

# Health Reform In Lebanon

## Key Achievements at a glance

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**This document lists a selection of 12 Key Achievements of the Ministry of Public Health over the last decade\*.**

### **1. Unified Beneficiaries Database**

In 2003, a unified Beneficiaries Database was created, including beneficiaries of the Ministry of Public Health (MOPH), National Social Security Fund (NSSF), Civil Servants Cooperative (CSC), Army, Internal Security Forces (ISF), General Security Forces (GSF) and State Security Forces (SSF). The unification of beneficiaries information implied that double-coverage or double-billing from more than one fund, was no longer possible for beneficiaries, and thus considerably improved the efficiency of the system. It also aimed at simplifying administrative procedures and reducing waiting time for getting the prior authorization of the MOPH for hospital admission.

### **2. Development of the visa system, its decentralization and linkage to database.**

Automation of beneficiaries' admissions and procedural approval was initiated in 1995. It was however, at the time, limited only to hospitals within Beirut. In 2003, the MOPH began a decentralization process by expanding the system throughout the country through web-linking of all visa centers. By February 2005, the system was completed covering all of Lebanon, and was linked to the Beneficiaries Database.

### **3. Post-graduate training of inspectors, controllers and other physicians**

Two extensive trainings have been held by the MOPH in recent years. The first trainings were on ICD10 classification, took place during 1999-2000, and occurred in two phases: the first targeting MOPH inspectors, who proceeded to the second phase to train both MOPH medical controllers and other physicians at all hospitals nation-wide. A second training was carried out from 2001-2002 at the Université Saint Joseph (USJ), during which MOPH inspectors and medical controllers completed extensive training on coding and controlling admissions and clinical management, with most being awarded University Diploma in this field.

### **4. Working on payment mechanism and flat rates.**

Prior to 1998, the MOPH payment mechanism was totally based on fee for service and auditing of itemized bills generating clear incentives for over doctoring. The MOPH has first introduced flat-rates for same-day surgeries in March 1998. Subsequently, as a 2<sup>nd</sup> step flat-rates were also introduced for the most frequent surgical procedures in 2000, and by 2002 all surgical procedures were covered by the MOPH through flat-rate payment. By reversing incentives, this new reimbursement modality had a significant impact on the total hospital bill and contributed to rationalizing the cost of health care.

\* **W. Ammar**; "Health Beyond Politics". WHO, MPH, I S B N 978-9953-515-489, Beirut. January 2009.

**5. Setting of a financial ceiling in every contract between hospitals and the MOPH.**

In the past, the MOPH contracted with hospitals based on bed capacity. This resulted in yearly overruns of the MOPH budget. However in 2005, the MOPH replaced this by setting fixed annual financial ceilings for each hospital, which allowed for more efficient control of hospital expenditures on the part of the MOPH. As a result, the MOPH did not experience any overruns of its budget set for hospitalization since 2005.

**6. Utilization review activities.**

The MOPH is currently engaged in the second emergency social protection implementation support project (ESPISP2), funded by a World Bank grant, whose purpose is to further improve efficiency of the MOPH's spending, in particular regarding funds allocated to contracted hospitals (private and public). To date this activity has centered around 3 areas: utilization review, clinical guidelines and performance contracting. Several clinical guidelines are currently under development, as well as ongoing utilization review of services covered, and the development of criteria towards building an automated, user-friendly utilization review system, which would also provide flagging of suspicious admissions by hospitals and physicians.

**7. Autonomy of public hospitals.**

By the end of the civil war, only one third of the country's, being 24 public hospitals, were operational, with an average of only 20 beds and very low occupancy rates. Following continuous restructuring, rehabilitation and building plans, this had increased to the current 28 public hospitals, with a total of 2550 beds. Through the mid 1990s, the MOPH sought extensively to also establish financial and administrative autonomy for public hospitals, an effort which succeeded by the issuance of a law to this effect in 1996, and was subsequently amended on several occasions. Under this law, administration boards of hospitals are able to sign contracts with financing agencies including the MOPH. Currently all public hospitals have autonomous administration boards appointed by government decrees (Tyr hospital located in a southern Palestinian camp and run by an officer of the Lebanese Army is an exception). Within such a system, the financial risk is shifted from the MOPH central administration down to the level of hospital management, and financial breakeven is essential for survival. Hence, incentives were created for public hospitals to attract patients and reduce transfers. At public hospitals, hospitalized uninsured patients pay 5% of the bill, in comparison with 15% in private hospitals, with the MOPH reimbursing the remainder. With public hospitals costing 10% less to the patient than private hospitals, created incentives for patients to use public hospitals, which have grown to exceed 30% of MOPH admissions in 2008.

**8. Contracting with hospitals based on quality and accreditation.**

In the past the classification system of hospitals had provided strong financial incentives for hospitals to invest in sophisticated equipment and services without rational planning. The MOPH began the process of introducing accreditation to address this issue in 2000 with the support of an international consultant, with survey of all 128 hospitals in Lebanon being completed by 2002 (47 successful hospitals from 128; 37%), and a follow-up audit in 2002-2003 (39 successful hospitals from 45; 87%). The high success rate in the follow-up indicated to the MOPH that hospitals were becoming committed to accreditation, and the MOPH accreditation system was subsequently updated through upgrading the National Standards and replacing scores by awards, to avoid misuse of the accreditation results by hospitals. A third

round of accreditation was held in 2004-2005, and work is ongoing to institute a new accreditation system which falls in line with international standards, using prequalification and selection of non-governmental auditing bodies by independent expert committee, with selected bodies subsequently being authorized by MOPH to officially perform hospital auditing against national standards.

***Box 1: Accreditation of Hospitals: A merit system serving efficiency, not only quality***

*Since May 2000, the quality of hospital care in Lebanon has been witnessing a paradigm shift, from a traditional emphasis on physical structure and equipment, to a broader multidimensional approach that stresses the importance of managerial processes, and clinical outcomes.*

*The impetus for change came from the MOPH that has developed an external evaluation system for hospitals with the declared aim of promoting continuous quality improvement. This was possible through a new shade of interpretation of an existing law, without the need for a new legislation.*

*The MOPH sought international expertise to overcome allegations of partiality, and the accreditation was intentionally presented as an activity independent of the Government and other stakeholders to foster elements of probity and transparency.*

*Accreditation standards were developed following a consensus building process and issued by decrees. Hospitals were audited against these standards in a professional, educative, non-threatening manner, respecting confidentiality, not without initial resistance from hospitals. For, results of the first auditing survey revealed a shocking failure by majority of hospitals in complying to basic standards, only to recover through a high success rate in the follow-up re-audit, showing a better use of resources and a higher degree of commitment to the programme. This allowed for standards upgrading and another round of auditing. The step-wise approach adopted by the Ministry ensured a smooth and gradual hospitals involvement, and led to the creation of cultural shift towards quality practices, although contracting with MOPH was an important incentive for compliance. The MOPH's undeclared aim was in fact to strengthen its regulation capabilities and to attain better value for money in terms of hospital care financing. As the selection of hospitals to be contracted could then be made on objective quality criteria, freeing the system from any kind of favoritism or discrimination, especially confessional and political ones.*

**9. Revision of pricing structure of pharmaceutical drugs.**

Under the old pricing system created in 1983, the price-dependent profits were in fixed percent for all price brackets of pharmaceutical drugs, which encouraged the importation, dispensing and overpriced expensive drugs. Two ministerial decisions issued by the MOPH in 2005 had considerable impact on the pricing structure. Decision 301/1 adjusted prices based on comparison with neighboring countries (Jordan, KSA), resulting in a price reduction of an average 20% for 872 drugs and estimated savings of USD 24 million per year. Decision 306/1 provided for a new stratified pricing structure that lowered mark-ups set in 1983 and in a degressive manner, and also introduced for the first time a mechanism for periodic price revision. This resulted in price decrease per drug ranging from 3 -15% and estimated savings of USD 27 million per year. The price revision of drugs registered between 2001 and 2006 was achieved targeting 1109 drugs in 2007, and resulting in lowering the public price of 360 drugs with a yearly saving exceeding USD 10 million

**10. Strengthening primary healthcare and promoting essential drugs.**

The first national conference on Primary Health Care was held in Lebanon in 1991, followed by numerous consultative meetings between the MOPH and relevant stakeholders which led

to the development of a National Strategy for Primary Health Care. This initiative subsequently choose among 800 facilities only 29 health centers to form the nucleus of a National Network that grew to include currently about 150 centers with most belonging to NGOs. The MOPH developed contractual agreements with NGOs and recently has included municipalities as third partners in the MOPH-NGO contract. The MOPH gave considerable support to this effort, with the development of guidelines and health education materials, training activities, developing incentives, purchasing and distribution of vaccines, drugs, medical supplied and equipment. Each health centre has a defined catchments area with an average of 30,000 inhabitants, with only few exceptions. The centers are committed to provide a comprehensive package of services including immunization, essential drugs, cardiology, pediatrics, reproductive health and oral health, and to play an important role in school health, health education, nutrition, environmental health and water control. Provision of essential drugs, vaccines and other services are reported to the MOPH for analysis, evaluation and feedback. Also, centers do not differentiate between insured and uninsured patients regarding nominal fees, with the MOPH policy being to ensure a safety net while providing an alternative to the uninsured to have access to affordable essential services through its network. Such a horizontal approach provided by primary health care complements and cross-cuts with vertical programs in place.

***Box 2: Lebanon reforms focused on primary health care have contributed to improving health system efficiency and to lowering of out of pocket spending***

*The first round of national health account analysis carried out in 1998 has shown that Lebanon was allocating 12.4 % of GDP on health, the highest in EMR, with a high proportion of out of pocket spending (60 %) affecting mainly lower income groups and medicines represented the main item for household health expenditure. Since the issue of the first national health account report, a series of reforms were implemented by ministry of health in order to contain health care costs and to improve equity and overall health system efficiency.*

*The focus of the policy reforms implemented by the ministry of health was and is on primary health care as being cost effective and more equitable arrangement for service provision in a country dominated by private delivery at various levels of health system.*

*Policy reforms have focused on revamping primary health care network, on improving access to public hospitals, on developing accreditation system for hospitals and on improving rational use of medical technology including increased penetration of quality assured generics in the Lebanese health care system, In parallel MOH has also strived to strengthen its leadership and governance functions through well functioning national regulatory authority for health and bio medical technology.*

*Health outcomes, as reflected in life expectancy, indicators of morbidity and mortality and utilization of preventive, promotive and curative services, have improved since 1998. National health accounts in 2005 have shown important improvement of health care financing function in Lebanon. Indeed total spending as a percentage of GDP went down from 12.4 % to 8.4 % and out of pocket spending decreased from 60 % to 44 %. Accessibility to primary health care services and to public hospital services for the poor has increased.*

***Strategic Directions to improve Health Care  
Financing in the EMR, Regional Committee meeting 57, 2010  
WHO-EMRO***

## **11. The Epidemiological Surveillance Program (ESU)**

Created in 1995, the ESU is responsible of the surveillance system of communicable diseases and national cancer registry. The ESU operates the national surveillance system for communicable diseases, screens epidemiological alerts, conducts field investigations and

analytic epidemiological studies, provides feedback to health professionals, and trains them on surveillance tools.

The national epidemiological information system consists of several components:

- Universal reporting system on communicable diseases for 37 target diseases and syndromes (Law of 1957)
- Hospital-based weekly zero reporting for immediately notifiable diseases (150 hospitals)
- Hospital active surveillance for high priority diseases
- Dispensary-based weekly/monthly zero reporting
- Ambulatory sentinel surveillance for private clinics
- Hospital causes of deaths surveillance
- Laboratory-based surveillance for salmonella with molecular subtyping
- School absenteeism monitoring
- Rabies exposure statistics reported from anti-rabies centers
- Snake bites surveillance reported from hospital Emergency Units
- Mass gathering surveillance (Francophony games Beirut 2009, Arabic School Games Lebanon 2010)...

Disease control includes Acute Flaccid Paralysis surveillance for poliovirus eradication as well as 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 publishes its reports and figures on the MOPH website with weekly updates on the following website.

<http://www.moph.gov.lb> (prevention, surveillance)

or <http://www.moph.gov.lb/Prevention/Surveillance/Pages/Surveillance.aspx>

## **12. Supply of human resources: Government intervention versus market forces**

Regulation of the supply of human resources could not have a significant impact unless it targets the admission of entrants to universities and technical schools. The most common approach, that proved to be effective in selecting a limited number of students, is the numerous clausus. Restrictive measures of this kind could not be implemented in Lebanon for two main reasons. First, because it is considered culturally and politically as an unacceptable interference with personal freedom of career choice. Second, because an important number of Lebanese health professionals are yearly graduating from foreign universities, and can hardly be subjected to national control mechanisms. Lebanese Diaspora, that counts more than the number of residence, is particularly out of reach in this regard.

In the absence of an up stream control, down stream measures such as licensing requirements and the colloquium exam have meaningless effect on the supply volume of concerned professionals.

Incapable of playing a meaningful role in reducing oversupply, the MOPH was only able to focus on addressing shortages, particularly that of nurses. MOPH interventions in financing university education programs, in conducting training, in creating and supporting the Nurses' Order and in improving their financial and work conditions, had a remarkable impact on promoting the nursing profession. The figure below illustrates how in a liberal health system, where government control is ineffective, oversupply can only be partially adjusted by market mechanisms (the slightly declining medical practitioners curve), whereas the regulation

authority may intervene and have a significant impact on undersupply by filling specific gaps (the mounting curve of nurses production).

### Licenses provided to medical practitioners, dentists and nurses 1994-2007

