The MOH Strategic Plan

January 2007

1. Analysis of the current situation

1.1- Context of the health system

The health care system in Lebanon is mainly oriented towards curative care with a rapid growth in the number of private hospitals and centers of high technology services. Before the July 2006 war the government was directing significant efforts towards strengthening its institutional capacity and reinforcing the public sector and its role in the provision of healthcare services. Facts remain that more than 80 percent of hospital beds are in the private sector and most of ambulatory care services are delivered by the private clinicians the remaining being provided by the Primary health care centers owned mainly by the NGOs.

This business oriented domination is driving the health sector towards favoring large cities, high income communities, at the expense of the poorer population groups. This has led to discrepancies in terms of physical access to health services as well as to discrepancies in affordability of the health care. However, the role of the MOH as an insurer of last resort, in covering hospital care of the uninsured population and in supporting the provision of essential services through a national PHC network in collaboration with NGOs, has contributed to improve significantly the accessibility of the poor to health care. Nevertheless regional discrepancies in terms of health outcomes remain to be addressed.

Several initiatives were launched aiming at improving the monitoring as well as the quality of the health services, namely the Hospital Accreditation exercise, the network of Primary Health Care Centers of excellence, the law of autonomy to the public hospitals, the Maternal and Child Health project in the Akkar region, the establishment of prevention and Control programs such as the National Tuberculosis program, the National AIDS program, The national Non Communicable Diseases program, etc…. Attempts at improving data on health also were made, including implementation of several national studies (National Household Expenditure and Utilization survey, National Health Account study, PAP Fam studies,etc…) as well as epidemiological surveillance and establishing registries (Cancer registry, Cardiac Intervention Registry , etc…)

During the Health Emergency caused by the July 2006 war, the MOH response was prompt and backed up significantly by the private sector and the NGOs. This has resulted in the fact that all casualties necessitating medical treatment had indeed received it, and also in the fact that the most affected populations as well as the rest of the country had no shortage of medications and medical supplies, despite a significant damage to Health facilities, and a very massive destruction of infrastructure.

In addition to the extra financial burden and capacity load incurred by the July 2006 war on the health system, it is expected that more people will be impoverished, and that subsequently the purchasing power (out of pocket) of the general population will be reduced.

1.2- Context of the health financing and expenditures

Lebanon currently outspends all Middle East and North Africa (MENA) countries on health as a percentage of GDP (US$510 per capita and 10.6 percent of GDP in 2003).
6 public health funds exist covering almost 38% of the population, whereas only 8% are covered by private insurance. The remaining 54% of the population is entitled to the coverage of the Ministry of Health for hospital care and expensive drugs. 60% of national health spending is paid out-of-pocket which exposes the poor to unbearable financial risks in the event of a catastrophic illness or injuries.

On the other hand, financing fragmentation and weak regulation of the private market represent serious obstacles for MOH and public funds to get good value for their expenditures in purchasing private health services.

The MOH has been incurring deficits since 1996. Health expenditures by the public sector (representing around 20 percent of all spending) are drained by the curative services. Health financing fragmented across multiple public health insurance funds entails high administrative costs within the system. The contribution rates, eligibility rules, benefit packages and provider payment methods vary across these funds. In an attempt to reduce the hospitalization cost, the MOH has already introduced the flat-rate reimbursement and is currently considering switching to a Diagnosis-Related Grouping (DRG) system for hospital reimbursement

Only 5 percent of public sector expenditures are devoted to primary care services and public health functions. In fact, the overall utilization of the primary health care network is low and seemingly motivated by the availability of free drugs. PHC performance evaluation is planned to be introduced, and attempts are made to develop a continuum of care starting at the PHC level, including referral to a third level system.

In general there is a need to define the roles and to coordinate activities among the various health sub-systems to reduce duplication and waste of the limited resources and to standardize and improve the Quality of health care. The question of whether the current spending levels are sustainable is a major issue in the health policy reform discussion. These were the pillars of the Health Sector Rehabilitation Project supported by the World Bank since 1995, based on the Governments' determination to contain escalating health care costs, provide services that are equitable, efficient, effective and financially sustainable, with the following main objectives:

1. Improve the country's health conditions through better allocation and use of resources in the public and private sectors.
2. Strengthen the planning, monitoring and quality assurance capacity of the MOH and rationalize health sector financing.
3. Improve service delivery and address equity issues.
4. Support the development of a broad health sector strategy.

1.3- Progress update on Health sector Reform

The MOH considers health reform as a continuous endeavor that has started a decade ago seeking a step wise approach. For any new investment to be effective, it should capitalize on the main efforts made so far.

The following represents a summary of the main achievements made, in each component, under the Health Sector Rehabilitation Project. They would be analyzed with respect to their future development and utilization as building blocks for the new health reform strategy.

Health Financing

Purpose: ***Develop a national strategy for health financing reform aiming at harmonizing the coverage system and improving efficiency.***

Accomplishments

- National Health Accounts survey for the year 1998, 1999, and 2002 (2003 under development).
- National Household and Health Services Survey 1999.
- Burden of Disease Study (BOD) 2002.
- Health system Responsiveness Study.
- Revising payment mechanisms and introducing a DRG reimbursement system.
- Analysis of financial and legal impact of different reform options.
- Actuarial study of health benefit package.
- Stakeholders analysis of social health insurance options.

Quality Improvement

Purpose: development and implementation of a hospital accreditation and quality improvement system for contracting with public and private hospitals based on established quality standards.

Accomplishments

- Development of hospital accreditation standards for acute care hospitals (first edition in 2001 and second edition in 2003)
- Conduction of two national hospitals surveys (first survey in 2001-2202 and second survey in 2004 and 2005).
- Conduction of two follow up surveys (first survey in 2002-2003 and second survey in 2006).
- Development of an action plan for future development of the accreditation program.
- Establishing a link between accreditation results and contracting with private and autonomous hospitals.
- Development of a model linking accreditation bands to hospital payment.

Pharmaceuticals

Purpose: To reduce the national drug bill, and make drugs more affordable and accessible.

Accomplishments

- In late 1999, a situation analysis of the pharmaceutical sector in the country was conducted.
- The MOH drug distribution center established in collaboration with WHO provides expensive drugs for cancer and other dread diseases, was fully informatized and provides services for the uninsured population.
- Strengthening the MOH department of pharmaceuticals inspection.
- Updating and reinforcing the drug registration system within MOH.
- Decision 1/301 issued in 2005 enabling the review of prices for 3400 pharmaceutical products compared to prices in Saudi Arabia and Jordan. The average price reduction for these products was 20%.
- Decision 1/306 issued in 2005 revisited the pricing structure and led to price reduction of all pharmaceutical products on average between 3 to 15%.

Management information system: MIS

Purpose; To establish a National Health Information System (NHIS) to automate and link different departments of the MOH the primary objective is to provide timely information for decision making and ensure transparency for public accountability.

Accomplishments

- Development of an information system master plan
- Implementation of a pilot district health information system
- Computerize and upgrade the visa system of MOH (prior authorization for patients admission to contracted hospitals) and decentralization of the electronic system to all districts.
- Establish a unified database on public funds beneficiaries with an electronic link with the MOH database.
- Development of workflow for internal transactions between MOH departments which is open to the public for tracking purposes through the MOH website.
- Development of the MOH website allowing the dissemination of information on MOH activities and programs.

Regulation (carte sanitaire) ***Purpose: strengthening the planning capacity of the MOH to meet the needs and priorities of health care in Lebanon.***
Accomplishments
• A GIS Base System was developed to include health care facilities, equipment, and manpower. This inventory system covers all types of health care facilities in Lebanon: hospitals, health care centers. Pharmacists, lab and X-ray centers,..etc. • Complete the inventory of health infrastructure and human resources in the Carte Sanitaire Database that was constructed in 1997. The health centers' questionnaires were completed, and the system was updated accordingly. The updating of hospitals' files was made using the MOH licensing register. • A carte sanitaire law was finalized and sent to the Council of Ministers. • Development of master plan for the heath needs assessment study. • Situational Analysis of Health Human Resources in Lebanon.
Primary Health Care ***Purpose: strengthening the PHC activities and improving the role of district health services through a national network including contractual agreements with NGOs and municipalities.***
Accomplishments
• Expansion of the PHC network to include 109 Healthcare centers with the aim of reaching 150 centers by the end of 2007. • Contracts with NGOs and municipalities were signed and monitoring system installed. • Rehabilitation of some PHC centers: physical restructuring and provision of medical and office equipment. • Development and dissemination of a guide for primary health care providers . • Development of a capacity building system (under development) • Development of a PHC national committee representing the key stakeholders in the field of PHC. • Development of a comprehensive basic healthcare service package to all citizens, especially those in under served areas(General medicine, Child healthcare, including well-baby care, school health and treatment of sick children, Reproductive Health, Oral/Dental Health, Management of chronic illnesses, Health Education, Essential Drugs). • Widening/Expanding the scope of the said PHC service package to include: Mental Health., Handicapped Health, Elderly Health, Basic Emergency Services. • Development of a pilot project on safe pregnancy, delivery , and ante- post natal care in the governmental healthcare center in Wadi Khaled- Akkar through a contractual agreement with an NGO. • Development and implementation of a health information system to automate the administrative and medical information at the Qada level and in the primary health care centers. • Training of PHC staff on developed HIS. • Development of training manuals in various PHC areas.

- Train PHC personnel on developed materials.
- Operationalization (in process) of system management tools such as:
  1. Delineation of "Catchments areas" for the Primary Healthcare Centers
  2. The "Health Card"
  3. Referral system (namely to Government Hospitals at Qadha level)
  4. Automation/Net working of Health Information System
  5. Accreditation of Primary Healthcare Centers (under development).
  6. Continuous Quality Improvement.

2. The revised Health strategy

The recent July 2006 war has added an extra burden on the health system. It has aggravated the weaknesses of the health sector, such as limited capacity to monitor primary care services, high expenditure on hospital-based care and human resource capacity constraints within the MOH, Beyond the immediate human losses (1,184 fatalities), treatment costs (5,500 injured) and infrastructure damage (16 hospitals and 65 outpatient facilities) brought about by the hostilities, there are other important effects on several aspects of the health sector. The trauma caused by the conflict, particularly on the vulnerable, may increase the overall levels of morbidity and cost of care. The economic slowdown stemming from the hostilities will reduce the scope of employer/employee contributions to Social Security, general revenues to support MOPH, and subsidies to the public health insurance funds. This will exacerbate the already sizable operating deficit in the 'sickness and maternity' fund of the National Social Security Fund (NSSF) (which will have serious implications for the 'end of service indemnity' fund) and will further curtail the ability of the MOPH to provide subsidized care for the uninsured population at a time when unemployment is on the rise.

This necessitates rapid interventions to alleviate the short term and the medium term impacts on the health sector. The main **goals** of the strategies proposed below include:

- improve the development capacity of the health system
- improve the equity of the system among the various population groups

The proposed development objectives revolve around the principles of **equity, financial sustainability, quality and macro-efficiency**.

The overall long term objectives include:

1) Improve the health indicators and reduce regional discrepancies (health status level and distribution), including early recovery program for the communities affected by the last conflict.
2) Improve the overall quality of health service delivery.
3) Sustain health care financing reform.
4) Provide cost effective and safe drugs and rationalize their consumption and prescription;
5) Strengthen the MOH preventive programs.

For the short and medium term periods, the following is suggested:

- focus the resources that can be made available on a defined set of service priorities.
- assure adequate financing to provide these services at a decent level of quality.

Based on organizations and incentives that can assure efficiency and quality in the provision of health care, the following **strategies** are proposed:

1- continue the health insurance reform aiming at harmonizing the coverage system and improving efficiency.
2-develop improved monitoring mechanisms aiming at ensuring a better MOH insurance coverage.
3- sustain the Hospital accreditation system and expand it to cover the PHC system.
4- apply the contracting with health facilities based on performance evaluation, especially in the most deprived areas.
5- establish a health card system aiming at promoting universal accessibility, improving monitoring and rationalizing expenditures on health services.
6- strengthen the core public health functions of the MOH.

The development **interventions** and priority areas shall focus on ways to leverage the proposed initiatives to effect strategic and sustainable changes to the Lebanese health sector.

There is a need therefore to ensure the provision of services through the expansion of the network of PHC centers within a health investment plan taking into consideration the priority needs and the availability of resources. Hence, the proposed ***"Carte Sanitaire"*** as a regulation tool would be adapted and tied to a new health technology assessment program. Without such safeguards on the supply-side investments, especially with the very high level of out-of-pocket expenditures, containing rising healthcare costs will remain exceedingly difficult. In this respect, the reconstruction of health facilities would require the coordination and rationalization of donor contributions to the reconstruction/rehabilitation of damaged infrastructure.

The existing health financing system is characterized by some level of allocative and technical inefficiencies in a highly fragmented risk pooling structure and poorly targeted public subsidies which leads to limited financial protection of households, especially the lower income groups from the negative effects of chronic and catastrophic illnesses. As these problems contribute significantly to the high cost of care on the one hand, and persistent lack of access and inadequate ***financial protection*** for the vulnerable groups, on the other hand, the Government will continue to move forward with its health financing reform agenda, which includes the following:

(i) reduce the high administrative costs and inefficiencies associated with the fragmented health financing by implementing a phased plan to harmonize and integrate the public health insurance funds;

(ii) strengthen the strategic purchasing capacity of the MOPH and the insurance funds to ensure that the services being contracted provide better value for money;
(iii) improve the targeting of public subsidies by identifying the uninsured and vulnerable population for appropriate exemptions and benefits.

In this respect , The ***health card project*** becomes a symbol of universal access to health care. It consists of establishing a system that will be built by phases:

Phase One:
The card would allow access to PHC services. It allows the expansion of primary care centers to cover all Lebanon and define catchment areas within a functional referral system.
The card will offer at this stage access to essential services, with a nominal fee and a wavering system targeting the poor and vulnerable population.
The services would include:

- Immunization
- Maternal and Child Health
- Reproductive Health
- Essential drugs
- Health Education
- Oral Health
- Mental health

The card would also allow the access to a ***referral system*** established between the PHC network and governmental hospitals and follow-up after discharge in the health center as well as home care services.
At this first phase, eligibility for hospital care coverage provided by the card would be restricted to the uninsured entitled for the MOH coverage. Public funds eligibles should continue to follow the routine administrative channels currently applied under each coverage scheme.

In order to help implementing this first phase, the MOH would examine ways to reallocate current resources to implement the ***new package of primary care services*** and ***expand the current network of PHC*** centers. The new PHC model would include the list of essential services within a referral system and new payment/contracting methods with the health centers. The new package of primary care services will be rolled-out all over the country. In addition, The MOH would also initiate a process to improve its core public health functions (epidemiological surveillance and emergency preparedness) and selected public health programs (school health, oral health, mental health, essential drugs, childhood nutrition, road safety, maternal and child). PHC centers will be eligible to subcontracting by the MOH based on Performance Indicators, namely as they relate to the improvement of the health status of the served community. (see annex for KPI)

Phase Two:

This stage would include a ***unification of the coverage system whereas public funds keep their autonomous identities. They would be assisted by a third party administrator*** that could manage hospital admission and reimbursement within a unified benefit package, administrative procedures, tarification and regulation norms. At this stage the ***unified health card*** entitles its holder to coverage of hospital services. This would involve the development of common business procedures and standards (forms and procedure codes) as a preparatory step towards harmonization and integration of administrative functions. It would also involve enhancing the organizational effectiveness and the business operations of the insurance funds and their capacity to negotiate effectively with the health care providers. This requires

- investments in the health management information systems (currently underway).
- revisions to the existing eligibility rules, contribution rates, covered benefits and payment/contracting methods.
- strengthening of the beneficiary registration system (through unique identifier).
- close coordination with the parallel reforms in social safety nets and the social protection system.

<u>Development Objective</u> 1. Improvement of Health indicators and reduction of regional discrepancies	
<u>Specific Objectives</u>	**<u>Activities</u>**
1. Launch an early recovery program for affected communities by JULY 2006 war	1.1 Rehabilitation of health facilities in affected areas 1.2 organize coordination meetings for tailoring of health facility investments in affected areas
2. upgrade primary health care system	2.1 review and adopt a basic health services benefit package 2.2 Extend network of PHC centers 2.3 enhance community involvement and accountability 2.4 review the licensing mechanism and eligibility
3. develop targeted programs to reduce maternal and child mortality	3.1 Roll-out implementation of the wadi khalid pilot project . 3.2 Preparation of educational material on negative impacts of smoking on pregnant women 3.3. develop maternal audit 3.4 reactivate the baby friendly hospitals and breast feeding program 3.5 Conduct training for health workers on safe motherhood.
4. Upgrade the existing PHC Management Information Systems	4.1 I.T. capacity building for new centers joining the network. This will include training and installation of hardware and software. 4.2 Redesign the system in order to support the expanded network of PHC. 4.3 Develop reporting and data analysis capability to support performance monitoring to match needs.
5. Improve accessibility targeting the poor and population with special health needs	5.1 design a referral system from primary health care centers to secondary and tertiary hospitals. 5.2 issue health cards on PHC eligibility enhancing accessibility and continuum of care. 5.3 pilot test alternatives to hospitalization such as home care and one day clinics 5.4 conduct studies on utilization of services and its link to health outcomes 5.5 develop a wavering system to exempt the vulnerable population from co-payment 5.6. extend provision of essential drugs and vaccines

Development objective 2. Improvement of overall quality of health service delivery	
Specific objectives	**Activities**
1. Improve the quality of hospital care	1.1 Continue the development of hospital accreditation system 1.2 Further develop and review accreditation standards to include evaluation of medical practice and highlight issues related to patient safety. 1.3 Develop a mechanism to expand the link between accreditation results and contracting to all public funds 1.4 Collect and analyze information regarding patient satisfaction 1.5 Development of Clinical Practice Guidelines in collaboration with scientific societies and professional bodies
2. Institutionalize the hospital accreditation program	2.1 Develop a time-bounded plan to institutionalize the hospital accreditation process with the help of an international accreditation body 2.2 create a quality management unit within the MOH 2.3 Reviewing the appropriateness of adopting the ALPHA standards for Lebanon's hospital accreditation program
3. Improve quality of primary health care programs	3.1 Develop PHC standards and initiate an Accreditation program 3.2 Development of key performance indicators and define means of information collection 3.3 Implementing the system for monitoring performance of facilities to ensure that they meet reform objectives 3.4 Preparation of disease management guidelines.

Development objective 3- Sustain health care financing reform	
Specific objectives	**Activities**
1. Proceed in reform plan to harmonize and integrate the public health insurance funds.	1.1 Recommission work on standardization of codes, forms , tarification and payment methods across the public insurance funds 1.2 Revisit eligibility policies, contribution rates, covered benefits, financial discipline and health management information systems of public insurance funds 1.3 Amend by-laws on insurance funds to allow for common administrative procedures
2. Implement phased integration of public health insurance funds and extend eligibility of health card to hospital care	2.1 develop terms of reference for the IRB (TPA) 2.2 Consolidate the beneficiary registration system (unique identifier-health card) in close coordination with parallel reforms in other social protection systems. 2.3 Integrate HMIS systems across public insurance fund
3. Balance and rationalize the various sources of financing	3.1 update the study on cost analysis of hospital services 3.2 Update and institutionalize national health accounts (NHA) 3.3 Assist in the implementation, monitoring and evaluation of the new DRG system within the MOH and transfer of the system to the NSSF and other public funds.

Development objective 4- provide cost effective and safe drugs and rationalize their consumption and prescription	
Specific objectives	**Activities**
1- regulate the pharmaceutical market	1.1 Review the current registration and pricing system 1.2 Adopt a code of ethics with the order of physicians, order of pharmacists and pharmaceutical companies to regulate the promotion and marketing of drugs
2- rationalize medical prescriptions	2.1 Promote the use of generic dugs and launch awareness campaigns and trainings on the use of drugs 2.2 Develop a prescribing guide for physicians that lists generic alternatives for frequently prescribed branded drugs and allow generic substitution for pharmacists if not explicitly excluded by the physicians

Development objective 5- strengthen the MOH preventive programs	
Specific objectives	**Activities**
1- promote injury prevention programs	1.1 Establishment of national data information system on injuries and burden of disease 1.2 Develop awareness programs on injuries prevention among high-risk groups (drivers, industrial workers,etc)
2-reinforce the school health program	2.1 Assess the situation on school health services and support regular medical visits. 2.2 develop a standard package on school health services with special consideration on immunization. 2.3 strengthen health education activities in schools and promote healthy lifestyles. 2.5 conduct the global school based student survey (GSHS) 2.6 develop teacher training programs to prevent HIV infection and related discrimination through schools 2.4. develop training material for teachers regarding health education topics such as Mental health, reproductive and sexual health, etc…
3. reinforce the EPI program	3.1. enhancement of EPI management through strengthening technical and logistic capacities at central and peripheral level 3.2 consolidate networking between public and private sector especially in terms of immunization 3.3 conduct training sessions on vaccine management issues for health care providers. 3.4 upgrade normative tools (service delivery guidelines, system management protocols…)
4. Enhancing epidemiological surveillance program	4.1 Conduct training program for MOPH teams at peripheral and central level on epidemiological surveillance and response 4.2 Conduct training sessions for doctors and lab technicians on surveillance systems for measles 4.3 Build operational Outbreak Rapid Response teams at peripheral and central level. 4.4 Develop the Information and Communication Technology to enhance reporting of modifiable diseases to the MOPH
5. reinforce the national AIDS program	5.1. expand the staff to include an IEC and an NGO coordinator 5.2. conduct a treatment resistance study 5.3. conduct IEC activities targeting vulnerable groups

6.reinforce the non communicable disease program	6.1. develop national control strategy and plan of action for non communicable diseases including diabetes, cardiovascular, cancer and obesity. 6.2. implement awareness activities and conduct targeted prevention programs.
7. reinforce the registries	7.1. expand the cancer registry to collect information based on clinical pathology 7.2.expand the Interventional Cardiology registry to cover all hospitals

Development objective 6. Strengthening the regulation capability of the MOH .	
Specific objectives	**Activities**
1. strengthen regulation capacities	1.1 develop regulation tools linking investments to health needs.. 1.2 follow up on issuing the law enforcing the Carte Sanitaire. 1.3 Prepare Technical specifications and norms for Healthcare infrastructures. 1.4 Building a health technology assessment capacity to evaluate the medical and economic appropriateness of all imported health technologies.
2. Develop a long-term Health Investment Plan based on a re-evaluation of priority needs and affordability of services	2.1 Update inventory of all resources available in the sector 2.2 Development of scenarios for the demographic growth and epidemiological transition and the demand and health care infrastructure needs. 2.3 Define implementation indicators for the management of projects and programs within the health master plan
3. Capacity building of the MOH .	3.1 Develop a training program for MOH Staff 3.2 Develop a strategy for developing stewardship functions of MOH. 3.3 define core public health functions and assist the MOH to fulfill its role as a public health authority.

Annex

Key Performance Indicators

1	2	3	4	5	6	7	8	9	10	11
	Identification of Five (5) Key Performance Areas	**Type of Key Performance Indicator** *(EI or APR)* [1]	**Key Performance Indicator (KPI)**		**Unit of Measurement** *(#, %, km, ratio, index, ...)*	**Weight** [2] ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** *(e.g. : name of document, records, computerized database, MIS, ...)*	**KPI Situational Analysis in Administration**		**Remarks and Explanations**
			Code	**Description** *(at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)*				**Target Setting on KPI Practiced** *(0 - 5 score)*	**Practice & Quality of KPI Data Collection** *(0 - 5 score)*	
1.	**Improvement of Health indicators and reduction of regional discrepancies** *(continued on next page)*	1.1 EI Effects / Impact	1.1.1	Maternal mortality rate	‰ live births	25.0%	- Demographic and Health Surveys; - Vital Registration.			Universally applied indicator
			1.1.2	Under-five mortality rate	‰	20.0%	- Demographic and Health Surveys; - Vital Registration.			Universally applied indicator
			1.1.3	Infant mortality rate	‰	20.0%	- Demographic and Health Surveys; - Vital Registration.			Universally applied indicator
			1.1.4	Average life expectancy at birth	years	5.0%	- Vital Registration - Population surveys by age group			Universally applied indicator, gender differentiated
			1.1.5	Differential maternal mortality rate	Component A ‰		Demographic and health surveys			Indicator measures differences between segments of population (distribution indicator). Composite indicator with total weight of 15% and consisting of … component indicators.
					Component B ‰					
					Component C ‰					
					Component D ‰					
					Component E ‰					
			1.1.6	Differential under-five mortality rate	Component A ‰		Demographic and health surveys			Indicator measures differences between segments of population (distribution indicator). Composite indicator with total weight of 15% and consisting of … component indicators.
					Component B ‰					
					Component C ‰					
					Component D ‰					
					Component E ‰					

1	2	3	4	5	6	7	8	9	10	11
Identification of Five (5) Key Performance Areas		**Type of Key Performance Indicator** *(EI or APR)* (1)	**Key Performance Indicator (KPI)**		**Unit of Measurement** *(#, %, km, ratio, index, ...)*	**Weight** (2) ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** *(e.g. : name of document, records, computerized database, MIS, ...)*	**KPI Situational Analysis in Administration**		**Remarks and Explanations**
			Code	**Description** *(at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)*				**Target Setting on KPI Practiced** *(0 - 5 score)*	**Practice & Quality of KPI Data Collection** *(0 - 5 score)*	
1.	**Improvement of Health indicators and reduction of regional discrepancies** *(continued)*	1.2. APR Activities / Process / Direct Results	1.2.1	Percentage of the population with access to basic, local health services	%		Ad hoc studies and surveys			* Primary Health Care (PHC) Package; * Terms "access" and "basic, local health services" to be operationally / measurably defined by MOPH
			1.2.2	Percentage of the rural population with access to basic, local health services	%		Ad hoc studies and surveys			In addition to 1.2.1, term "rural" to be operationally / measurably defined by MOPH
			1.2.3	Percentage of the urban population with access to basic, local health services	%		Ad hoc studies and surveys			In addition to 1.2.1, term "urban" to be operationally / measurably defined by MOPH
			1.2.4	Composite indicator: Percentage of full immunization of children: (a) Percentage of infants fully immunised; (b) Percentage of two years old fully immunised; (c) Percentage of five years old fully immunized.	Component (a) % Component (b) % Component (c) %		- Regular monthly reports of the National Immunization Programme - Studies and surveys			* Infant: from birth to 12 months; * Fully immunized: in accordance with the standards of the National Immunization Programme (Imm. Card) * Surveys need to cover both the public and private sectors
			1.2.5	Composite indicator: Total number of vaccines distributed by MOPH in relation to the total number of children needing vaccination against: (a) MMR (b) HIB (c) Heptatitis B (d) Polio (e) TDP	Component (a) % Component (b) % Component (c) % Component (d) % Component (e) %		- National Immunization Programme - Vital Registration - Demographic and health studies and surveys			* Composite indicator consisting of 5 component indicators, one for each of the five most important immunisations; * Relative weight of each component indicator within the composite indicator to be determined .
			1.2.6	Percentage of deliveries attended to by skilled health personnel	%		- Records of hospitals and maternity wards - Studies and surveys			Skilled health personnel: Ob-Gyn specialist or midwife
			1.2.7	Percentage of pregnant women having a minimum of four visits to skilled health personnel per pregnancy	%		- Records of hospitals and maternity wards - Studies and surveys			
			1.2.8	Percentage of women having post natal care	%		- Records of hospitals and maternity wards - Studies and surveys			
			1.2.9	Composite indicator: Accessibility of (rural) Health Centres: (a) Percentage of Qadas (Districts) having one Health Centre per 20,000 inhabitants; (b) Percentage of Qadas (Districts) having at least two Government Health Centres	Component (a) % Component (b) %		Records of the Primary Health Care Bureau in the Ministry of Public Health			* Composite indicator consisting of two (2) component indicators * Health Centres are owned by the Government
			1.2.10	Composite indicator: Number of operational ambulances and average covered population: (a) Number of operational ambulance vehicles, per district (Qada), per 10,000 inhabitants; (b) Percentage of operational ambulances in relation to the total number of inventorized ambulances, and; (c) Percentage of ambulances that belong to the Ministry of Public Health	Component (a) # / 100.000 Component (b) % Component (c) %		Records of the Bureau of Equipment and Storage in the Ministry of Public Health			* Composite indicator consisting of three component indicators; * Geographical consolidation per Muhafaza or rural/urban differentiation possible; * Technical specifications / classifications of ambulances must be developed still.

Notes : *(1)* *EI = Effects / Impact KPIs ; APR = Activities / Process / Direct Results KPIs*

(2) *Relative weight of clustered EI indicators vis -à-vis clustered APR can be adjusted over time (at first more intense concentration on processes later more on impact - first things first and moreover time lag of impact). Suggestion: at start about 50 - 60 % weight for clustered APR KPIs, with gradual reduction to about 25 - 30 %.*

(3) *Main sources: "MOPH Strategic Plan and Programmes (2003-2006)"; MOPH Reports to WHO; "Health System and Reform in Lebanon"*

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Identification of Five (5) Key Performance Areas		**Type of Key Performance Indicator** *(EI or APR)* (1)	**Key Performance Indicator (KPI)**		**Unit of Measurement** *(#, %, km, ratio, index, ...)*	**Weight** (2) ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** *(e.g. : name of document, records, computerized database, MIS, …)*	**KPI Situational Analysis in Administration**		**Remarks and Explanations**
			Code	**Description** *(at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)*				**Target Setting on KPI Practiced** *(0 - 5 score)*	**Practice & Quality of KPI Data Collection** *(0 - 5 score)*	
2.	**Improvement of the quality of health care delivery**	2.1 EI Effects / Impact	2.1.1	Average satisfaction of patients with ambulant care	% or categories		Patient satisfaction assessment tools (in facilities)			Presupposes availability and actual use of standard patient satisfaction assessment systems, tools and methodologies
			2.1.2	Average satisfaction of patients with hospital care	% or categories		Patient satisfaction assessment tools (in facilities)			Presupposes availability and actual use of standard patient satisfaction assessment systems, tools and methodologies
			2.1.3	Average patient / consumer impression about health facilties: health centres	% or categories		Utilization surveys			Presupposes availability and actual use of standard patient satisfaction assessment systems, tools and methodologies
	(continued on next page)		2.1.4	Average patient / consumer impression about health facilties: hospitals	% or categories		Utilization surveys			Presupposes availability and actual use of standard patient satisfaction assessment systems, tools and methodologies
			2.1.5	Proportion admittance difficulties for hospitalization experienced by patients / consumers, by type of institution	%		- Patient satisfaction assessment tools - Utilization surveys			Presupposes standard assessment / measurement system. Three types of institutions: public, private and NGO

Identification of Five (5) Key Performance Areas	Type of Key Performance Indicator (EI or APR) (1)	Key Performance Indicator (KPI)		Unit of Measurement (#, %, km, ratio, index, ...)	Weight (2) ∑ EI = 100% ∑APR=100%	Empirical Evidence / Means of Verification (e.g. : name of document, records, computerized database, MIS, …)	KPI Situational Analysis in Administration		Remarks and Explanations
		Code	Description (at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)				Target Setting on KPI Practiced (0 - 5 score)	Practice & Quality of KPI Data Collection (0 - 5 score)	
2. **Improvement of the quality of health care delivery** *(continued)*	2.2. APR Activities / Process / Direct Results	2.2.1	Number of insurers adopting the Accreditation System	#		MOPH Accreditation Committee reports			
		2.2.2	Composite Indicator: Number and percentage of accredited health care providers: (a) Percentage of hospitals officially accredited; (b) Number of Health Centres accredited, and; (c) Percentage of total number of Health Centres officially accredited	%		MOPH Accreditation Committee reports			* Composite indicator: Relative weight of the three component indicators needs to be determined. * Presupposes existence of standard official accreditation system and operational practice
				#		Department of Health Centres records and statistics			
				%		Department of Health Centres records and statistics			
		2.2.3	Composite indicator: Number of guidelines / protocols prepared and complied with: (a) Total number of guidelines / medical protocols developed; (b) Number of Primary Health Care (PHC) guidelines developed, and; (c) Percentage of these guidelines effectively complied with by Health Care Providers.	Component (a) #		MOPH and decrees			* "Guidelines / Protocols" and "developed" need to be operationally defined by MOPH * Requires adoption of protocols by Professional Bodies
				Component (b) #		Department of Primary Health Care Centres			
				Component (c) %		MOPH monitoring and quality control records and reports			
		2.2.4	Composite Indicator: Trained health care personnel: (a) Number of Health Care Providers trained; (b) Percentage of total Health Care Providers trained, and; (c) Number of training sessions conducted for Health Care Providers	Component (a) #		Records and statistics of MOPH General Directorate and of training institutes			* Composite indicator: Relative weight of the three component indicators needs to be determined. * "Trained" needs to be operationally defined by MOPH
				Component (b) %		Records and statistics of MOPH General Directorate and of training institutes			
				Component (c) #		Records and statistics of MOPH General Directorate and of training institutes			
		2.2.5	Number of nursing training units established and operational	#		Nursing Programme			
		2.2.6	Percentage completion of Health Care Information System	%					Process, procedures, forms, computerization, etc.
		2.2.7	Composite Indicator: Extent and average score of health care provider controls: (a) Number of health care provider controls executed by the competent units / persons of the MoPH; (b) Percentage of health care provider controls effectively executed in relation to the planned number of controls, and; (c) Percentage of health care provider quality controls which had positive results.	Component (a) #					Composite indicator - Component (a): Requires quality control plan with target setting by types of providers and types of services
				Component (b) %					Composite indicator - Component (b): Requires quality control plan with target setting by types of providers and types of services
				Component (c) %					Composite indicator - Component (c): Presupposes quality control system established and minimum standards set.

1	2	3	4	5	6	7	8	9	10	11
Identification of Five (5) Key Performance Areas		Type of Key Performance Indicator (EI or APR) (1)	Key Performance Indicator (KPI)		Unit of Measurement (#, %, km, ratio, index, ...)	Weight (2) ∑ EI = 100% ∑APR=100%	Empirical Evidence / Means of Verification (e.g. : name of document, records, computerized database, MIS, …)	KPI Situational Analysis in Administration		Remarks and Explanations
			Code	Description (at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)				Target Setting on KPI Practiced (0 - 5 score)	Practice & Quality of KPI Data Collection (0 - 5 score)	
3.	**Sustain health care financing reform** *(continued on next page)*	3.1 EI Effects / Impact	3.1.1	Health expenditures as % of GDP	%		National Health Expenditure Survey			
			3.1.2	Increase of share of non-state actors and citizens in financing of NSSF	%		National Health Accounts			NSSF = National Social Security Fund
			3.1.3	Number of Insurance Providers implementing the L-DRG	#		MOPH monitoring / inspection records and statistics			
			3.1.4	Percentage of total number of Insurance Providers implementing the L-DRG	%		MOPH monitoring / inspection records and statistics			
			3.1.5	Percentage of total number of hospitals whose bills were controlled were controlled with a positive result	%					Requires / presupposes a standardized control system
			3.1.6	Percentage of population covered by a health insurance	%		- NHEUS; - Insurance schemes records; - Population census (for population data)			Comprises all types of health insurances
			3.1.7	Percentage of population covered by a health insurance, by type of insurance scheme	% / type		- NHEUS; - Insurance schemes records; - Population census (for population data)			Types include: NSSF, CSC, military schemes, private insurance, complementary private insurance, mutual funds, municipalities, insurance during work or school hours, …
			3.1.8	Average degree of satisfaction of insured population with insurance scheme, by type of scheme	% or categories		- Consumer satisfaction studies - Utilization surveys			Presupposes availability and actual use of standard assessment systems, tools and methodologies
			3.1.9	Average waiting time to get Ministry's approval in hospitalization cases covered by MOPH	hours		- Visa billing sections - Inspecting doctors			

1	2	3	4	5	6	7	8	9	10	11
Identification of Five (5) Key Performance Areas		**Type of Key Performance Indicator** *(EI or APR)* (1)	**Key Performance Indicator (KPI)**		**Unit of Measurement** *(#, %, km, ratio, index, ...)*	**Weight** (2) ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** *(e.g. : name of document, records, computerized database, MIS, …)*	**KPI Situational Analysis in Administration**		**Remarks and Explanations**
			Code	**Description** *(at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)*				**Target Setting on KPI Practiced** *(0 - 5 score)*	**Practice & Quality of KPI Data Collection** *(0 - 5 score)*	
3.	**Sustain health care financing reform** *(continued)*	3.2. APR Activities / Process / Direct Results	3.2.1	Percentage of hospitalization budgetary allocation in relation to the total public health budget	%					
			3.2.2	Percentage overshooting of expenditures for hospitalization in relation to the approved budget	4 categories					(1) no overshooting = 100%; (2) <5%= 50%; (3) <10% = 25%; (4) ≥10% = 0%,
			3.2.3	Percentage of total number of hospitals which have been controlled on hospitalisation subsidies	%					Hospitalization subsidies particularly in relation to eligibility (entrance) of patients
			3.2.4	Percentage of total planned hospitalisation subsidies controls effectively executed	%					
			3.2.5	Percentage of the total number of hospitals of which the bills needed to be controlled also effectively controlled	%					
			3.2.6	Percentage of the total number of hospitals of which the bills have been controlled complying with the minimum standards	%					
			3.2.7	Completion of the database of the clients / beneficiaries of insurance providers	%					
			3.2.8	Percentage of the total number of insurance providers which are connected to the insurance beneficiaries database system	%					
			3.2.9	Percentage of total number of Centres connected to the Database and providing automated visa, by type of Centre: (a) Type 1 (b) Type 2 (c) Type 3 (d) Type 4	% % % %					This is a composite indicators, with the different types of centres as component indicators. MoPH needs to provide a classification of the main types of centres which should be reflected as component indicators under this composite indicator. The sheet provides for four types, but of course more or less types may be possible. Pls. add or delete table rows accordingly. Types of Centres may include: MOH, NSSF, CSC, Military Centres, …
			3.2.10	Number of Insurance Providers that have adopted the unified tarification scheme	#					
			3.2.11	Number of Insurance Providers that link the accreditation system to the pricing scheme	#					

1 Identification of Five (5) Key Performance Areas	2 Type of Key Performance Indicator (EI or APR) (1)	4 Key Performance Indicator (KPI) Code	5 Description (at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)	6 Unit of Measurement (#, %, km, ratio, index, ...)	7 Weight (2) ∑ EI = 100% ∑APR=100%	8 Empirical Evidence / Means of Verification (e.g. : name of document, records, computerized database, MIS, …)	9 KPI Situational Analysis in Administration: Target Setting on KPI Practiced (0 - 5 score)	10 Practice & Quality of KPI Data Collection (0 - 5 score)	11 Remarks and Explanations
4. Provision of cost effective and safe drugs and rationalisation of their consumption and prescription *(continued on the next page)*	4.1 EI Effects / Impact	4.1.1	Percentage of total expenditures for drugs in total health expenditures	%		- MOPH department of pharmacy - Drug store in Karantina			
		4.1.2	Percentage of generic drugs in total drugs sale	%		- The Technical Committee - MoPH Department of Pharmacy Special Research Studies			Calculation of annual increase in sale of generic drugs as a derived indicator.
		4.1.3	Market share of generics drugs produced locally	%		- MOPH department of Pharmacy - Syndicate of Pharmacists - Special Research Studies			
		4.1.4	Percentage of MOPH inspected pharmacies complying with pricing rules and regulations	%		MOPH Inspector Pharmacists reports			
		4.1.5	Average knowlegde score of citizens about generic drugs	% or categories		KAP studies to be conducted			KAP stands for "Knowledge, Attitude and Practice". Knowledge assessment system to be developed, if not yet in place.
		4.1.6	Percentage of drugs that are in compliance with the international drugs protocols out of the total number of drugs tested by the Central Laboratory of the MoPH or by other laboratories accredited by the MoPH	%					Requires regular drugs testing programme and available facilities
		4.1.7	Compliance of physicians with rational prescribing practice	% or categories		- Order of Physicians monitoring records - Specialized Surveys			- The term "rational' needs to be operationally defined in an objectively verifiable and standard manner. - There is a need to develop medical protocols.

1	2	3	4	5	6	7	8	9	10	11
Identification of Five (5) Key Performance Areas		**Type of Key Performance Indicator** (EI or APR) (1)	**Key Performance Indicator (KPI)**		**Unit of Measurement** (#, %, km, ratio, index, ...)	**Weight** (2) ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** (e.g. : name of document, records, computerized database, MIS, …)	**KPI Situational Analysis in Administration**		**Remarks and Explanations**
			Code	**Description** (at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)				**Target Setting on KPI Practiced** (0 - 5 score)	**Practice & Quality of KPI Data Collection** (0 - 5 score)	
4.	**Provision of cost effective and safe drugs and rationalisation of their consumption and prescription** *(continued)*	4.2. APR Activities / Process / Direct Results	4.2.1	Number of awareness raising and training activities on the use of drugs, by type of activity	# / type		MOPH Department of Pharmacy			Classification of main types of awareness raising and training activities to be established, if not yet
			4.2.2	Total number of MOPH inspections of pharmacies on compliance with pricing rules and regulations	#		MOPH Department of Pharmacy			
			4.2.3	Percentage of total number of planned MOPH inspections of pharmacies on compliance with pricing rules and regulations which have been actually executed	%		Reports of the Pharmacy Inspections by the MOPH Inspectors in the Muhafaza			
			4.2.4	Average number of licensed pharmacies per 1.000 inhabitants	# / 1000		MOPH Department of Pharmacy			Scoring categories to be established
			4.2.5	Decrease in percentage difference between the lowest and highest scoring kaza in terms of number of licensed pharmacies per 1.000 inhabitants	%		MOPH Department of Pharmacy			
			4.2.6	Ratio of pharmacy inspectors / number of pharmacies	ratio		MOPH Department of Pharmacy			Scoring categories to be established in relation to the standard
			4.2.7	Percentage of the planned drugs tests which the MoPH Central Laboratory has the ability to test, that were also effectively executed	%		MOPH Department of Pharmacy			Indicator related to above indicator 4.1.6
			4.2.8	Percentage of total number of registered drugs which are generic drugs	%		MOPH Department of Pharmacy			
			4.2.9	Percentage of total value of imported drugs which are generic drugs	%		MOPH Department of Pharmacy			
			4.2.10	Status of the development of a Doctors Control System of medical prescription behaviour	%					Medical protocols need to be developed

1	2	3	4	5	6	7	8	9	10	11
Identification of Five (5) Key Performance Areas	**Type of Key Performance Indicator** *(EI or APR)* (1)	**Key Performance Indicator (KPI)**		**Unit of Measurement** *(#, %, km, ratio, index, ...)*	**Weight** (2) ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** *(e.g. : name of document, records, computerized database, MIS, ...)*	**KPI Situational Analysis in Administration**		**Remarks and Explanations**
		Code	**Description** *(at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)*				**Target Setting on KPI Practiced** *(0 - 5 score)*	**Practice & Quality of KPI Data Collection** *(0 - 5 score)*	
5. Strengthening of the MOPH preventive programmes	5.1 EI Effects / Impact	5.1.1	Incidence of selective communicable diseases : 1. Pulmonary TB	‰		Records of the National Anti-TB Programme			Incidence rate is defined as the number of new incidences per year related to the total number of the population in the middle of the year
		5.1.2	Incidence of selective communicable diseases : 2. Diphtheria	‰		ESU			Incidence rate is defined as the number of new incidences per year related to the total number of the population in the middle of the year
		5.1.3	Incidence of selective communicable diseases : 3. Neonatal tetanus	‰		ESU			Incidence rate is defined as the number of new incidences per year related to the total number of the population in the middle of the year
		5.1.4	Incidence of selective communicable diseases : 4. HIV / AIDS	‰		National AIDS Programme			Incidence rate is defined as the number of new incidences per year related to the total number of the population in the middle of the year
		5.1.5	Percentage of married women (15-49) using contraceptives / contraceptives prevalence rate	%		Household surveys (DHS, …)			Notion of regularity in use is built in. All types of contraceptives covered (incl. permanent methods)
		5.1.6	Total fertility rate	#		DHS involving history taking			Universally applied indicator
		5.1.7	Average number of decayed, missing and filled permanent teeth (mean DMF-T), by age group (Group 1 : at 12 years)	#		- Household Health and Demographic surveys - Databases / records of dentists			
		5.1.8	Average number of decayed, missing and filled permanent teeth (mean DMF-T), by age group (Group 2 : at 15 years)	#		- Household Health and Demographic surveys - Databases / records of dentists			
		5.1.9	Average number of decayed, missing and filled permanent teeth (mean DMF-T), by age group (Group 3 : at 35-44 years)	#		- Household Health and Demographic surveys - Databases / records of dentists			
		5.1.10	Average number of decayed, missing and filled permanent teeth (mean DMF-T), by age group (Group 1 : at 65-74 years)	#		- Household Health and Demographic surveys - Databases / records of dentists			

1–2	3	4	5	6	7	8	9	10	11
Identification of Five (5) Key Performance Areas	**Type of Key Performance Indicator** *(EI or APR)* [(1)]	**Key Performance Indicator (KPI)** **Code**	**Description** *(at least 4 KPIs per Sectoral Key Performance Area, with minimum 2 for both EI and APR types of KPIs)*	**Unit of Measurement** *(#, %, km, ratio, index, ...)*	**Weight** [(2)] ∑ EI = 100% ∑APR=100%	**Empirical Evidence / Means of Verification** *(e.g. : name of document, records, computerized database, MIS, …)*	**KPI Situational Analysis in Administration** **Target Setting on KPI Practiced** *(0 - 5 score)*	**Practice & Quality of KPI Data Collection** *(0 - 5 score)*	**Remarks and Explanations**
5. Strengthening of the MOPH preventive programmes	5.2. APR Activities / Process / Direct Results	5.2.1	Number of public health IEC materials developed, by type: (a) Material type 1 (b) Material type 2 (c) Material type 3	Component (a) # Component (b) # Component (c) #					Composite indicator. Covers all types of media: leaflets, posters, TV or radio spots, internet web sites, bilboards, etc. Classification of main type of materials to be developed.
		5.2.2	Number of public health IEC materials distributed to patients / customers in health centres, by type: (a) Material type 1 (b) Material type 2 (c) Material type 3	Component (a) # Component (b) # Component (c) #					Composite indicator. Classification of types of IEC (Information, Education and Communication) materials to be defined
		5.2.3	Number of health care providers trained on developed materials, by type of providers: (a) Provider type 1 (b) Provider type 2 (c) Provider type 3	Component (a) # Component (b) # Component (c) #					Composite indicator. Classification of main types of providers to be developed.
		5.2.4	Number of health workers trained on protocols for maternal care	#					Requires operational definition of "trained"

Government of Lebanon
Health Sector Reform Strategy

Reform Priorities and Financing Requirements for Three Years

Reform Objectives and Policy Intervention	Action Steps	Funding Requested for Consultancy Services	Funding Requested for Training = T, Goods = G, Civil Works = CW, & Budget Support = BS	Comments
Improve health/equity outcomes	**#1**			
Completing recovery program	1. Reconstruction of health facilities 2. Provision of special services for injured and affected communities	$50,000	$1 million CW $ 3 million BS	Check with WHO after completion of survey
Upgrading primary healthcare services and referral system	3. Develop and roll out new PHC package of services for 30 catchment areas 4. Initiate health card pilot initiative for eligible MOH beneficiaries of 30 catchment areas 5.Expand IT infrastructure of 30 catchement areas	$1.5 million	$ 30 million BS $ 3.05 million G $ 430,000 T & G & BS	
Implementing targeted interventions for maternal and child mortality reduction and improved access	6. Implement safe motherhood initiative 7. Roll out implementation of Wadi Khalid p roject (Akkar)	$30,000	$200,000 T&G $10 million BS	
Quality assurance	**#2**			
Continuing implementation of quality assurance program	1. Continue implementation of hospital accreditation program; 2. Development of process to produce of clinical practice guidelines	$ 17,000	$ 10,250 T & G	$ 1.6 million CS to be covered though the MOH budget
Institutionalization of hospital accreditation	3. Implementation of plan to institutionalize the hospital accreditation program			Covered through French Government Assistance
Expansion of accreditation to PHC	4. Develop and implement PHC accreditation program and disease management guidelines	$45,000	$35,000 T & G	

Health financing reform	**#3**			
Developing common health insurance standards & procedures	1.Amend by-laws of public funds to allow for common procedures; 2.Re-commission the work on the standardization of codes, forms, and payment methods across the funds; 3.Revisit the eligi bility policies, contribution rates, covered benefits of the insurance funds	$ 120,000 $200,000		
Harmonizing and integrating insurance functions across funds; completing visa billing system and integrating HMIS across funds	4 Pilot a common TPA for public funds (IRB) 5. Complete visa-billing system 6. Integrate HMIS across funds	$ 500,000 $135,000 $120,000	$ 1.5 million BS $484,340 T &G	
Rationalizing resource allocation	7 Update and institutionalize NHA 8. Undertake economic analysis of public subsidies of public insurance funds	$750,000		Activity covered through TA under 3.3.
Pharmaceutical reform	**#4**			
Developing regulatory framework	1.Review and improve current registration system and review and improve current reference pricing system 2.Adopt code of ethics for marketing and promotion of drugs	$ 130,000 $60,000	$10,000 T	
Implementing rational drug use policy	3.Develop and implement generic drug policies 4. Develop prescribing and dispensing guide for physicians and pharmacists regarding generic substitution		$200,000 T & G	Activity covered through TA under 4.1
Core public health functions	**# 5**			
Expanding public health functions and programs	1.Enhancing national EPI program 2. Strengthening epidemiological surveillance 3. Supporting emergency management services 4 .Strengthening public health programs (injury	$ 203,500	$11 million T & G $ 627,260 T & G $5 million T & G $600,000 BS	$4 million of EPI budget covered though MOH budget WHO allocating $500,000 for Injury prevention

	prevention, school health, HIV/AIDs) 5..Enhancing NCD programs		$1,400,000 BS $210,000 BS	for school health program
MOH Stewardship	**# 6**			
Improving regulation and planning capacity	1. Implementing Carte Sanitaire system 2. Develop health technology assessment program	$135,000 $150,000	$80,000 T & G $30,000 T & G	
MOH capacity building	3. Assessment human resources and HR policies of MOH; 4. implement training plan	$100,000	 $1.5 million	Gap analysis of HR
	Total	$4,245,500	$70,366,850	$74,612,350

Government of Lebanon
Health Sector Reform Strategy

Implementation/Procurement Timetable and Key Performance Indicators

<table>
<tr><th>Action Steps</th><th colspan="4">Year 1
Short-Term</th><th colspan="4">Year 2
Medium-Term</th><th colspan="4">Year 3
Medium-Term</th><th>Mid-Term Key Performance Indicators</th><th>Final Key Performance Indicators</th></tr>
<tr><td># 1</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td></td><td></td></tr>
<tr><td>1. Reconstruction of health facilities</td><td></td><td colspan="7">**</td><td></td><td></td><td></td><td></td><td>% of facilities reconstructed</td><td>% of facilities reconstructed</td></tr>
<tr><td>2. Provision of special services for injured and affected communities</td><td colspan="12">***</td><td># of health facilities providing special services</td><td># of injured receiving following-up care</td></tr>
<tr><td>3. Develop and roll out new PHC package of services for 30 pilot in-network centers</td><td></td><td></td><td></td><td></td><td colspan="8">***</td><td># of new centers included in PHC package</td><td>% of population with access to new PHC package</td></tr>
<tr><td>4.Initiate health card pilot initiative for eligible MOH beneficiaries of 30 centers</td><td></td><td></td><td></td><td></td><td colspan="8">***</td><td># of health facilities equipped with health card system</td><td># of MOH health beneficiaries using health card</td></tr>
<tr><td>5.Expand IT infrastructure of 30 centers</td><td></td><td></td><td></td><td></td><td colspan="8">***</td><td># of health facilities with upgraded IT infrastructure</td><td>% of health facilities reporting through IT system by month</td></tr>
<tr><td>6. Implement safe motherhood initiative</td><td></td><td></td><td colspan="10">**</td><td># of hospitals using baby friendly approach</td><td># of breast-fed newborns within first 12 hours in BF hospitals</td></tr>
<tr><td>7. Roll out implementation of Wadi Khalid project (Akkar)</td><td colspan="12">***</td><td></td><td>25 percent reduction in MMR in Wadi Khalid from 2000-2009</td></tr>
<tr><td># 2</td><td colspan="12"></td><td></td><td></td></tr>
<tr><td>1.Continue implementation of hospital accreditation program;</td><td colspan="12">- -</td><td># of insurers adopting accreditation results</td><td>% increase in accredited hospitals since 2006;</td></tr>
</table>

2.Development of clinical practice guidelines	***	# of guidelines developed	# of healthcare providers using guidelines
3. Implementation of plan to institutionalize the hospital accreditation program	***	% of external financing (non-MOH)	% of external financing (non-MOH)
4.Develop and implement PHC accreditation program	**	Accreditation criteria adopted	# of healthcare facilities accredited
# 3	**Year 1 Short-Term** (Q1 Q2 Q3 Q4) / **Year 2 Medium-Term** (Q1 Q2 Q3 Q4) / **Year 3 Medium-Term** (Q1 Q2 Q3 Q4)		
1.Amend by-laws of public funds to allow for common procedures;	********************************	Enactment of by-laws to allow for common procedures	# of common forms, codes, and payment methods adopted
2.Re-commission the work on the standardization of codes, forms, and payment methods across the funds;	**	Contract signed for the consultant	
3.Revisit the eligibility policies, contribution rates, covered benefits of the insurance funds;	***		% increase in insured population by insurer since 1998
4.Pilot a common TPA for public funds (IRB);	**	% of hospitals equipped to use billing system	Completion of integrated database of public funds;
5. Complete billing system of visa-billing system;	********************** **	Contract signed for consultant	% of claims billed electonrically

6. Inter-operability of HMIS across funds and TPA	**		% inter-operability between funds and TPA
7.Update and institutionalize NHA;	**	Commissioning of NHA study	Dissemination of NHA results
8.Undertake economic analysis of public subsidies of public insurance funds;	**	Commission of subsidy analysis	Dissemination of subsidy analysis results;
# 4	**Year 1 Short-Term** (Q1, Q2, Q3, Q4) · **Year 2 Medium-Term** (Q1, Q2, Q3, Q4) · **Year 3 Medium-Term** (Q1, Q2, Q3, Q4)		
1.Review current registration system and review current reference pricing system;	**	Contract of study signed	New registration system adopted; adoption of reference pricing system
2.Adopt code of ethics for marketing and promotion of drugs;	**	Code of ethics developed	% of pharmaceutical using code of ethics
3.Develop and implement generic drug policies;	**	Generics substitution policies developed	% of generic drug in total surveys
4.Develop prescribing and dispensing guide for physicians and pharmacists regarding generic substitution	**	Guidelines developed	% compliance of physicians and pharmacist with guidelines

# 5	Year 1 Short-Term: Q1 Q2 Q3 Q4 · Year 2 Medium-Term: Q1 Q2 Q3 Q4 · Year 3 Medium-Term: Q1 Q2 Q3 Q4		
1.Enhancing immunization, epidemiological surveillance and emergency response management;	***.	# of health facilities providing EPI, % of centers with EPI surveillance system in place;	% of fully immunized children under 1 year of age; % of health facilities reporting notifiable diseases
2.Strengthening public health programs (injury prevention, school health, HIV/AIDs	- -	School health package officially adopted	# of schools adopting school health package
3.Enhancing NCD programs	- -	No. of IEC materials developed	
# 6	**Year 1 Short-Term: Q1 Q2 Q3 Q4 · Year 2 Medium-Term: Q1 Q2 Q3 Q4 · Year 3 Medium-Term: Q1 Q2 Q3 Q4**		
1. Implementing revised Carte Sanitaire system;	**	Ratification of law	Carte Sanitaire system integrated within MOH
2.Develop HTA Plan	*** (from Year 1 Q4)	Preparation of HTA Development plan	Creation of HTA unit within the MOH
# 7	**Year 1 Short-Term: Q1 Q2 Q3 Q4 · Year 2 Medium-Term: Q1 Q2 Q3 Q4 · Year 3 Medium-Term: Q1 Q2 Q3 Q4**		
1. Assessment human resources and HR policies of MOH	***	Contract signed	
2.Implement training plan	******************************		# of MOH staff receiving training