The current system for monitoring the progress and effectiveness of health services is inadequate. The methods used for collecting and analyzing information are not up-to-date, and communication between sectors providing health services is inadequate. Efforts are being made to establish a modern database of health indicators and to set up a specialized unit for monitoring and follow-up.

Data availability and access

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

Sources of information

Monitoring of health programs is done through statistical analysis of data collected by the different departments of the Ministry of Health, reports of short term WHO consultants, analysis of patient's complaints and numbers of patient visits to health facilities in comparison to the population. Available data show that some aspects of health services in Qatar are good and with good facilities.

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

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

- Systems and procedures are needed for the development and maintenance of health records, clinical information and medical documentation according to international standards and which will support both clinical practice and administration and finance in addition to research, such as burden of disease studies.
- A central information body should be created to coordinate, collect and report on national health data sets.

5.4 Health Systems Research

There is no unit responsible for health research at the Ministry of Health, and no health research policy based on priorities has yet been established.¹² Health system research has yet to be developed as an integral part of national health system development.

5.5 Accountability Mechanisms

The shifting burden of disease to non-communicable diseases caters for longer and more costly care. This is coupled with the ever increasing expectation of the community,

technological development, and present health investment in hospital infrastructure. Such shifts may leave little resources for health promotion which is a strategic priority at this stage. In addition to the various efficiency measures which need to be introduced, there is a great need to make physicians and teams at all levels of care accountable, not only for their patients' health, but also for the wider resource implications of any treatments involved, including referrals from primary care to secondary and tertiary care. There is a need to adopt management protocols in order to curb the cost of services and to improve the quality and accessibility of care.

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Per capita spending on health care in Qatar is the highest in the Middle East at \$935 quoting figures from the World Health Organization (WHO)¹³. The UAE and Kuwait rank second and third with per capita medical care spending being \$812 and \$547, respectively. There has been a massive increase in public spending on health care in Qatar since 1991.

The Hamad Medical Corporation (HMC), in 1991, spent a billion Qatari riyals less than it and the National Health Authority (NHA) are collectively spending today. In 2004, the HMC and NHA together spent QR1.67 billion (\$458 million) on health care, while the figure was QR1.3bn in the previous year (2003). Over the past five years, between 2000 and 2004, the spending by HMC and NHA has grown by a huge 71 per cent.

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2002
Total health expenditure/capita,		1397	1581	2247
Total health expenditure as % of GDP		3.0	2.0	1.9
Investment Expenditure on Health				
Public sector % of total health expenditure			75	

Source:

With regard to the health expenditure, the total expenditure of the Ministry of Public Health and Hamad Medical Corporation reached to QRs.1,308,383,145 in 2002/2003 with an increase of (99.6%) as compared to 1990/1991.

The budget allocated for public health for the 2006-07 financial year is QR3.8bn, out of which QR239 million has been set aside for public works in the health sector. Expenditure on the health sector in the 2003-2004 financial year stood at QR1.5bn, an increase over the QR655.5m in 1990-1991. These amounts do not include health-related public work projects. While the budget allocated to public health for the fiscal year 2006-2007 was QR3.8b out of this QR239m to public work in the health sector¹⁴.

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2004
General Government				
Central Ministry of Finance				
State/Provincial Public Firms Funds				
Local				
Social Security				

Private

Private Social Insurance

Other Private Insurance

Out of Pocket

Non profit Institutions

Private firms and corporations - - - -

External sources (donors) -

*Source:***6.2 Tax-based Financing****Levels of contribution, trends, population coverage, entitlement**

As government income increased in the wake of the oil price changes of the 1970s, Qatar was able to provide free healthcare to all nationals and expatriates. However, rising costs and increased pressure on the budget led the government in 1999 to require nationals and expatriates to purchase health cards. The costs are still low and do not come close to meeting the actual cost of health provision, but signal an erosion of the all-embracing free welfare system. This change in the government's attitude to the public provision of healthcare is reflected in the establishment of Qatar's first private hospital, built at an estimated cost of US\$27.5m.

6.3 Insurance

The State of Qatar supports and develops the insurance sector through modernizing insurance policy in particular and the insurance legislative infrastructure for the financial sector in general. The State is encouraging the introduction of more insurance instruments such as health insurance and insurance for corporate and individual needs. The State is enhancing its supervisory role over the insurance industry so that it can meet its obligations under the global mechanisms of free market economy and free private investment. There are 10 insurance companies operating in the country: 5 national, 3 Arab and 2 foreign companies.

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.

There is a likelihood that a new law that awaits to be enforced in the country sooner than later may make it mandatory for employers to provide health insurance to their workers¹⁵.

The potential for health insurance is by far massive in Qatar with an estimated 495,000 people awaiting to be tapped out of a total population of 743,000.

Higher-income non-Qataris (in monthly income brackets of over QR15,000) are estimated to be 37,000. Some 43,000 people are engaged in government sectors. Health insurance claims work out to 44 per cent at present. In Saudi Arabia, medical insurance claims work out to 87.7 per cent annually, still making the health insurance business a profitable proposition.

Private insurance programs: trends, eligibility, benefits, contributions

Doha Bank has launched a health insurance scheme, which individuals, families and groups can access, with premiums starting from an incredibly low of QR35 a month per person.

The policy will cover medical expenses up to QR100, 000 in a year for in-patient and QR50, 000 for outpatient treatments¹⁶.

American Hospital, Hamad Hospital and Doha Clinic are included in the scheme for in-patient treatment. And, for outpatient treatment Al Rafa Clinic and Apollo Clinic have been designated. Customers will have the choice of opting for either in-patient or outpatient or both coverage.

Launched in coordination with Qatar General Insurance and Re-insurance Company, the scheme has been aptly named 'Medical Care'. It is open to all individual residents of Qatar as well as corporate entities of any size operating from Qatar.

Annual premium per person starts from QR399 for in-patient coverage and is QR899 per person for combined (in-patient as well as outpatient). Special discount will be available for families if all members are insured together. Groups of 10 persons or more and corporates of any size will also be offered special discounts on quoted prices.

The scheme comes as a boon especially for low-income expatriates above the age of 40 and middle-income expatriate families. The scheme is extremely flexible in terms of benefits and provides worldwide coverage, excluding the USA and Canada, for the customers.

The coverage outside Qatar is available on an emergency basis for 30 days treatment cost up to the specified limit in his or her home country as well. Home country treatment, barring the USA and Canada, will be subject to approval from the insurance company. The scheme had been designed on a direct debit basis. This means that policy holders would not need to pay anything to the designated hospitals or clinics except deductible under the policy.

Studies are under way to assess the feasibility of launching an Al Ahli Hospital health card on the lines of a membership card that would offer several privileges to a holder, aside from enabling him or her to access the various services of the hospital over a fixed duration for a one-off fee¹⁷.

6.4 Out-of-Pocket Payments

Cost Sharing

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

6.5 External Sources of Finance

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

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

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

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

6.6 Provider Payment Mechanisms

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
Physicians	1.48	1.27	2.01	2.35
Dentists	0.19	0.20	0.32	0.36
Pharmacists	0.45	0.50	0.75	0.99
Nurses midwives	3.50	3.02	4.42	5.48
Paramedical staff (other HCPs)	1.34	1.34	1.48	2.06
Community Health Workers	-	-	-	-
Others	-	-	-	-

Source: ^aEastern Mediterranean Regional Office Database: reports from member states

Development of human resources for health is an area of priority. The policy of the government is nationalization of health workforce. Hence, encouraging and increasing the number of nationals in the health field network is given top priority. Although no plan is yet formulated, it has been concentrated for the last few years towards employing nationals in every occupational category and gradually decreasing the dependence on foreign personnel.

During the year 2003, a group of over 6310 medical staff with a broad expertise in the various branches of medicine have been working in the Hamad Medical Corporation and Ministry of Public Health, which can also boast of having a team of trained and skilled physicians, nurses and technicians. During the year 2003, there were 1624 physicians, 281 Dentists, 4042 nurses and 731 pharmacists working in the health field who serve the whole population of Qatar (724125).

This following data gives us the rate of medical staff per 10,000 population, which is as follows:

- Physicians: 22.4/10,000 pop
- Dentists: 3.9/10,000 pop
- Nursing personnel: 55.8/10,000 pop
- Pharmacists: 10.1/10,000 pop¹⁰

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

As the health services are expanding, there has been a growing trend in the medical staff to support the health care delivery system. The year 2003 has witnessed about 90% increase in the total number of medical staff compared to the year 1996. Among the most important medical professions like Doctors, Dentists and Nurses, there has been a substantial increase in number: Doctors (80%), Dentists (65%), and Nurses (101%). Among physicians, the number of specialists has increased by 83% in 2003

compared to 1996. Since the policy of the Government is Qatarization, there has been a significant increase of Qataris in certain categories. However, nursing profession needs more attention, as the percentage of Qatari nurses is still only (10%) and nursing strength reached to 3513 nurses in 2003.

The main problem in Qatar has been the reliance on expatriate workers in the health sector, although a specific policy to encourage the local population is in place with various incentives. In regard to human resources planning, there are no clear plans to match needs with number and categories of health personnel. There is poor linkage between continuing medical education (CME) programmes and career development, and inadequate training in management.

Table 7-2 Human Resource Training Institutions for Health

Type of Institution*	Current		Planned		
	Number of Institutions	*Capacity	Number of Institutions	Capacity	Target Year
Medical Schools					
Schools of Dentistry					
Schools of Pharmacy					
Nursing Schools (high)					
Midwifery Schools					
Paramedical Training Institutes					
Schools of Public Health					

Source:

Qatar's "Education City," houses several branches of renowned American universities. After signing an agreement with Carnegie Mellon University to open a branch in Education City, Sheikha Mozah bint Nasser al-Missnad, the wife of the Qatari emir, formally opened the Liberal Arts and Sciences building on the 2,400 acres of land allotted by the government for educational institutions. The agreement with Carnegie Mellon University allows the Pittsburgh-based institution to offer undergraduate programs in computer science and business at a branch campus in Education City.

Carnegie Mellon expects to enroll 25 undergraduates to study computer science and 25 to study business by the fall of 2004. Other universities with branches in the huge Education City campus include Weill Cornell Medical College, Texas A&M University (which offers undergraduate programs in petroleum, chemical, electrical and mechanical engineering) and the College of Design Arts, a division of Virginia Commonwealth University, The Edmund A. Walsh School of Foreign Affairs of Georgetown University¹⁸.

The Weill Cornell Medical College has been established in Qatar with the Cornell University and opened in the Fall of 2004. It offers a two year premedical and four year medical program leading to a MD degree.

Nursing

Nursing education in Qatar is provided through two major institutions, the University of Qatar, which graduates nurses at the BSc level, and the Ministry of Public Health, graduating diploma-level nurses through the Secondary Technical School of Nursing. The number of Qatari nurses constitutes a very small percentage of the total nurse force¹⁹.

Nursing Technical Secondary School

The School of Nursing was established in 1969 and has continued up to 1999 to accept students from the intermediate school level at the age of 15 years. This program has not been able to meet the demands of health services for nursing human resources. The program has graduated nearly 389 national and non national nurses at a rate of 15–20 annually, resulting in the very slow nationalization of nursing forces in Qatar. Only 8.4% of the nurses are nationals of Qatar. Over the past years the program has undergone several changes in relation to its length and language of instruction (from Arabic to English and back to Arabic²⁰).

The student gets a monthly allowance of QR 1800, school uniform for theoretical and practical classes and free transportation and stationary. The School works to qualify the Qatari cadres in the nursing profession and provide qualified female nurses capable of practicing family and community nursing services. The certificate is equivalent to a high school diploma.. The World Health Organization has appointed the director of nursing at Hamad Medical Corporation as a consultant in nursing affairs at the organization. This is Qatar's first international representation in the field of nursing.

The program is perceived by both Ministry officials and senior nursing personnel to be of inadequate standards and quality. The graduates have had a difficult and prolonged transitional period into nursing services. There seems to be no articulation between the school graduates and the university, making the educational career ladder quite difficult as students undergo four years of university education following the three years of high school nursing studies, in addition to inservice and staff development training. These factors have led to the phasing out of the high school nursing program effective September 1999 and the establishment of an Associate Degree Nursing (ADN) program that accepts students after 12 years of high school education.

Nursing education in the Secondary Technical School of Nursing is of three years' duration. Graduates receive a diploma certificate that enables them to work as nurses in hospital settings in any specialization, and in primary health care centres. The current graduates are predominantly qualified to work in hospital settings. Students enrolled in this school are those who have completed nine years of education in the schools belonging to Ministry of Education. This nursing school provides them with the opportunity to get their secondary certificate; they can complete their education at the university if they so desire.

Students get their clinical training in very good training areas. Training usually takes place in general and specialized hospitals such as Hamad General Hospital, the Women's Hospital and the Rumailah Rehabilitation Hospital. Nursing skills are taught in such settings. Community training takes place in primary health care centres. Nurses choose the nearest ones to save time as most of those centres provide same services; facilities in those centres are very good but the students do not get the whole benefit of it because of their curriculum, which is not community oriented.

The Secondary Technical School of Nursing has some good technical resources such as computers and laboratory equipment, but the library resources are very weak; most books are old, though some recent journals have been acquired. All teaching staff

members except one are not Qataris, while all students are Qataris except for a small percentage. More Qatari teaching staff are needed in the School.

The High Institute of Nursing is a national educational body affiliated to the Ministry of Public Health. It was inaugurated in October 1999. It offers a two and a half-year program to obtain the Associated Diploma of Nursing (ADN) in English instruction, and in the future it will introduce a bridge program to qualify for a bachelor's degree course in collaboration with the Faculty of Sciences at Qatar University. The institute aims to prepare qualified nursing national cadres, with a special emphasis on encouraging women to take up this profession. The image of the nursing profession in Qatar is not positive; poor working conditions in terms of salary, shift rotations, work load, etc., result in low enrolment in nursing programs.

In a study²¹, Qatari nursing students most commonly stated that their reasons for joining the nursing profession were their interest in medical work and the humanitarian nature of the nursing profession. The majority of the sample (92.98%) was mostly satisfied or fully satisfied with their chosen career. Most of the students in the study acknowledged that there was a negative community attitude towards nursing. The main reasons given for it were the fact that nursing involves contact with the opposite sex, whether patients or colleagues and the pattern of working hours. Students agreed that mass media campaigns, governmental and religious leaders' support were potential strategies to change the negative community attitude towards nursing. Many previous studies have recommended strategies for recruitment and retention of nurses, including changes in organizational structure and management, improvements in working conditions and salaries, improvements in nursing image, continuous education.

Some recommendations can be drawn from the study. Health authorities should improve the organizational and financial conditions of nurses, taking into consideration the cultural characteristics of the community. Thus the problems of mixing with the opposite sex and the pattern of working hours and shifts should be addressed. This may take the form of allocating female nurses to the wards and clinics of female patients. Health authorities should cooperate with the mass media, religious leaders and other concerned sectors to implement planned long-term campaigns to improve the image of nurses, and change the negative community attitude towards nursing. Efforts should be made to increase and maintain the job satisfaction of nurses and improve the profession's image. This might involve offering scholarships for further education or establishing a nursing council.

The Hamad Medical Corporation (HMC) and the North Atlantic College, Canada, signed an agreement providing for training students from the college's various health programs²². Under the agreement, HMC will receive students of the College from various health programs for training in various sections of the corporation. The training will include the following programs: a) technology of respiratory system diseases. b) technology of radiology. c) medical aid services. The agreement provided for the students to spend most of the final academic year on training at the Corporation which will be supervised by the Corporation's experts as well as lecturers of the North Atlantic college. The college will closely follow up the students' training and performance level.

7.2 Human resources policy and reforms over last 10 years

The year 2005 has witnessed a 15.5 per cent increase in the number of medical staff in National Health Authority (NHA) and Hamad Medical Corporation (HMC), compared to the previous year. And against the 1998 figures, there is a substantial increase in the number of doctors (97.5 per cent), Dentists (69.2 per cent) and Nurses (129.1 per cent), says the annual health report of HMC²³.

The year 2005 also witnessed a significant increase in Qataris in certain categories. For instance, 58 per cent of Dentist in HMC is Qataris. 27 per cent of the physicians, 32 per cent of the lab technologists and technicians, 100 per cent of the social workers, 53 per cent of Prosthetics and Orthotics Technologists and Technician, 55 per cent of psychologists and 60 per cent of Diabetic Educators are also Nationals. However, the representation of the nationals in nursing profession is a negligible nine per cent.

A nationality break-up of physicians at NHA and HMC also proved Qataris on top with 503 physicians 326 female and 177 male. The second largest number of physicians are from Egypt-322.

7.3 Planned reforms

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

The total number of visit to health centers covering all the specialties increased in 2005 by 9.9 per cent, compared to 1998. However, there is a slight decrease in total number, compared to the previous year. The fall in the visits is being attributed to the opening of hospital in Al Khor.

Patient visits to the General Medicine clinics of health centers were 1,755,788 during the period with 41.7 per cent males, 28.9 per cent females and 29.4 per cent children.

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			43.2*	
Pregnant women attended by trained personnel	100	100	100	100
Deliveries attended by trained personnel	100	100	100	100
Infants attended by trained personnel (doctor/nurse/midwife)	100	100	100	100
Infants immunized with BCG	97	96.4	100	100
Infants immunized with DPT3	82	91.8	80.4	97
Infants immunized with Hepatitis B3		89.7	83.3	99
Infants fully immunized (measles)	79	85.9	91.4	100
Population with access to safe drinking water	100	100	100	100
Population with adequate excreta disposal facilities	100	100	100	100

Source: Annual health report 2003

* UNICEF/UNPOP

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	100	100	100	100
Deliveries attended by trained personnel	100	100	100	100
Infants attended by trained personnel	100	100	100	100
Infants immunized with BCG				
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	100
Deliveries attended by trained personnel	100	100	100	100
Infants attended by trained personnel	100	100	100	100
Infants immunized with BCG				
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

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

Access to secondary care:

Same is true for secondary care

8.2 Package of Services for Health Care

8.3 Primary Health Care

Infrastructure for Primary Health Care

Qatar has a well-established Primary Health Care System which provides comprehensive services to the entire population on equitable bases. Primary health care services are provided through 3 separate departments: Primary Health Care Department, Preventive Health Care Department and Medical Commission. Qatar has almost completed the establishment of health centers except few clinics in semi urban areas. During the last three decades, the Ministry of Public Health has established 21 health centers that are distributed across the country with a referral system to hospitals for specialized care.

All health centers provide comprehensive primary health care services, both preventive and curative, to all the people in Qatar under the direction of the **Primary Health Care Department**. All health centers were brought under the umbrella of the Hamad Medical Corporation in the year 2002 in order to increase the efficiency of the staff and improve services. The Primary Health Care Department also coordinates with other governmental and private sectors concerned with primary health care. The health centers are supported by highly qualified Family physicians and General Practitioners with long years of experience in the field of primary health care.

With regard to the Curative services in health centers, there are clinics for general medicine, family medicine and chronic diseases like Diabetics and Cardiology on certain days to facilitate the follow up of chronic patients in the health centers. Also, there are clinics for Ophthalmology and ENT in most of the health centers mainly outside Doha. All these specialized clinics reduce the burden on the outpatient clinics of the hospitals. Dental clinics at health centers provide preventive and curative services like restorative dentistry, pulp therapy, periodontal treatment, minor oral surgery and pediatric dentistry.

The system for primary health care centers was designed with catchment area populations averaging 11,000 persons. Currently, the catchment areas population for health centers outside Doha average between 5,000- 20,000 and the health care centers in Doha have catchment areas averaging over 35,000.

Twenty-one health centers contribute to the high coverage of services and substantial improvement of health indicators. The workload varies from one PHC centre to another. But the PHC centers visited showed a high number of daily visits in the two shifts during which the centers are open. A physician sees 40–50 patients in his/her shift, with an average time of 8 minutes per visit. Communication with the users appears to be satisfactory and friendly. The referral to secondary and tertiary care is made through certain agreed upon practices according to the seriousness of the case. To this effect protocols have to be developed, in collaboration with WHO . But before developing clinical guidelines and protocols, there is a need to reassess the role and functions of PHC centers, as epidemiological factors have changed since when these centers were first established. Job descriptions of the staff should focus more on promotion, communication, administration, quality, safe practice, efficiency and local target setting.

Health facilities/services, Qatar	2002
Total number of public hospitals	3
Total number of beds in public hospitals	1362
Total number of beds in private clinics	110
Total number of beds all hospitals	1472

Rate per 10 000 population of beds	20.3
Primary health care (PHC) facilities	21
– PHC facilities per 10 000	0.3
– Physicians per 1 000	22.4
– Dentists per 10 000	3.9
– Pharmacists per 1 000	10.1
– Nurses and midwives per 10 000	55.8

The notion of catchment area based on population is relevant in strengthening efficiency measures and assessing performance, as well as in developing a better rapport with the community. It will also contribute to building the home health care subsystem, which is needed for addressing lifestyle patterns, long-term care and care of the elderly. The responsibility for PHC centers was shifted 2 years ago to the autonomous Hamad Medical Corporation. The rationale behind this is to split the provision of care, and purchasing and policy-making. The Government contracted out policy and planning, reorganization of services, training, and improvements in the quality of care to foreign consultant firms in 2004.²⁴

Public/private, modern/traditional balance of provision

Public-private ownership mix;

Comprehensive health care, including preventive, curative and rehabilitative services are provided to all nationals free of charge by the public sector. The main public hospitals operate at high occupancy rate, but no information is available regarding unit costing, employment of staff and efficiency in the utilization of the resources.

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

Public Sector:

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

The Preventive Health Department of the Ministry of Public Health provides for the following services for identifying and eradicating communicable diseases:

1. Follow-up of vaccinations given at health centers to prevent out-break of communicable diseases;
2. Follow-up of contacts with patients suffering from communicable diseases;
3. Detecting disease carriers and checking newcomers to the country;
4. Study of disease patterns in the country and epidemiological statistics;
5. Issue of 'Communicable Disease-Free' License to food handlers and persons in contact with humans or animals;
6. Providing vaccination to travelers to endemic countries, and vaccination to all inhabitants during epidemics in near-by countries; and (7) Ensuring quality of food and water.

Public sector: Package of Services at PHC facilities

Primary health care aims to realize social development by adopting health programs that help citizens to become productive elements in society. The programs implemented by the Primary Health care include health awareness, maternity and childhood health care, immunization against childhood diseases, diagnosing and treating chronic diseases, providing medicinal drugs, healthy food and clean water and ambulance and medical emergency services.

Medical services at the health centers have been developed in order to support the role of primary health care. Three extensions were added to the most densely frequented health centers to cater for X-ray, maternity and childhood, healthy woman clinics and early diagnosis of cancer. New clinics including X-ray, eye, mother and child care, heart and ENT have been added to Almutazah health center at the cost of QR 1.3 million.

The X-ray unit at Madinat Khalifa health Center has been opened. Some clinics were opened outside Doha as well, including eye, ENT, and minor injuries sections at Al-Wakra, Al-Khor, Al-Shamal and Al-Shahaniya health centers. Currently a new health center is under construction at Al-Matar Al-Qadim area.

Private sector: range of services, trends

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

With private hospitals playing a vital role, the private health sector in the state of Qatar has developed considerably. In 2003, the private health sector included 23 health complexes, 131 dental clinics, 128 medical clinics and 2 general hospitals, in which 1294 doctors were employed.

Al-Ahli Specialized Hospital occupies 43,000 square meters of space. The outpatient clinics started on November 2004 to receive patients in the pediatrics, internal medicine and dentistry clinics, as well as the laboratories, X-Ray department, physical therapy department and the pharmacy. The remaining clinics are to be opened respectively.

Health care facilities in the private sector have expanded, as reflected by the increasing number of private clinics and private hospitals opened. Due to the rapid investment in the private sector, private health care facilities have a significant contribution to health care delivery in the of Qatar.

There was an impressive and significant increase in the number of polyclinics and individual clinics in the private sector:

- 7 polyclinics in 1996 increased to 23 polyclinics in 2003.
- 87 individual clinics (Medical and Dental) in 1996 reached to 131 clinics in 2003.
- Also, 2 multi specialty private hospitals with 100 beds offer high class medical services with the help of highly qualified and experienced in-patient medical staff.

The last decade witnessed a dramatic increase in the number of medical staff working in the private sector 1294 in 2003, more than three times in 1996 (416 staff) . Private sector polyclinics and individual clinics have appointed physicians in most of the important specialties of medicine. This is a major step to increase the standard of medical services and at the same time to reduce the pressure on Hamad Medical Corporation. There has been a remarkable increase (132%) in the number of physicians (345 physicians) in 2003 from (149 physicians) in 1996.

Referral systems and their performance

The referral system among these levels is lax allowing direct access to tertiary care once a patient is registered and given a file. Such open access creates a burden on the tertiary level and could partially explain why the outpatient per capita visits to PHC centers are as low as 1.7. This requires a more efficient feedback mechanism between the PHC centers and the tertiary care level.

Utilization: patterns and trends

It is thought that the overall utilization rate of primary health care services, as evidenced from the number of patients visiting PHC centres (1.7 visits per person per year) and other primary care outpatient services in the public and private sectors, should be greater.

Current issues/concerns with primary care services

The following list summarizes issues and constraints facing identification and eradication of communicable diseases:

- Inadequate communication between departments providing health services.
- Improper system of notification of communicable diseases.
- Responsibility of water and food safety is spread over many departments and in more than one ministry.
- A variety of disease pattern due to presence of persons from different parts of the world.
- Difficulty in searching for a source of a communicable disease due to traditional customs of the population.

8.4 Non personal Services: Preventive/Promotive Care

Availability, accessibility and Affordability:

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

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

Organization of preventive care services for individuals

Regarding preventive services provided in health centers, there are clinics for well-baby, Vaccination, Ante-natal and well women. The immunization covers 10 preventable diseases. Antenatal services are provided in all health centers by a well trained team. Antenatal clinics take care of pregnant women till 32 weeks. Unless there is a known risk factor, they will not be transferred to Women's hospital. Well women program is screening for breast cancer and cervical cancer. Health centers offer diagnostic services like laboratory, radiology and ultrasound. All the health centers have laboratory services except two health centers situated in a far off semi urban area. Emergency services have

been recently introduced in health centers through trauma centers and pediatric emergency centers.

Health education is the main policy of health centers to promote and improve the attitudes and behaviour of the population towards health practices. Maternity and child health is also in progress and is developing to meet its " Health for All " goals. The main goal of Maternal and Child Health Section is to improve the health of mothers and children through maternity and child health services. To improve maternity and child health services, they provide educational programs for patients, families and professionals working in the community and family medicine field. Special emphasis has been given for better utilization of family physicians in Primary Health Care. School health services have got greater attention as it became a part of the primary health care department. There are educational programs for school children to reduce all forms of malnutrition. More than 2.1 million visits were registered in the health centers during the year 2003.

The Preventive Health Department is responsible for fighting contagious diseases, carrying out vaccination, immunization, and food and quarantine watch control at the airport and seaports, providing health education in the field of mother and child care and insuring environmental health and safety. Immunization against Hepatitis B was carried out in the context of the nation-wide immunization campaigns against contagious diseases. A Childhood Diseases Immunization system was entirely applied. A Pre-school immunization program was adopted as a regular practice. Efforts continue to virtually irradiate polio and measles, and Qatar was one of the first countries to have added anti-influenza vaccine B to their newborns comprehensive immunization programs.

Non Communicable Disease Surveillance System has been established for controlling the non-communicable diseases in the year 2002. A Database is established to register the non communicable diseases for evaluation and monitoring. Community Nutrition Surveillance System and anti-smoking are also under the supervision of the Non communicable Disease Surveillance system. The preventive Health Care Department is in a major move to widen its functions to provide preventive measures and control on communicable and non-communicable diseases to the community.

Access to safe drinking water and sanitation

Regarding safe drinking water, the whole population of Qatar has access to safe drinking water through water distribution network systems which is being constantly examined and maintained. But in remote areas, where the network does not reach, water is delivered to communities by tankers.

As for excreta disposal, most of the city areas are connected with public sewage piping system. In other city areas which are not connected with public sewage, they are using septic tanks. Garbage collection and solid waste disposal are undertaken on regular basis by the Municipality. In general, the whole population has adequate facilities for excreta disposal.

8.5 Secondary/Tertiary Care

In Qatar, there are 3 government hospitals in accordance with international standards for secondary and tertiary care under one Organization, Hamad Medical Corporation (HMC). During a relatively short period, the HMC flourished and gained an outstanding reputation for providing health care services for the community. The three hospitals coming under the Hamad Medical Corporation offer specialized medical care in all

branches of medicine. With the various medical specialties available in the Hamad Medical Corporation, the number of patients sent abroad for specialized treatment has been reduced. At present, there are 1450 open beds available in these hospitals. All these hospitals are well-equipped and staffed with specialized personnel. Accident and Emergency Section, Pediatric Urgent Care Center, and Emergency Section in the Women's Hospital are open 24 hours to provide immediate care for injuries and emergency cases.

Hamad Medical Corporation

Hamad Medical Corporation is considered to be one of the most outstanding specialized medical establishments in the Arabian Gulf region. It was established in 1982 after completing the merger of all hospitals belonging to HMC into an integrated administrative body comprising Hamad General Hospital, Rumailah Hospital and the Women's Hospital. A study has recently been completed on a proposal project to affiliate health centers to HMC so as to unify the management of health services in all facilities.

Hamad General Hospital

Hamad General Hospital extends a highly specialized care to all the people of Qatar through a modern and well-equipped facility at Rayyan Road. The hospital opened in 1982 and has a total of 621 beds for inpatient care, a large outpatient department providing 65 specialty clinics, an Accident and Emergency Department, five intensive care units, eight operating theaters, and a pharmacy. Modern diagnostic facilities consisting of Department of Laboratory Medicine and Pathology and a Department of Radiology support all therapeutic services. Continuous upgrading of all equipment and protocols of care has kept Hamad General abreast of new developments in all specialties. The steady rise in the number of patients seeking care at Hamad General Hospital has stimulated the expansion of services to meet the demand. Demand for specialized care is the result of continuous population growth.

Hamad Medical Corporation (HMC) is to set up a 526-bed psychiatric hospital²⁵. A new project is also on the anvil for the building of a treatment center for those with drug-related problems. Details of the projects are to be announced soon. News of the establishment of a new psychiatric hospital came about following a report in the Arabic daily which pointed out innumerable complaints from mental patients. The report had also pointed out that patients with various types of mental illnesses were clumped together in one unit. HMC has completed work on the construction of an outpatient clinic, pharmacies and a separate building in which to keep patient files. In-patient facilities and doctors' offices have also been completed.

Rumailah Hospital

The Rumailah Hospital is Qatar's oldest health facility. Originally built in 1956, Rumailah Hospital opened in 1957 as a 200-bed general hospital with ambulance services and a large outpatient facility. Following the opening of Hamad Hospital in 1982, Rumailah Hospital became a rehabilitation center for disabled adults, elderly people and handicapped children. With many of its units requiring major renovation, management launched a 10-year program to rebuild the facility in three phases.

The completion of the renovation program for Rumailah Hospital in 1997 was a hallmark for the Corporation. Qatar's oldest health care facility was refurbished into a modern yet quiet hospital offering a 306-bed facility with a spacious, clean and restful environment.

In addition to its current rehabilitative and therapeutic services, Plastic Surgery, ENT Surgery, Ophthalmology, Day Care Surgery and a Stroke Unit were added to Rumailah. The Hospital will have seven operating theaters; a laboratory and a diagnostic imaging facility with an MRI, ultrasound and bone densitometry equipment. Rumailah Hospital is run by a team of experienced administrators and physicians

The Women's Hospital

The State of Qatar provides highly specialized care to women and infants. A well-equipped facility for women and babies was built at Rayyan Road and opened in 1988. The Women's Hospital is one of three hospitals managed by Hamad Medical Corporation. The maternal facility is patronized by women of all nationalities in the state and handles 1000-1200 deliveries per month. The hospital offers a total of 334 beds to women. The private wing offers 31 private rooms and 4 wings for the newly born babies at the neonatal intensive care unit.

Women's Hospital has 334 beds in five upper floors. Most of the rooms are twin-bedded with a bathroom. The rooms are grouped according to the type of care required by the patient: They are antenatal, postnatal, gynecology and high dependency areas. The Hospital has highly furnished wing composed of 35 beds, on private hotel quality level providing privacy, special menu food and cable programs. The Women's Hospital provides a superb hospital service for pregnant women and newborns. Most services are accessible to everyone with a minimal charge.

AL Amal Oncology Hospital

With the opening of the QR 90 million AL Amal Oncology Hospital in mid-2004, cancer patients in Qatar now have a total cancer care facility that compares with the best in the world. The new hospital is a one-stop facility, with services including early detection, therapy, counseling, rehabilitation, education forums and workshops. The hospital is operated in collaboration with Germany's University Clinics of Heidelberg (UCH), one of Europe's top institutions for cancer care and which was treating radiotherapy patients from Qatar for a number of years.

Al Amal, which has an inpatient facility of over 70 beds, expects to receive 600 new cancer cases yearly and treat up to 4,500 patients suffering from existing cancers annually. It aims to become the Middle East's premier facility for cancer treatment, education and training. Several new, state of the art diagnostic and therapeutic equipment used to detect and treat 200 different kinds of tumors and cancers will soon be imported by the Al Amal Cancer Hospital²⁶. Some of the latest equipment has already been installed at the hospital and will be commissioned shortly. One of these latest equipment is a machine for Brachytherapy, now the treatment of choice for victims suffering from cancerous growth or tumors in the neck, head, breast and lymphatic system. The hospital is now awaiting the radioactive isotopes required to operate the machine. Other equipment proposed include a Pet Scanner, a magnetic resonance imaging (MRI) scanners of high precision and resolution, breast scanners and high resolution digital imagery equipment.

The 100-bed hospital at Al Khor is the first phase of a large medical project coming up near the Al Khor Community Housing Complex with another 100-bed hospital planned as the second phase²⁷. The multi-speciality hospital is intended to fulfill the needs for advanced medical care among the residents of Al Khor and Ras Laffan. The Al Khor Hospital is one of four hospital facilities planned for setting up before the Doha Asian Games of December 2006.

A 250-bed, QR220-million hospital in Wakrah and regional hospitals in Ruwais and Shamal are part of the initiative to extend modern healthcare facilities throughout Qatar. The Shamal hospital will be a four-storey QR76-million project built near the Ras Laffan residential complex. The hospital will have 100 beds and cover a 192,500 sq m area. Provision has been made to expand the hospital to 200 beds at a later stage.

Private Hospitals

Al Ahli Hospital: Al Ahli Hospital looks set to be a major private hospital in Qatar. It opened with limited services in December, and full operations are scheduled to be launched in phases throughout the first half of 2005. The Al Ahli Hospital Company (AAHC) signed amended loan agreements with leading banks in Qatar in line with the Islamic financing methodology and the Article of Association of the Company.

- **Al Emadi Hospital:** Besides nursing patients back to health, the management at Al Emadi Hospital aims to provide comprehensive healthcare education to its patients. It believes in knowledge-sharing and planning with patients and their families. Its wide range of specialty care includes treatment of obesity, general surgery, plastic and reconstructive surgeries, dermatology, dental services and emergency services.
- **American Hospital Doha:** Opened in mid October 1999, American Hospital Doha was Qatar's first private hospital and has recently upgraded its equipment and facilities.
- **Doha Clinic Hospital:** Doha Clinic started life as a polyclinic in 1994 and expanded over the years to become a fully integrated hospital in 2001. It was renamed Doha Clinic Hospital.

An increasing number of Qataris and expatriates are turning to alternative medicine seeking treatment of diseases that are chronic and declared incurable by modern medicine²⁸. However, since alternative medicine is not permitted to be practised in Qatar, people are prompted to go overseas for treatment, spending a lot of time, money and effort. A large number of Qataris and Western expatriates visit India every year for Ayurvedic treatment, says a doctor who runs an Ayurvedic massage centre in Doha.

In the past three years, this doctor has treated some 10,000 patients, at least 80 per cent of them Qataris. They suffered from diseases like neck pain (cervical spondylitis), back ache (lumbago), nerve pain in the back (sciatics), frozen shoulder, sport injuries and most importantly, rheumatism and paralysis. Qataris, suffering from aforementioned diseases prefer to avoid pain killers prescribed by practitioners of modern medicine and like to undergo Ayurvedic treatment in India.

Table 8-2 Inpatient use and performance

	1990	1995	2000	2002
Hospital Beds/1,000*	270(89)	227	232	236
Admissions/1000		41637/1140	46133/1324	49323/1357
Average LOS (days)**	-	6.0	6.7	5.7
Rumailah hospital (including Geriatrics)		140	31	30
Women's hospital		4.0	4.0	2.0
Occupancy Rate (%)**	-	77	72	81

Source: *Annual health report 2003

** Hamad general hospital

Reforms introduced over last 10 years, and effects

The Gulf state of Qatar is to embark on one of the world's most ambitious medical projects. It will spend Dollars 900m over the next four years to build a huge teaching hospital - and will provide an Dollars 8bn endowment for staff to carry out world-class research there, as well as medical education and patient care.

Qatar Foundation's Education City is to build an all-digital medical care and research centre with an endowment fund of USD8bn. The new centre will match the highest international standards in patient care, teaching, medical research and clinical practice, and will have particular expertise in the area of women's and children's health and be ready in four years' time²⁹.

Qatar Foundation, the ruling family's vehicle for channelling oil and gas revenues into education and science, announced the project yesterday. The Specialty Teaching Hospital, as it is provisionally known, will become the center piece of Education City, a futuristic cluster of learning and research facilities emerging on the edge of Doha, the capital city.

The hospital is a partnership with a leading US university, Cornell in New York, which already runs a branch medical school in Education City. It will have more than Dollars 200m (Euros 165m, Pounds 110m) a year to spend on research, concentrating initially on women's health and paediatric medicine.

Oil-rich countries in the Gulf have invested heavily in western-style hospitals. Their emphasis has been on healthcare rather than research. Qatar states that its objective is to be a visible generator of knowledge for the world through our research programs.

8.6 Long-Term Care

The Qatari Institution For Elderly Persons' Care

The Qatari Institution for Elderly Persons' Care is a private institution with a recognized independent identity and it enjoys full autonomy and its headquarters is in Doha city.

The Institution aims at:

1. Sheltering elderly persons whose families are unable to look after them of those without families.
2. Providing health, social and psychological service necessary to them.
3. Offering services and care to elderly persons in their homes and among their families.
4. Awareness-raising among the families to embrace the elderly and direct them to the best ways of caring for them.
5. Rehabilitating the elderly to face the problems resulting from aging and how to cope with them.
6. Endeavoring to integrate the elderly in the community each according to his/her capabilities and capacities.

The Institution is non-profitable and non-political, and it achieves its objectives by means of:

1. Cooperating and coordinating with the related bodies inside as well as outside the State of Qatar in the area of the Institution's activities.
2. Educating families that care for elderly persons and giving them consultative services.
3. Conducting seminars, meetings and conferences related to the Institution's activities.
4. Receiving gifts, donations and wills in order to achieve the Institution's purposes

The Qatari Association for the Special Needs

The association was established in 1992 and it has three branches: the Cultural and Social Center, the Educational Center and Mother's Awareness Center. The Association works to establish suitable quarters in which to accommodate young special needs in preparation to provide them with care services and academic and vocational education. It produces and imports all educational aids and artificial limbs for the benefits of its registered beneficiaries.

Al-Shaffallah Center for special Needs Children

A new state of the art centre for children with special needs was inaugurated in May 2006 alongside an international conference on disability. The Shafallah Centre for Children with Special Needs will provide access to a world-class facility for Qatari children³⁰. "The centre is a non-profit, private institution, serving as a therapeutic and healthcare support service for children with disabilities from birth to 21.

In Qatar, a country where disability is still a taboo subject and people with special needs are met with social and physical barriers, the centre is one of the very few initiatives addressing the issue.

Al-Shaffallah Center for special Needs Children was established in response to directives of Her Highness Sheikha Mozah bint Nasser Al-Misned, President of Supreme Council for Family Affairs to fulfill the Qatari community need for the establishment of a center specialized for children with special needs, as the Special Needs Committee was appointed to establish the center.

Objectives of the Center

- Providing educational, rehabilitatory, social and health services to children with special needs.
- Offering supportive and family counseling services to families of children with special needs, including individual and group counseling.
- Participating in societal awareness in so far as dealing with children of special needs is concerned and to accept and realize the disability nature.
- Preparing national cadres specialized in this area.
- Seeking to find and develop legislations and laws that affirm the necessity of offering an opportunity for providing nurtural and teaching services appropriate to special needs

The Groups Served by the Center

Al-Shaffallah Center offers educational and rehabilitatory services for both sexes from ages 0-18 of the entire disability groups and this includes:

- Mental retardation with all its degrees.

- Mobile disability.
- Autism.
- Slow learning

Program and Services of the Center

- Program of Family support and social awareness-raising.
- School education program.
- Autism program.
- Vocational rehabilitation program.
- Supporting rehabilitatory services.
- Diagnosing and evaluating services.

According to data provided by the Planning Council in its 2004 census, there are 2,399 Qatari nationals with one or more disabilities. Deafness, muteness and blindness as a result of consanguineous marriages which are still very common in the country, are the most common forms of disability. Cultural aspects and lack of awareness programs in the country still prevent people with special needs from enjoying their full rights.

The Shafallah Centre, under the patronage of Shaikha Mouza Bint Nasser Al Misnad, wife of the Emir of Qatar and chairwoman of the Qatar Foundation, will include cutting-edge therapies such as a swimming pool with a hydraulic floor.

Origin of disability and number of cases

- Congenital 1,307;
- Accident 205;
- Pathological 776 and
- others 111

Disabled Qataris who have a job

- Men 188;
- Women 60

The major disabilities among Qataris are deafness, mental disability, paralysis and blindness.

The only advocacy centre for disabilities is the Qatar Society for Rehabilitation of People with Disabilities³¹.

8.7 Pharmaceuticals

8.8 Technology

9 HEALTH SYSTEM REFORMS

9.1 Summary of Recent and planned reforms

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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.



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