Chapter Six

HEALTH SECTOR REFORM

1-THE CHANGING ROLE OF GOVERNMENT

The 1990s witnessed a reconsideration of policies and paradigms adopted by international organizations. The World Bank, the "advocate of privatization", reconsidered its position towards the role that governments should play in different sectors especially the social ones. The government's intervention in the health sector regained importance, and the rationale for such an intervention was rediscussed[1]. Elements of the rationale were:

- *Provision of public goods* considered as services provided to the population at large or to the environment, in addition to some services that carry substantial externalities.
- *Reduction of poverty* by providing essential services highly cost-effective that would greatly improve the health of the poor.
- *Market failure* where governments can further improve how markets function by providing information about the cost, quality and outcome of health care. Simply by defining an essential clinical package, the public sector provides valuable guidance on what is and what is not cost-effective.

Assisted by a World Bank loan in the mid-nineties, the Government of Lebanon aimed at enhancing its role in the planning of health resources and services development, and in the regulation

of the health sector. Before dwelling on this issue of reform, it is important to briefly highlight the historical evolution in the role of government in providing, financing and regulating health services.

International tenets historically developed in Germany under Bismarck (1883) and Lord Beveridge in the UK after WWII (1948) had a significant impact on the Lebanese health system. The role of health authorities has been evolving, along with the occurrence of political and administrative changes. The only public role that has been maintained since the Ottoman Empire is the one related to the protection of the environment and public hygiene. This role has increasingly developed in parallel to scientific progress and the rising public awareness. Regulatory tasks have been introduced progressively, whereas the financing role has been gaining more importance with the weakening of the government's direct providing role.

1.1 The Providing Role

The first three public hospitals in Lebanon were established in Baabda, Beiteddine and Beirut under the Ottoman Empire during the eighteen sixties. The public authority that was till then responsible of hygiene measures, food and water safety and waste disposal, started providing medical services to security forces members, the prisoners and the indigent.

During the First World War, three new public hospitals and two dispensaries came into existence, as Lebanon faced new epidemics, mainly of smallpox and typhus.

By 1920, under the French Mandate, a health directorate was established as part of the Ministry of Interior. Five additional hospitals were built. One of them was dedicated to leprosy, another to tuberculosis. With Lebanon independence in 1943, the Government started building regional hospitals (Baabda, Zahleh, Tripoli, Saida). This came within the context of decentralization efforts. The number of public hospitals beds increased from 160 to 570 beds. Tuberculosis centers were also built as well as dispensaries in remote areas.

Public hospitals reached their climax in the early nineteen seventies in terms of capacity, occupancy rate, performance standards, and even in provision of medical training fellowships.

During the civil strife (1975-1991), public facilities were degraded, while the private sector was blossoming. In 1994, the Government engaged in rehabilitating public hospitals and building 12 new ones, including a University hospital of 500-bed capacity in Beirut. Twenty modern health centers were also built. This was part of the huge physical reconstruction plans, launched by the Hariri cabinets (1992-1998). The Government was criticized for favoring the rehabilitation of the physical infrastructure mostly in Beirut, with the hope of inducing a financial and economic boom, while neglecting health and social affairs and rural development. The Government needed to improve its image in response to critics, by investing in the social sector. It therefore started building public facilities such as hospitals, health centers and schools in all regions. Thus, the main reason lying behind the massive construction of medical public facilities was political. There were doubts that the public administration would be capable of handling these facilities properly once they became functional. However, the declared official strategy was to contain cost, to enhance the bargaining power of public funds and to lessen their dependence on private providers. This strategy clashed profoundly with the Government's declared goal of privatization.

The MOH had to find ways for better managing public hospitals. A law on public hospitals' autonomy was issued in 1996. This law gives more managerial and financial flexibility to hospital managers, especially in terms of recruitment, procurement and contractual arrangements with insurers. According to this law, no government budget is allocated to autonomous public hospitals. These are instead allowed to contract with financing agencies including the MOH[2]. Consequently, their revenues depend on their productivity. Similarly to private hospitals, public hospitals are now being subjected to a selection policy based on cost and quality standards, and to regulation measures including the control of supply and demand.

1.2 The Financing Role

The beginning of health financing schemes goes back to 1920, when the French governor of Lebanon issued the decision 220 on the treatment of the indigent in public hospitals. The municipality had to bear the financial cost of this care. In 1928, when the MOH was created, treatment of indigent and mentally ill-patients became part of its paternalistic mission. The requirement of a certificate of indigence to receive care was confirmed by the decree 16661 in 1964, but was later abolished in 1971[3]. Conditions for MOH contracts with private hospitals were established in 1963 (Decree 12788, modified in 1964 by Decree 15206).

Under the influence of European social policy development, which started in the UK after WWII, the Lebanese health system moved slowly from the paternalistic ethos to that of health as a human right. In the nineteen sixties, a government budget was allocated for public hospitals and for covering services provided by private hospitals under contracts with MOH.

The law establishing the National Social Security Fund was issued in 1963 and partly enforced in 1964. Rules related to the Sickness and Maternity Fund were put in application only in 1971.

The Ministry of Health has been contracting with almost all private hospitals operating in the country. According to the contract, a predetermined number of beds are reserved for patients referred by the MOH with prior authorization. The MOH has been taking part in financing health services in the private sector for the sole purpose of equity. However, cost containment and quality assurance are becoming concomitant issues to be fully integrated in MOH's financing role.

In 1998, along with the declared strategy of the Government to lessen the dependence on private hospitals, Minister Frangieh decided not to renew contracts with almost one third of private hospitals. However, under political pressure, all

contracts were subsequently renewed, though the number of contracted beds was decreased by 30%[4].

End of 1999, Minister Karam took the decision of contracting with autonomous public hospitals for additional 287 beds. Instead of reducing private beds by the same number, he chose to also increase the share of private hospitals by 225 beds. As a result, the MOH-contracted beds increased by 34%[5], together with a 30% increase in the number of contracted open-heart centers. This led to clear financial consequences as shown in figures III-1, VI-1, VI-3 and VI-4.

Reducing contracted beds number through a quality-control selection process, is currently taking place, and will be discussed in the following sections.

The MOH is trying to make proper use of its power as the major financer for most hospitals, in order to strengthen its regulatory role. The reform plan presumes taking full advantage of the MOH financing power to rationalize spending on health care and contain cost[6].

1.3 The Regulating Role

The Government intervention in regulating the health care market has become more imperative as privatization expanded. Lebanon illustrates best, how inefficient the private care sector could be in the absence of regulation, and the subsequent negative effect on both cost and quality.

It is worth emphasizing at this stage the worldwide debate regarding Government's intervention in regulating the health sector. In developing countries, the private sector including NGOs, has been encouraged to intervene more in health care, while Governments were being advised to minimize their intervention in providing health services. This has been the recommendation of the World Bank for example, as well as other international agencies. Consequently, and especially because of an inherent market failure Government's regulation role has become

imperative. This role becomes more and more important as the government intervenes less and less in direct provision. The solution to the dilemma of minimizing provision by the public sector because of its weak capabilities while maximizing its regulation role, which necessitates more sophisticated skills and manpower categories, remains enigmatic.

Regulation needs constraining laws. Attempts to issue such laws have failed repeatedly in Lebanon, being considered incompatible with the free market economy[7]. Liberalism not withstanding, pertinent laws can be legislated, and applied especially in licensing, controlling supply and demand, monitoring and taking appropriate coercive measures.

The MOH is considering currently more "institution-light" options. Contracts between financer and provider present an available potentially effective mean for regulation. It has the advantage of being based on a common understanding of concerned parties, and of being more flexible than laws, and easier to modify and adapt to changing circumstances.

It is generally said that the one who has the money can set the rules. This puts a financer such as the MOH in a privileged bargaining position when negotiating contracts. However, money ownership is not enough to monitor and implement regulation policies. i.e, to detect poor and good performers and to take necessary sanctioning or rewarding actions. For that, the provider who possesses the information has a greater advantage over MOH.

Based on our experience, countries like Lebanon where information systems are not well structured and sophisticated enough, need rather simple indicators on what has been done that are easy to obtain and analyze. The more regulations depend on details on how things are done, the more powerful the provider becomes, and consequently the lesser the regulation’s effectiveness. A thorough work is being done to determine these indicators that could be generated by on-going activities. The MOH is not betting on major changes in the system for getting sophisticated indicators.

Process indicators need many details and are cumbersome, while outcome or impact indicators are difficult to get and cannot easily be attributed to only one activity of interest. Therefore, output indicators linked to quality and based on product specifications are practical, easy to get, better defined and more relevant.

In order for regulatory interventions to be manageable within institutional constraints, the MOH considers sacrifying some degree of precision for the sake of practicality. The procedural monitoring is left to self-regulation by peer-groups which is encouraged to be developed at two levels: internally by colleagues from the same institution, and externally by professional associations.

In this context, the MOH started working with the order of physicians on consensus-building for the elaboration of clinical protocols, but this is a long process that requires a certain level of maturity.

In conclusion, maintaining an important role for MOH in the financing of health services is not only necessary for equity purposes, but is also a powerful leverage for regulating the sector.

2-OPPORTUNITY FOR REFORM

The important deficit in government budget, and restraints on other public funds, do not bear anymore the rapidly increasing health expenditures. Likewise, households that are already bearing a big share of health spending can hardly afford a heavier burden. Consequently, available and projected financial resources will not be sufficient to feed the cost-increasing trend of the current system. On the other hand, diminishing returns and delays in reimbursement are pushing private providers to considering new alternatives. The Private Hospitals Association and the Order of Physicians are now more receptive to ideas of change. Big hospitals capable of delivering efficiently services of good quality are in an unfair competition with mediocre hospitals who invest in

high technology they are incapable of handling, providing poor quality services to an uninformed clientele.

Moreover, general practitioners and specialists practicing outside hospitals are marginalized by this system, as hospital doctors form “clans” inaccessible to new comers. This situation has started creating tension within the medical guild. The traditional struggle between the AUB clan and that of the USJ during elections in the Order of Physicians, is progressively gaining a different dimension. Beirut big hospitals' physicians on one side are increasingly in opposition to practitioners of the periphery. This new struggle is still mitigated by the conflict between physicians and hospital owners, and by confessional rivalries.

From the consumer perspective, medical services are very expensive. Complaints from providers are frequently reported by the media. The 1999 Household Survey revealed a meaningful degree of dissatisfaction with funding agencies, especially with the NSSF (table V-28). Reforming the health system is becoming a very popular concept often mentioned in political speeches.

Considering that private hospitals depend heavily on public funds reimbursement, which is expected to become more important with decreasing households’ ability to pay, public financing authorities are well placed to lead the change.

3- PROGRESS UPDATE AND REFORM PERSPECTIVES

In 1997, the Ministry of Health made public a working paper on health sector reform. Known as the “Frangieh Paper for Reform”, this paper summarized principles and guidelines, agreed upon with the Order of Physicians and the Syndicate of Private Hospitals, and set main objectives to be achieved. A national strategy for health reform and a plan of action were to be elaborated, following a consensus building process that had stopped with the changing of government in October 1998.

Although no blue print on reform was formally adopted, the MOH working paper of Minister Frangieh was considered as an official reference.

A health financing assessment was launched early in 1998 under the Health Sector Rehabilitation Project with the support from WHO. It consisted of a National Household Health Expenditures and Utilization survey, the National Health Accounts, and the Burden of Disease study. The project aimed at providing evidence and technical support for health sector reform efforts.

A meaningful step was made by the creation of the "Inter-ministerial Committee for Health Reform" in 1999. This committee, chaired by the Prime Minister, reflects the high level of political commitment. It consists of all Ministers concerned with health financing and human development: Finance, Social Affairs, Economy, Labor, Higher Education and Health.

Three health financing reform options were developed and a stakeholder analysis was conducted. This will be covered thoroughly in chapter VII.

Whereas the MOH failed to reach some objectives, such as controlling the supply side and setting a well-defined benefits package, important achievements have been made in other areas. Various components of the health system reform were actually planned and/or implemented since the return of civil peace. In the following sections, these components will be described and analyzed. The chapter will conclude on a comprehensive model which will integrate those different components and show their interaction towards overall reform.

3.1 Empowerment of the Ministry of Public Health

A meaningful progress has been achieved in modernizing the institutional machinery of the MOH. Information technology has been introduced in various departments and necessary staff

training has been carried out. The automation of MOH financing functions, especially those related to managing contracts with providers, enhanced the regulation capabilities of the Ministry. With available results of important studies made in the after-war period and improved performance, the MOH steadily regained its leading role.

In its efforts towards decentralization, the MOH has engaged in a long-term process of empowerment of health district officers, allowing them to coordinate health activities between stakeholders and leading health programmes in their areas.

The law of public hospitals autonomy[8] issued in 1996, represents also an important progress in devolving authority. Five hospitals are operating currently under this law with a remarkable improvement of their performance. Two of these were included in the accreditation survey and met standards to score relatively well.

The MOH role in health prevention and promotion was enhanced through the activation of the horizontal PHC network and the vertical preventive programs. This bidimentional approach together with the creation of the "Epidemiological Surveillance Unit" (ESU) have promoted the MOH image as a public health authority.

The ESU is one example of the organizational reform of the MOH. Created in 1995, the ESU is responsible of the surveillance of communicable diseases, and of field interventions for disease control. The ESU conducts epidemiological studies, provides feedback to health professionals, and trains them on surveillance tools.

The surveillance system relies on the collaboration of hospitals, health centers, dispensaries, laboratories and private clinics. District officers are directly involved and coordination takes place with different ministries: Social Affairs, Interior, Defense, National Education and others.

The national epidemiological information system consists of the universal reporting system on communicable diseases, the

hospital-based weekly zero reporting (150 hospitals), and the dispensary-based monthly zero reporting (almost 600 dispensaries). The ESU conducts as well a weekly active surveillance for acute flaccid paralysis (AFP) in 25 sentinel hospitals, supervises the animal bites reporting system from the 6 anti-rabies centers, and implements the water surveillance program in collaboration with WHO.

Disease control includes AFP surveillance for polio eradication and rash and fever surveillance for measles elimination. Other Entities under control are: food poisoning, meningitis, neonatal tetanus, rabies typhoid fever, viral hepatitis A, dysentery, brucellosis and others.

The Epidemiological Surveillance Unit conducted in 1999 the perinatal national study in collaboration with UNICEF, and in 2001, the salt iodization and the iodine deficiency disorders with WHO. It publishes a biyearly bulletin (Epinews), circulates the weekly report on communicable diseases, and disposes of a webpage: www.public-health.gov.lb.

The timeliness and completeness of reporting has been improving gradually. Within the framework of polio eradication, the number of reported AFP cases that has reached 14 in 2001, exceeding thus the barrier of 12 (one case per 100000 children under 15) considered an indicator of the completeness of the surveillance system. The last case of endogenous poliomyelitis was declared in 1994. The National Certification Committee has submitted its final report on polio eradication in April 2002, and Lebanon is expected to be declared polio free early in 2003.

3.2 Strengthening Primary Health Care

Expanding and strengthening Primary Health Care remains one of the main important strategic goals of the health sector reform. Public and NGOs health centers operating within the PHC program led by the MOH have proven their capability to involve

local communities and to provide, in a sustainable manner, affordable services, in accordance with WHO comprehensive PHC package.

The Ministry of Health has started formalizing its traditional relation with NGO's, through contractual agreements for establishing a Primary Health Care network. These contracts provide for the first time an official framework of accountability. The MOH assistance is directly linked to proper implementation of programmes, and their impact on community health, rather than on the increase in patients' number as in the traditional evaluation approach. This may be considered as a first step towards the regulation of ambulatory care and the reorientation of these services to meet population needs. It shows the willingness of the MOH to reallocate funds towards more cost effective means.

Clinical protocols for physicians and manuals for health workers were developed, and training for medical, paramedical and managerial manpower were carried out. An information system is now operational and covers administrative and medical activities. Developing quality standards and strengthening the monitoring system are underway. Special efforts are put to develop measurable outcome indicators reflecting changes in the health status of the community. Which could be attributed to health centers activities, in order to assess the performance of those centers.

The MOH encourages municipalities to manage public dispensaries and health centers especially the newly built ones. Some contracts have been signed whereby the MOH delegates the management of a public health center to a municipality. This contractual relationship similar to that with NGOs is under evaluation and review.

Initially, 40 health centers were involved in the PHC network that expanded gradually to reach now over one hundred center. It is estimated that the number of PHC centers necessary to cover national needs varies between 130 and 150. In the past the MOH lacked the capacity to expand PHC centers to this number. Currently, it is the lack of minimum requirements of existing

health centers that constitutes the limiting factor for additional contracting.

Improving the affordability, accessibility, and quality of PHC services, is not enough to get a significant increase in the utilization of these services. Important lessons could be drawn in this regard from our experience with the Expanded Immunization Program (EIP). Considerable resources and efforts were put to purchase good quality vaccines, ensure an operational and safe cold chain, train health workers, mobilize professional associations and NGOs, along with intensive awareness campaigns. The EIP program provides vaccination free of charge in all dispensaries and health centers operating in the country, in addition to mobile units for remote villages. However, the highest immunization rate ever reached by the program on its own was no more than 50% of the target population. Almost half of parents still prefer to vaccinate their children in private clinics despite the cost and doubts regarding the integrity of cold chain in the private sector. Therefore, it becomes crucial to build a new image for NGOs and public PHC centers, socially market their services and work seriously on consumer satisfaction issues. Wide information campaigns are needed on the comprehensiveness and good standards of PHC services including the good quality of vaccines and essential drugs purchased through UNICEF.

Along with improving the management of PHC centers and upgrading the MOH contractual relationship with NGOs and municipalities, existing vertical programs are to be sustained.

Nevertheless, new health programs should be more focused on reducing disparities in terms of health outcomes, by targeting poorer and underserved districts. In this perspective, the MOH is undertaking a pilot project aiming at reducing maternal and child mortality in Wadi Khaled, a remote area of the Akkar district. For this purpose, the MOH contracted with the Makassed NGO, a well-established "health care provider", to run the new public health center and to provide PHC services with particular emphasis on safe pregnancy and delivery in Wadi Khaled. The NGO is responsible for identifying all pregnant women, about 500,

in a catchment area of 25000 people where 400 deliveries per year are expected. In accordance with the contract the NGO provides prenatal services following established guidelines, performs normal deliveries in the PHC center and ensures regular follow-ups for mothers and children. Cesarean sections when needed are performed in a hospital at the expense and under the oversight of the contracted NGO, that is held responsible for the continuum of care. In return the MOH provides for free essential drugs and vaccines, and assigns a global budget for the project based on a flat rate per pregnant woman and per delivery. The global budget would be subjected to reevaluation at the end of the financial year. This financing and delivery arrangement involves shifting funds from the MOH budget item for hospitals to that for PHC. It introduces new incentives through a capitation-based payment mechanism. The success of this project that targets a remote area while focusing on delivery, ante-natal and post partum care would have an important impact on the MOH strategy.

On the other hand, the MOH financing of nation-wide services and programs conducted by some NGOs should be maintained and upgraded. The most vital programs now are: the Essential Drugs Program for chronically ill patients managed by the YMCA, and the emergency transportation program implemented by the Lebanese Red Cross.

3.3 Reimbursement Mechanisms

The MOH has been reimbursing private hospitals upon reception of detailed bills based on an itemized tarification, which did not include any kind of medical information on the patients status. This fee-for-service reimbursement is believed to have resulted in unnecessary hospitalizations and over-prescription of diagnostic and treatment procedures. Therefore, the MOH has introduced a new payment mechanism in order to reverse incentives. This mechanism is based on a flat rate reimbursement introduced gradually starting May 1998 and applied presently on all surgical procedures.

As a result today, reimbursement of providers by the MOH involves 5 types of payment methods:

- Budgetary transfers for non-autonomous public hospitals.
- Fee-for-service based on detailed bills, for non-interventional hospitalization.
- Case-based payment for surgical procedures.
- In-kind payment for comprehensive PHC services delivered by NGOs centers.
- Capitation payment introduced recently for delivery and follow-up of pregnant women.

The flat rate mode of payment had a significant impact on utilization and costs of hospital services as shown in figure VI-1.

The number of contracted beds was 1514 in 1998 and 1999, and increased to 2020 beds in 2000. The 2001 contracts did not set a ceiling in terms of bed numbers. This has led to a steep increase in numbers of admissions in 2000 and 2001 (fig VI-1a).

The introduction of flat rate reimbursement related to 658 procedures (Same Day Surgery) in May 1998, and then for additional 483 procedures (Most Common Surgeries) in October 2000, has contributed in lowering the MOH total bill in 1999 (fig VI-1a), and the average cost per admission in the following years (fig VI-1b).

Fig VI-1: The impact of (over) supply and payment methods on utilization and cost of hospital services

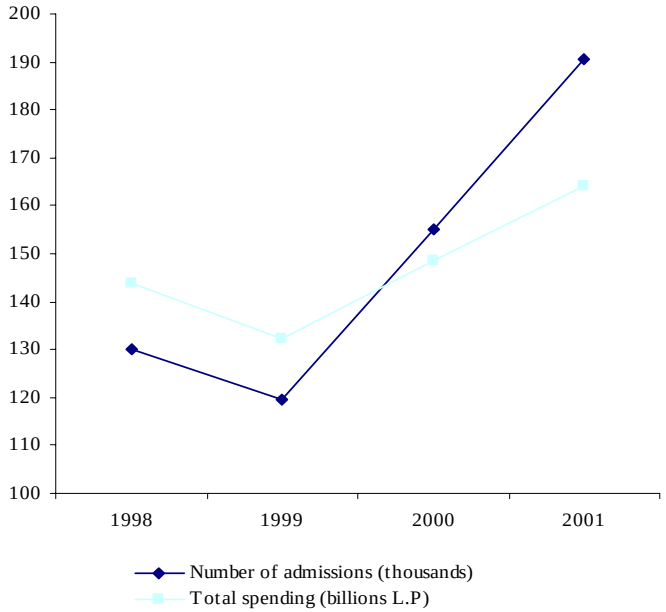


Fig VI-1a *Number of admissions in MOH contracted hospitals and incurred spending from 1998 to 2001*

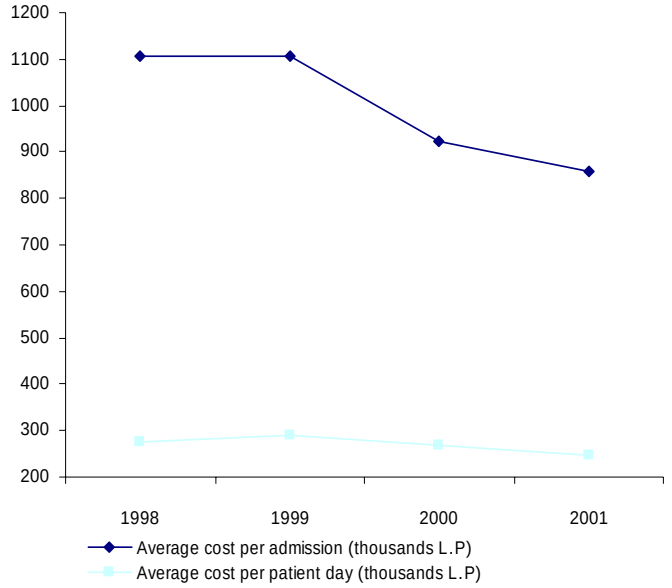


Fig VI-1b *Average cost per admission and per patient day from 1998 to 2001*

Fig VI-2: Supplier induced demand and the impact of cutting down surgical fees and introducing co-payment

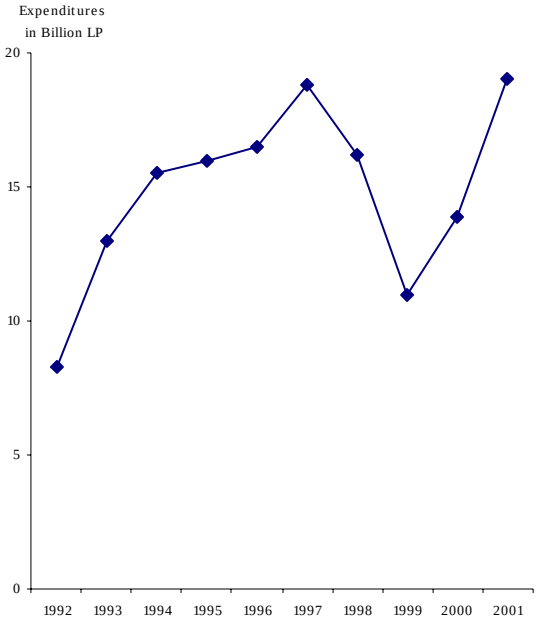


Fig VI-2a: Spending on Open Heart Surgery between 1992 and 2001

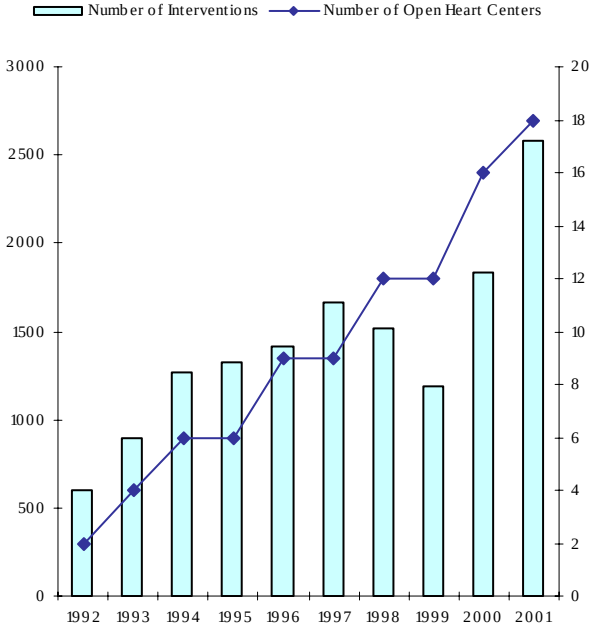


Fig VI-2b: Number of open Heart interventions in relation with the number of Centers between 1992 and 2001

While reconsidering payment mechanisms, tarification and co-payment revealed to be effective means for reducing (supplier-induced) demand. However, this effect cannot be sustained in the absence of supply control mechanisms.

A good example of an incomplete success can be seen with open-heart surgery that was fully covered by the MOH between 1992 and 1997, at a flat rate of 12.75 million L.P.

Fig VI-2a shows how open-heart surgery expenses has been steadily increasing from 1992 till 1997. No waiting lists have been needed since 1994, indicating that the number of centers since then had become sufficient enough to meet the needs. This is revealed by the insignificant increase in expenditures in 1995, where the number of centers (6) remained the same as in 1994.

The Fig VI-2b illustrates clearly the strong direct relationship existing between the number of operations performed and the number of existing centers, between 1992 and 1997. The three new centers that were opened in 1996 became fully operational beginning 1997, leading to the sharp increase, noticed that same year.

In 1998, the MOH decided to cut down the flat rate, and to introduce a copayment. The decided total fee per intervention was set at 9 million L.P., 8 to be covered by the Ministry and 1 to be paid by the patient. This change explains the sharp sloping down in both, expenditures and number of interventions in 1998 and 1999, inspite of the rising number of centers, as shown in both figures VI-2a and VI-2b.

The reduction of the provider's profit margin resulted in adopting more conservative indications for surgery. The co-payment had probably an additional effect on the patient’s attitude, who started questioning physicians on alternatives to costly surgery. Patient renouncement to undergo cardiac surgery for financial reasons is unlikely to have occurred with the existing system of fee waiver for the needy.

Therefore, the decrease in number and cost of open-heart surgery in 1998 and 1999 could be attributed mainly to the modification of the payment mechanism. However, the rebounding number of operations in 2000 and 2001 along with the increase in the number of contracted centers confirm that control of supply should be a concomitant measure to get a sustained effect.

3.4 Control of Supply

The Carte Sanitaire has been made available as a technical tool to regulate the supply side through licensing based on needs assessment. The issuance of a Decree on the implementation of the Carte Sanitaire, considered as contradicting the free market principles, was initially rejected by the Council of State (Decision no. 16/93-94, 1993). Therefore, in the absence of an up-stream control of supply, a downstream approach is sought by contracting with a smaller number of selected hospitals. The 1998 attempt not to renew contracts with small inefficient hospitals failed for political reasons. Instead, the total number of contracted beds was reduced by 30% and contracts with providers were reviewed to include budget ceilings and penalty clauses. The management of these contracts has been improving with the upgrading of the monitoring capabilities of the MOH.

All regulatory measures, mentioned previously have shown to be insufficient for controlling over-consumption. Enforcement of the Carte Sanitaire seems to be indispensable for controlling supplier-induced demand and cost escalation. It is worth mentioning that the control of supply is not only quantitative. It rationalizes the distribution as well. The regulation of pharmacies' licenses in accordance with the Pharmacy Practice Law had a significant impact on the regional distribution of pharmacies, as explained in chapter II section 4 and clearly shown in table II-15. The MOH is following up with the Council of State on enacting an acceptable Carte Sanitaire Law. Legislative amendments would be needed whereby a hospital's "Construction Permit" and "Operation License" are granted based on the Carte Sanitaire, the hospital master plan (Projet d'Etablissement) and the compliance with Basic Standards.

The Basic Standards set within the framework of hospitals accreditation are in fact requirements for licensing which represent an additional tool for controlling the supply of hospital beds and sophisticated services.

On the other hand, the selection of hospitals for contracts by MOH and other public funds can be based on the Basic Standards and the hospital's accreditation score. The decree number 7363 issued in February 2002 requested the MOH to contract only with 80 selected hospitals out of 140. This would enhance competitiveness and deprive below standard hospitals from important financial resources. Consequently, a significant impact on supply of hospital services is expected.

Fig VI-3 Control of Supply: Normative (Up-stream) versus Incentive (Downstream) approach

<table>
<tr><td>Needs Assessment

(Carte Sanitaire)</td><td rowspan="2">Construction Permit

Licensing

Operation License</td><td rowspan="2">Control of Supply

Selection of Providers

Contracting

Tarification</td></tr>
<tr><td>(Project d'Etablissement)

Basic Standards

Accreditation Standards</td></tr>
<tr><td></td><td>Quality improvement

(continuous process)</td><td></td></tr>
</table>

The same problematic of controlling the supply of hospital services applies to the issue of human resources. An up-stream

control of MD graduations is absurd in a country where the private sector prevails in higher education, and considering the large number of graduates from foreign universities and the meaningful proportion of Lebanese residing abroad. At most, the MOH could promote health professions that are in shortage, as it does currently by subsidizing nursing training in the Lebanese and the USJ Universities, and by establishing training units in 30 collaborating hospitals and health centers.

3.5 Pharmaceuticals Cost Containment

Despite the limited capacity for drug analysis at the Central Laboratory, the strict regulation of drug registration guaranties to a large extent the quality of imported and domestic pharmaceuticals. The exceptions are the relatively small quantities of drugs donated to NGOs that bypass the system and reach dispensaries after obtaining a special permit from the Minister of Health. An increasing awareness about the safety of donated drugs is taking place, and the problem should be dealt with at a political level.

With regard to pharmaceuticals cost, a price index that takes into consideration currency exchange rates is issued regularly. The MOH watches over price decreases in the countries of origin and lowers the market price accordingly. Sanctions are taken against pharmacies practicing over-pricing. The MOH cost containment policy had its impact on consumption prices as shown in the 2002 report of the Central Administration of Statistics. The consumer price index between 1998 and 2001 marked an increase in transportation and communication (11.6%), education (10.3%), clothing (8.4%) and housing (4.9%), while a decrease was noticed by 5.9% for health (including drugs, hospital and ambulatory services), followed by food products (5.5%), furniture and equipment (2.1%), and house maintenance (1.8%)[9].

However, the high cost of drugs that represents 25% of the total health expenditures remains a major concern. Three areas of intervention can be identified for cost containment:

1- Enhancing competitiveness: The 1994 Pharmacy Practice Law requires pharmacists to adhere to prices set by the Ministry of Health. An amendment was subsequently approved by the Council of Ministers and sent to Parliament for ratification. It stipulated that the price set by the MOH is considered a ceiling that could not be exceeded, but that could be lowered. This would enhance competitiveness and would probably lower market prices.

2- Modifying the price structure: According to the price structure, the imported drug price is set at 1.7 times of its FOB price (chapter IV section 5). Even though profit margins for importers and pharmacists are relatively high, any reduction would face great opposition and is unlikely to happen.

The price-dependent profit margin is thought to encourage importation and dispensing of expensive drugs. A degressive scale was proposed starting with a higher profit percentage for cheaper drugs. However this proposal would have had an adverse effect on the total bill, since the market share of cheaper drugs is much higher than that of expensive ones. Considering the sale value for the year 2000, drugs with a unit price less than 5 USD represented 37% of the total bill, and those less than 10 USD 60%. Drugs with a unit price exceeding 20 USD accounted for less than 15% of the total expenditure on pharmaceuticals (IMS Health 2000).

The 11.5% margin allocated in the price structure for clearance and commission is exaggerated considering customs exemption on imported drugs. On the other hand, shipping and insurance expenses are uniformly calculated for both far and close countries. The freight percentage was set at 7.5% as an average for USA, Canada, Australia, European and other countries. It may be over-estimated for most pharmaceuticals imported from the nearby European countries. On the other hand, the freight is calculated as a percentage of the price, not in relation to shipment fees which are based on volume. This means that expensive drugs with small volume and high price generate more profit than less expensive ones. This phenomenon is further magnified by the cumulative price structure.

Therefore, expenses and profit margins as well as the incremental calculation method should be revisited. Scheduling this item in the reform agenda needs to be considered carefully.

3- Promoting generic drugs: The current price structure does not encourage the importation of inexpensive generics. In addition to that, physicians prefer not to prescribe generic drugs for perhaps a lack of confidence in their quality, but most importantly because their university education and hype promotion campaigns that constitute the main source of pharmaceutical information for many of them. Manufacturers and their agents use aggressive and persuasive techniques that are sometimes ill-founded scientifically and even unethical.

Changing prescribing habits may have to include reconsidering medical curricula and conducting training through a continuing education program, in collaboration with universities and Physicians Orders. New incentives should be created through a new price structure to encourage the importation of cheaper drugs. Rationalizing the prescribing habits should be sought by adopting a list of MOH and NSSF reimbursed drugs, biased towards generic drugs including licensed and labeled ones.

3.6 Quality Assurance

The Quality Assurance framework considers three levels of interventions: structure, process and output. It implies the active involvement of all players especially those involved operationally in health services provision. The MOH adopts two different approaches for hospital and ambulatory care, and its intervention is restricted to tasks that are clearly defined and undertaken in an explicit manner. The MOH supervises also the overall quality improvement process and makes sure that each party is playing properly its role.

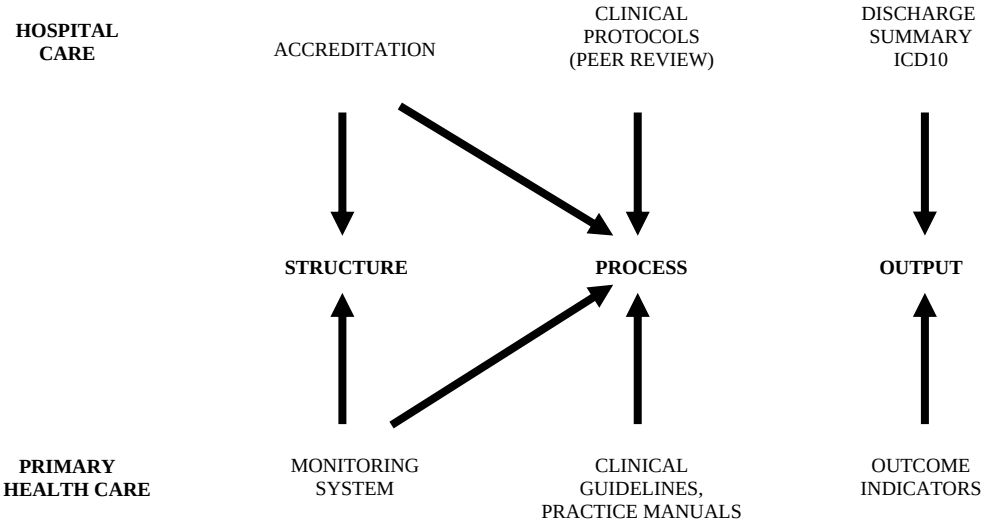
With regard to hospital care, the MOH conducted recently the first national hospitals accreditation survey as explained in the following section. Accreditation focuses on structural and organizational matters and pays particular attention to the adoption

and implementation of explicit policies and procedures. It scores the existence of managerial tools, clinical protocols, technical committees such as infection control committee, record-keeping and other quality-related systems. Examining documents such as medical files, meeting minutes, etc. indicates whether these systems are or are not functioning in accordance with established norms, which also impacts the score. Therefore, and in addition to focusing on the structure, accreditation tackles also the process level. However, the main work on the process has to be done internally through peer review. This falls clearly under the responsibility of the medical and paramedical professions, overseen jointly by the MOH, the Order of Physicians and other professional associations.

As for output evaluation, the MOH requested that a Standardized Discharge Summary (SDS) should be joined to the bill of every hospitalization case, otherwise it would not be reimbursed. The SDS provides information about the medical history, the diagnosis, therapeutic interventions, as well as pertinent laboratory, radiology, and pathology results, in addition to treatment and follow-ups. Almost all hospitals are now more or less complying with the system that is generalized to all financing agencies. The MOH has been for the last six years upgrading the quality of the SDS information, and has conducted training sessions on coding according to the International Classification Disease (ICD10). The automation of this system is currently underway. However, much more efforts are still needed to be put in this area, and a fully computerized system is not expected to be operational before 2004. The MOH is working now on integrating simple quality indicators in order to link reimbursement to product specifications. This quality-related payment system (QRP) will make the contractual relationship with private providers easier to manage, and will allow incentive-based regulation and quality assurance. On the other hand, the flat rate payment would relieve the administration from the heavy burden of detailed bills auditing, and enable it to evaluate the output once codification and automation are accomplished.

With regard to quality assurance of ambulatory care, attention is currently focused on PHC centers that are expected to play a more important role in the future. Private clinics quality

Fig VI-4: Hospital and Primary Health Care Quality Assurance



assurance requires human and financial resources, tools, and skills that may not be available in the foreseen future. Therefore, private for profit solo practice will not be included in the quality assurance program for the time being.

As for PHC, a different approach is required than for hospital care. Basic standards related to amenities and human resources as well as the adoption of a defined package of services are a prerequisite for a center to join the network. Policies and procedures are set jointly by MOH, concerned NGOs and professional associations, and are standardized for all health centers. Hence, clinical protocols for physicians, and guidelines and manuals for health workers were developed, and managerial as well as clinical trainings were conducted. Since the MOH supervises directly PHC activities, the monitoring system becomes a crucial component of quality assurance. Finally, outcome indicators that go beyond the output of PHC centers to assess the

health status improvement of the community, reflect better the quality and the effectiveness of interventions.

3.7 Accreditation of hospitals

The First National Hospital Accreditation Survey[10] is a landmark project that represents an important achievement on the way to improving the quality of health care services.

In May 2000, a consultant was contracted to set Basic and Accreditation Standards for acute care hospitals, as part of a Total Quality Program. The main requirement of the project was to develop, test, adapt and finalize a Hospital Accreditation Manual, suitable to local circumstances, while taking in account the international experience in this field.

A consultative process, including key stakeholder groups, took place during the development of standards. Those were tested in a group of 6 pilot hospitals, chosen to be representative of the acute care hospital system in Lebanon.

The two-tiered approach was meant to delineate Basic Standards that should have been required for hospital licensing, and higher level Accreditation Standards that are based on Quality Assurance. Guidelines were set to explain the Standards and provide hospitals with additional information and examples, for the purpose of achieving those Standards.

The Survey based upon the Manual was conducted between September 2001 and June 2002. Surveyors were hospital administrators, nuurses and physicians with clinical and administrative experience.

The scoring system used for Basic Standards was: one point for "Yes" and zero points for "No". For the Accreditation Standards 0.5 points were given for items which "Need improvement". In both Standards and Accreditation scores, the items "Not applicable" were excluded from calculation.

Following the 1- to 3-day onsite visits to each hospital, detailed survey assessment reports were completed and forwarded to concerned hospitals and the MOH. Each report included an assessment of all standards that were applicable to the surveyed hospital at the Basic and Accreditation levels, and the score obtained. A number of Strengths and Opportunities for Improvement were documented for each applicable standard, and customized recommendations for each hospital were set.

The Strengths indicated areas where the hospital is performing well, and should continue to work to maintain the standard. Opportunities for Improvement and Recommendations suggested areas where the hospital needs to review the situation and implement changes, or continue to work on a current plan for improvement. These opportunities are a valuable source of information for the hospital's planning process, particularly the Quality Assurance Plan. It may not be possible to implement all of the opportunities immediately. The hospital will need to prioritize the most important ones and the easiest to implement, and incorporate these into the budgeting and planning processes. The information in the report provides each hospital with a valuable tool for continuous quality improvement.

Among the 128 surveyed hospitals, only 47 met the requirements of 80% for the Basic Standards score and 60% for the Accreditation Standards score.

Most importantly, 32 hospitals were found not meeting minimum safety requirements.

As expected, small hospitals with 100 beds and less, accounting for the majority of hospital beds in Lebanon were on average operating below standards. Hospitals with 101 to 200-bed capacity got a somewhat better average score than larger hospitals with more than 200 beds (figure VI-7).

Fig VI-5: Basic Scores for all hospitals – bar chart

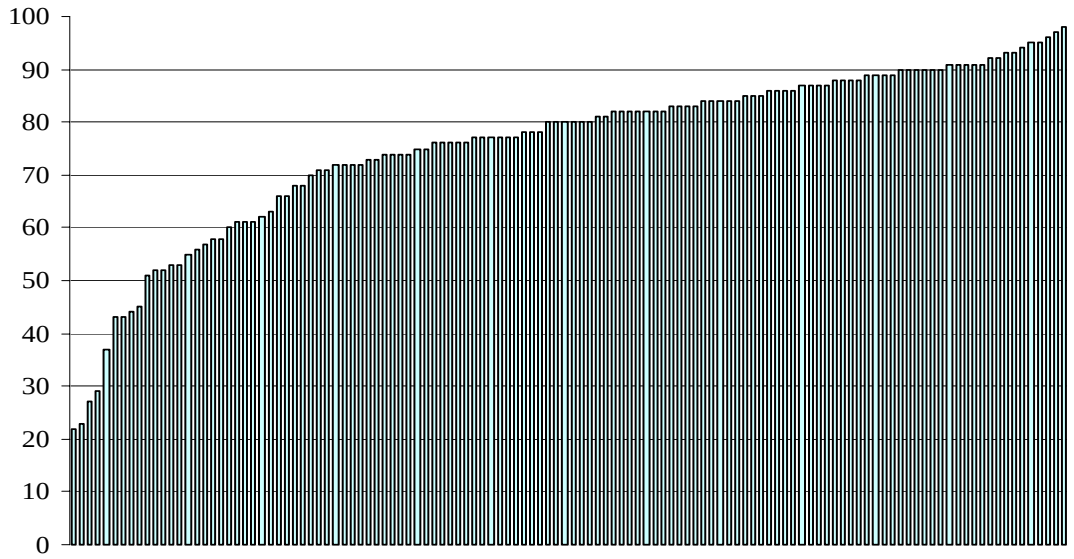


Fig VI-6: Accreditation Scores for all hospitals – bar chart

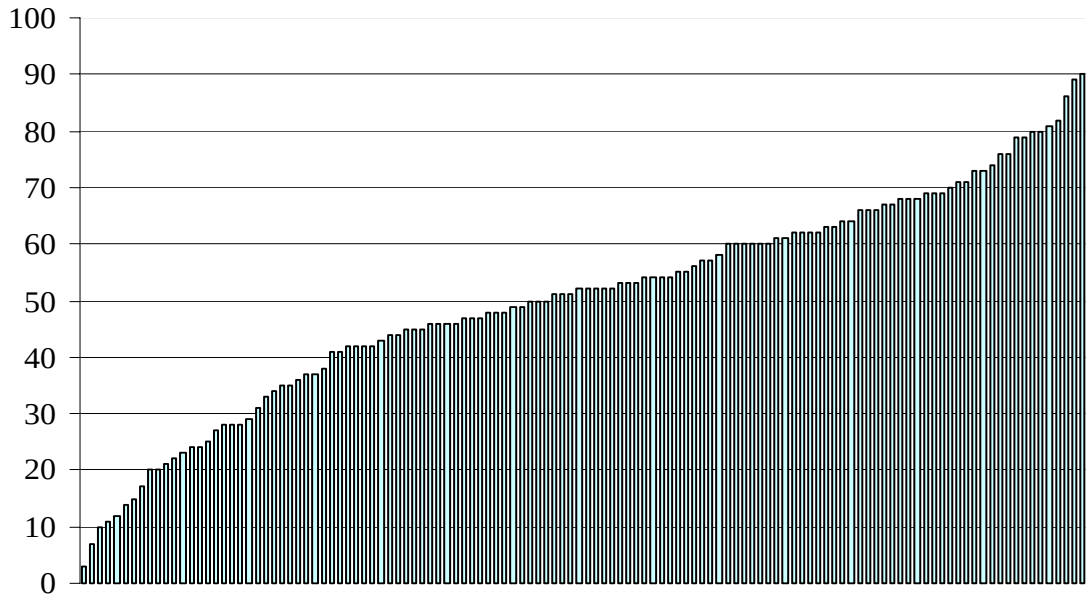
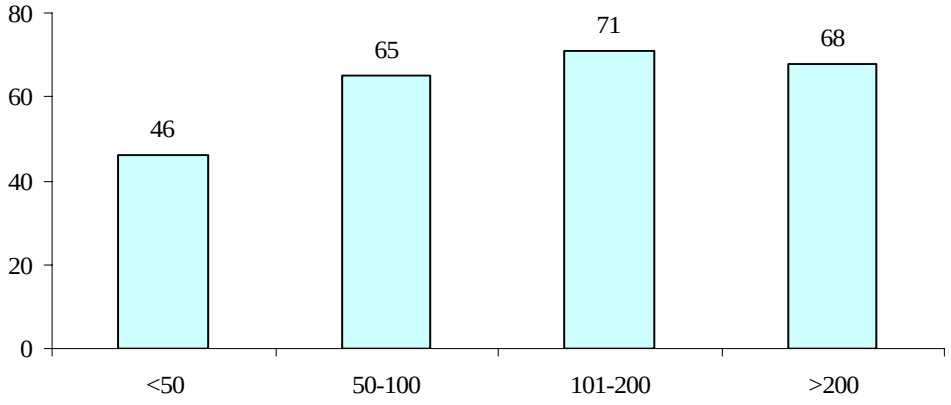
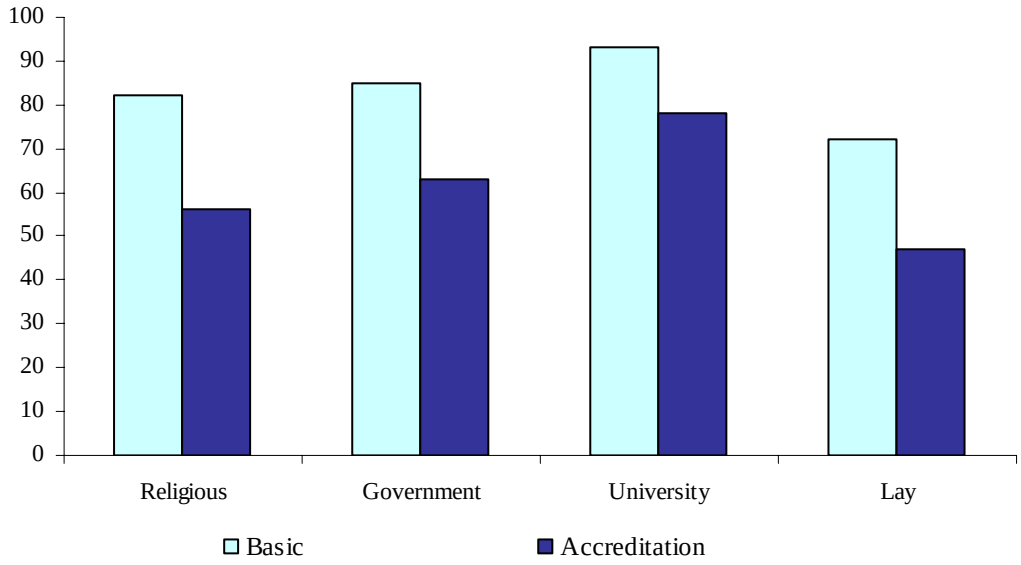


Fig VI-7: Score average by hospital bed capacity



The ownership type has an impact on how well the hospital management is able to meet requirements, as shown in figure VI-8. It is worth mentioning that the 2 autonomous public hospitals included in the survey realized a relatively good score.

Fig VI-8: Basic and Accreditation scores by type of ownership



3.8 Interconnecting the Database of Public Funds Beneficiaries

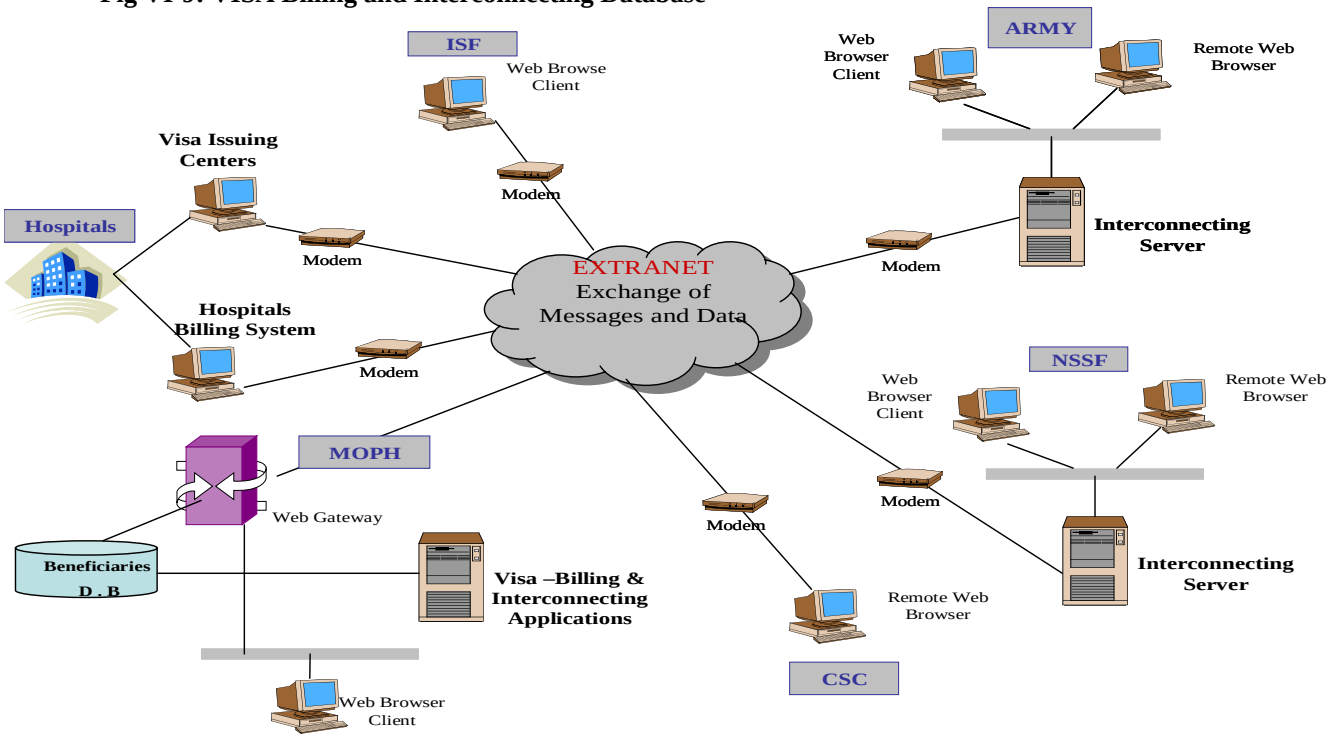
The Council of Ministers issued a decision in January 2001 on setting up beneficiaries databases in different public funds, to be linked electronically to the Ministry of Health.

This interconnecting database would allow the MOH and other public funds namely the Army, the Internal Security Forces (ISF), the National Social Security Fund (NSSF), and the Civil Servants Cooperative (CSC), to share information about eligibility. The primary objective is to avoid overlapping and double coverage, to relief funding agencies from cumbersome administrative procedures of issuing non-eligibility certificates, and the citizens from the burden of obtaining them. This database could be integrated to the VISA/Billing System and could serve at a later stage for assessing utilization patterns of different population categories, and for evaluating the financial burden and the performance of each fund.

The database stores beneficiaries' demographic and eligibility information. Each fund updates on a daily basis information related to its own pool by adding new adherents, updating dependents' status, and removing outgoing members, whose burden is in practice shifted to the MOH. The Central Information System located at the Ministry of Health collects automatically these files from different funds and updates the consolidated beneficiaries database.

The MOH assisted other public funds in collecting and processing the missing beneficiary information. It has equipped funding agencies with interconnecting PCs, modems, dedicated phone lines, and the necessary communication software and configuration. This set-up allows the Central System at the MOH to automatically establish a connection and download files containing the updated beneficiaries information. Public funds can access remotely the centralized MOH database for searching purposes.

Fig VI-9: VISA Billing and Interconnecting Database



The MOH is equipped with a dedicated access server and 60 phone lines available for remote users and eventually contracted hospitals. This network allows the establishing of a connection with the database using special search forms designed to be used from a WEB browser.

This Interconnecting system provides a platform for the development of new applications for utilization of services and incurred spending. For this purpose, the MOH and public funds are working on the standardization of the application, and the coding system and on unifying authorization and billing forms.

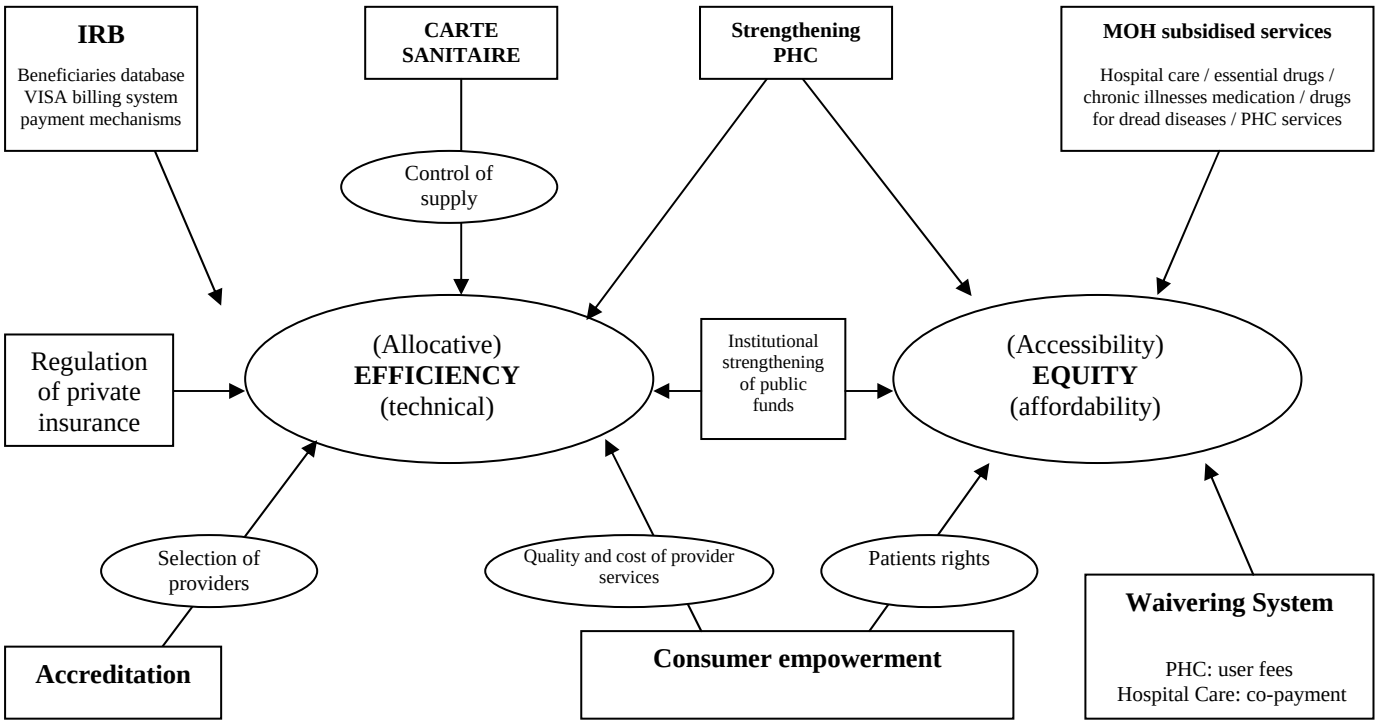
3.9 Reform Components Integration

Health reform is a continuous process, it involves multidirectional activities that should be coordinated and objective-oriented. The agenda should consider the institutional capabilities of funding agencies and providers, as well as stakeholders interests that vary with the topic and in the course of change. Therefore, a stepwise approach should be adopted, where alliances adapt in a dynamic way to interests at stake.

Figure VI-10 shows the articulation of different components of reform aiming at addressing efficiency and equity issues.

The Financing reform is the most important component of the health reform and deserves a chapter by itself (chapter VII), whereas the creation of an Interface and Resource Body (IRB option) is addressed in details in the annex. Creating a unified database of public funds beneficiaries, establishing a VISA/Billing system in the MOH and working on payment mechanisms, are important steps towards the IRB reform option. This allows avoiding eligibility overlapping, controlling demand, and redressing provider incentives. Altogether these would have an important impact on the efficiency of health services provision. On the other hand, regulation of private insurance, selection of providers based on accreditation scores and controlling the supply side would also have a positive effect on efficiency.

Fig VI-10: Integration of reform components targeting efficiency and equity



Expanding and upgrading PHC services represents a cost effective use of resources, and at the same time contributes to ensuring equity by improving accessibility to affordable basic services. Consumer empowerment by providing information on cost and quality of providers services and on patients rights, would also have an impact on both efficiency and equity. Finally, for the sake of equity, the MOH should continue to be an insurer of last resort, and modernize its contractual relationship with hospitals and NGOs. The waivering system should be rationalized and transparent where the poor, properly identified, would be exempted from user fees. A large information campaign about subsidized services and waivering policies should target, poor and remote population, among which the percentage of the uninformed is the higher.

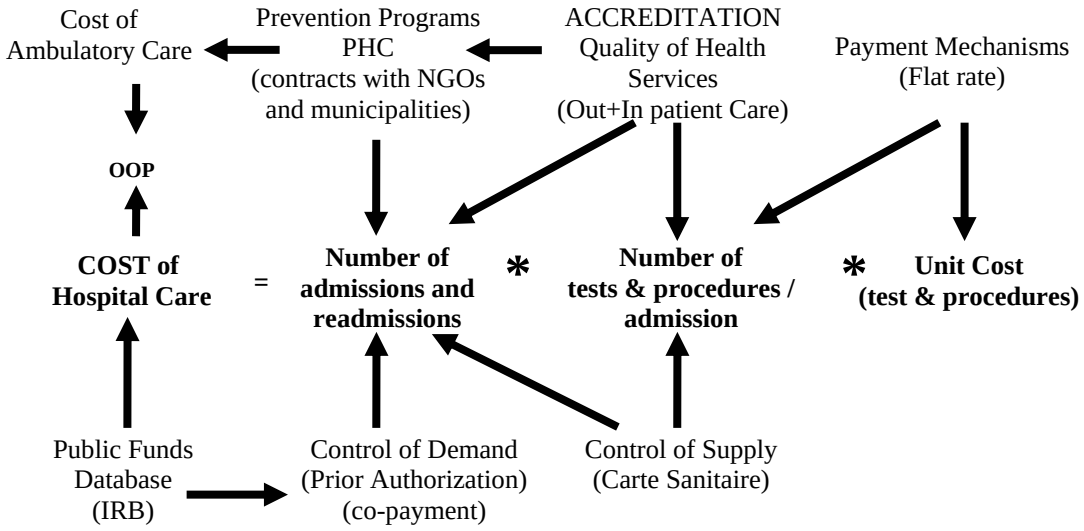
Figure VI-11 shows reform components that deal with high cost of health services and the heavy burden on households. These are of course related directly to issues of efficiency and equity of the previous diagram.

Enhancing accessibility to PHC would on the short term reduce the dependence on private for profit clinics, lowering thus the households out-of-pocket payment especially that of the poor, and would, on a longer term, improve the health status of the population, and consequently lessen the need for hospitalization.

On the one hand, avoiding unnecessary admissions and interventions is an integral part of quality assurance. On the other, the case-based payment rationalizes unit costing and discourages over-utilization.

The public funds beneficiaries database would prevent double billing and allow for a better control of demand. And finally, the Carte Sanitaire would minimize provider-induced demand.

Fig VI-11: Integration of reform components targeting cost containment of ambulatory and hospital care, and households out-of-pocket.



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