Chapter Four

CHARACTERISTICS OF THE MARKET

1-PRIVATE PREDOMINANCE AND SUPPLIER-INDUCED DEMAND

The seventeen years of civil unrest have damaged the physical, institutional and financial capacities of the public sector. Meanwhile, Non Governmental Organizations (NGOs) and the private for-profit sector grew in both numbers and capacity. As a result today, 90% of hospital beds are in the private sector, and the majority of the 845 PHC facilities belong to NGOs[1], whereas ambulatory care is provided mostly by private physicians' clinics. The flourishment of the private sector and the weakening of public services left the government with no other alternative than contracting out with the private sector for a yearly widening range of services. This predominance of private service delivery is defended by a powerful syndicate of private hospitals and professional associations.

The private sector continues to grow in a largely unregulated environment, allowing uncontrolled investment and generating a supplier-induced demand. The overuse of hospital services is aggravated by the absence of a functional referral and gate-keeping system. This leads to oversupply in hospital beds,

high technology equipment, such as scanners and MRI machines, and sophisticated services, such as open-heart surgery, bone marrow and organ transplantation and in-vitro fertilization (table III-2). This oversupply of services is closely linked to the oversupply of some manpower categories especially medical doctors, as explained in section II-4.

2-FINANCING FRAGMENTATION AND LACK OF ACCOUNTABILITY

Private hospitals depend heavily on public financing, which represents 64% of their income. Thirty percent of private hospitals' financial resources are derived from the MOH alone. This dependence is more meaningful for small hospitals[2].

The existence of six different public funds reporting to the Presidency of the Council of Ministers and to three different ministries other than the MOH, is responsible for financing fragmentation. This multiplicity in the absence of a unified database on beneficiaries, the lack of inter-agency coordination, the adoption of different tarification systems and control mechanisms, weakens the purchasing power and control capabilities of these agencies. Private insurance companies and mutuality funds that report to two additional ministries, further complicates the system and makes the MOH monitoring and regulatory mission even more difficult.

As a result of financing fragmentation, neither MOH nor any other public agency has access to complete data allowing the monitoring of utilization and cost of health services. This is aggravated by the lack of transparency in the private sector and the weak regulation capabilities of the public sector.

During and after the war period, abuse of the system by the private sector has been going unnoticed. Following attempts towards capacity building, fraudulent practices were discovered. However, the MOH was unable to take the appropriate sanctions because of political pressure. Attempts to breach contracts with badly performing and fraudulent private hospitals were unavailing.

The MOH continues to be a major financer of these hospitals, thus protecting in a way, mediocrity. On the other hand, public funds' administrative procedures are also not transparent, thus hiding malpractice. Accountability of employees in the public sector is hindered by procedural oriented bureaucratic control, whereas a framework for private sector accountability is completely lacking.

3-NON COMPLIANCE OF PUBLIC SERVICES WITH MARKET PRINCIPLES

Public services, especially public hospitals that are overstaffed and operating with rigid administrative rules, were not able to compete with the market. A performance management alternative was sought through the public hospitals' autonomy law. This law issued in 1996 was meant to create financial incentives for these hospitals to compete with the private sector, and for physicians to increase their productivity. This autonomy was supposed to relieve hospitals' administrators from political pressures mainly in terms of recruitment policies. Market mechanisms are introduced through contracts with financing agencies including MOH, and performance targets are set through the budget formulation.

It is too early to evaluate the impact of hospitals' autonomy on cost and quality of services. However, a substantial increase in public hospitals admission rates and a lessening in consumer's complaints are already noticed. Nevertheless, political interferences in staffing public hospitals are still prevailing and are periodically revealed by the media. Favoritism is practiced by MOH by transforming advanced payments to public hospitals into donations, and by giving them priority over private hospitals in terms of reimbursement schedules. This preferential treatment goes against free market mechanisms and hinders the claimed free competition.

4-MARKET FAILURE

Many factors contribute to market failure: the lack of competitiveness in services' provision, institutional weaknesses, the fragmentation of public financing, and consumer perceptions in confusing quality with high technology and expensive pharmaceuticals.

The coverage of hospital care for all the uninsured by MOH, contributes in making people cost-unconscious. For advice and treatment, patients depend on their doctors. These are encouraged by the system to overuse hospital beds, and to over-prescribe diagnostic tests and drugs. This tendency is enhanced by the absence of practice guidelines, and the medical guild principle of free choice of treatment.

In addition to moral hazard, adverse selection and cream skimming are further aggravating market failure. Private insurers being selectively offering products attractive to the healthier thus, discouraging pooling arrangements. Only 8.2% of the elderly (60 and above) hold a private insurance policy compared to 12.2% of those between 15 and 59.

On the other hand, the selection of providers by public funds is not based on cost and quality criteria. Instead, political, regional and confessional interferences are to be considered. This lack of competitiveness is sustained by the social belief in the free choice of provider which weakens the bargaining power of insurers. The impediment to free competition is also a major reason for cost escalation which threats the sustainability of the system. One common aggravating factor relates to payment mechanisms. The fee for service reimbursement that encourages over consumption and the itemized bills' auditing generate a tremendous workload, preventing the MOH and other financers from evaluating the product being paid for.

5-PHARMACEUTICALS

The Pharmacy Department in MOH is the regulatory body

for pharmaceuticals and drug dealers. It is assisted by a Technical Committee, which includes members from professional associations and universities.

The Technical Committee was created in accordance with the 1994 Pharmacy Practice Law, and is responsible for registration of new or imported drugs. Drug samples are tested at the Chemistry Branch in the Central Laboratory prior to registration. However, this laboratory has limited resources in terms of equipment and trained staff to perform the necessary analysis of all drugs.

The number of drugs currently registered exceeds 5000, of which less than 3000 are imported regularly by 75 agents and are widely available in the market. A total of 30 drugstores, 1579 pharmacies, and 3304 pharmacists are currently operating in the country (table II-15).

Nearly all drugs are imported or procured locally most often as highly priced brand-name drugs, rather than the cheaper generic equivalents. Imported drugs are produced by 380 firms in 21 countries of origin. Their share exceeds 90% of the market. Nine local manufacturers, all-operating below capacity, produce less than 10%.

There exists many difficult problems with the use of drugs in Lebanon. There is a wide practice of over-prescribing and reliance on expensive injections rather than on lower-cost tablets or capsules. There is also considerable public demand for drugs and until recently, the public was able to buy almost all drugs over the counter without prescriptions. The large number of physicians and pharmacists in the private sector contributes to the non-rational use of drugs and cost escalation.

According to the law, MOH sets a fixed price for marketed drugs that takes into consideration the ex-factory price, shipping and other fees and the profit margins for importers and pharmacists. An incremental pricing formula is applied as follows:

Ex factory price (FOB)	100
+ 7.5 % shipping and insurance expenses	107.5
+ 11.5% customs clearing and commission	119.8
+ 10% importer profit	131.8
+ 30% pharmacist profit	171.4

Drugs retailers should stick to the set price. While MOH sanctions overpricing, the Order of Pharmacists is more concerned with underpricing to "prevent illegal competition".

Imported drugs prices in 1997 amounted to 226,552,267 USD, which corresponds to a retail official price of 294,518,000 USD. This represented, 20% of the 1997 total health expenditures, before adding the locally produced drugs.

In 1997, the MOH drug budget amounted to 20.3 billion L.P. (USD 13.5 million) or 8% of its budget. In addition, pharmaceutical products cost accounted for about one third of MOH reimbursements to private hospitals.

As revealed by the 1999 NHHEUS, 30.2% of respondents reported having incurred illness or injury in the previous month, 18.4% of them have consumed drugs without medical prescription. More than 90% of the national pharmaceutical bill derives from households out-of-pocket[3].

In 1998, pharmaceutical expenditures accounted for over 25% of total health expenditures. The annual per capita expenditure on drugs is estimated to be 120 USD, more than twice the amount paid for instance in neighboring Jordan.

Analyzing the consumption of pharmaceuticals by therapeutic class shows that antibiotics account for 18%, followed by anti-inflammatory drugs (14%), and cardiac-hypertension drugs (9%). Vitamins account for 6% of all drugs, steroids account for 5% and antacids for 4%[4].

REFERENCES

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3- Ammar, W; Nandakumar, AK; Mechbal, AH. Lebanon National Health Accounts 1998. Ministry of Public Health, December 2000.

4- ibid