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Reform follows failure: II. Pressure for change in the Lebanese health sector

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This paper describes how, against a background of growing financial crisis, pressure for reform is building up in the Lebanese health care system. It describes the various agendas and influences that played a role. The Ministry of Health, backed by some international organizations, has started taking the lead in a reform that addresses both the way care is delivered and the way it is financed. The paper describes the interventions made to prepare reform. The experience in Lebanon shows that this preparation is a process of muddling through, experimentation and alliance building, rather than the marketing of an overall coherent blueprint.

Introduction

In the aftermath of the civil war in Lebanon, the health care system was characterized by a very rapid expansion of private health care provision. In the absence of any regulation, this has led to a crisis situation. Private expenditures on health care are already high in terms of GDP (Van Lerberghe et al. 1997), and public expenditure is growing too fast for the government to sustain. Rationing or regulating mechanisms would endanger returns on private investment, and generate strong opposition from interest groups. On the other hand, the strain on the Ministry of Health (MOH) and social security schemes is rapidly becoming unbearable. The MOH is faced with (i) a budget that does not leave enough funds to ensure its own activities, including competitive payment of its personnel; (ii) a growing demand for reimbursement of care provided by private hospitals; and (iii) limited scope for increasing the total budget, or for further cuts in budget lines other than those for reimbursement of private hospital care. In the meantime, the economic and cultural effects of the unregulated expansion of the private sector are becoming apparent.

A first paper (Van Lerberghe et al. 1997) has described how this crisis developed between 1991 and 1995. This second paper documents how pressure for reform built up between 1994 and 1996, and identifies the key issues that, for better or worse, are on the reform agenda today. It is a reconstruction of events and positions in a rapidly changing environment, based on a reconstruction of the sequence of events, document analysis and their (often contradictory) interpretation in discussions with key players. It suffers from the biases of participant observation.

Putting reform on the policy agenda

Recognition of the need for reform usually emerges gradually among various actors with different and often contradictory agendas. It is the work of coalitions, by no means always led by the same groups. The MOH in Lebanon, which initially had a marginal role, has come to have a central position in the health reforms, using an alliance with some of the international organizations present in Lebanon. This is unusual since reform is usually put on the agenda by politicians (Hunter and Stockford 1996), professionals (von Otter and Saltman 1991) or, in developing countries, by the international development agencies, often in the wake of structural adjustment programmes (Okuonzi and Macrae 1995).

This central role for the MOH was possible because the ministry filled a policy vacuum. There is no easily

identifiable leadership in the sector. The actors are extremely diverse and fragmented, and none emerges with recognized authority. Whereas NGOs had prestige and authority during the war, both operationally and in the eyes of the public, this diminished afterwards. Professional organizations play only a limited role, and each private hospital looks after its own immediate interests. Lay politicians in Lebanon are rather indifferent to the organizational structure of health care delivery, or to proposals for change. They look at the health care system basically as one of the tools to help ensure political equilibrium. Ideologically biased in favour of hospitals, technology and private enterprise, they seem unaware of the financial predicament of the health care sector – considered a marginal problem compared to the political and economical challenges of reconstruction. Dissatisfaction with health care delivery is interpreted as an expression of the need for expansion of health care supply (physicians and hospitals), rather than as a need for rationalization and a change in policy and the health care provision model.

The ideological climate in Lebanon clearly favours private sector development, making it difficult to restrain expansion of the private sector hospital capacity or equipment. At the same time, the strategy for economic reconstruction is to be driven by public works. In the case of the health sector this means that the major focus is on hospital construction. Saudi, Kuwaiti and OPEC grant and soft-loan money is presently being used for the construction of seven, and possibly more, new public hospitals. This is clearly done more with a view to creating opportunities for public works than with a health sector development rationale.

Managers within the MOH view the prospect of having to operate these hospitals as a future budgetary and manpower nightmare. They find it difficult to envisage how they will recruit the necessary staff and liberate the operating funds, given (i) the MOH's track record in the operation of existing public hospitals; (ii) the restricted margin for reallocation of funds in a budget tied up by the present system of care purchasing in private hospitals; (iii) the scarcity of nursing staff; and (iv) the already existing hospital over-capacity in the private sector. On the other hand, they see the political necessity to (i) maintain some negotiation power by offering an alternative to the private sector; (ii) be able to deal with emergencies in case of armed conflict; and (iii) be able to refer patients that need secondary level care.

Conflicting agendas within the MOH

The current predicament of the health care sector within the MOH is by no means universally agreed. The main lines of thinking and the influences are schematized in Figure 1.

A first agenda is that of transforming Lebanon into a 'hospital for the Middle East'. In line with the private sector ideology that fuels the reconstruction policies in Lebanon today, this is an agenda that those in the MOH with a political constituency share with lay politicians. It receives support from different groups: political parties, the majority of the private sector medical establishment, interest groups within the MOH and, given the prevailing specialist and secondary care oriented ideology, the public as well. This agenda results in policy options favouring expansion of hospitals and a status quo in matters of regulation and financing mechanisms. It is made possible by the easy availability of both Lebanese and donor capital for heavy investments, and is fuelled by the high short-term returns on investment. A major advantage is that it responds to the political constraints typical for Lebanon. Decisions on hospitals and financing can be used as ways to obtain short-term political goals of maintaining or shifting equilibria within an extremely heterogeneous 'house of many mansions' (Salibi 1993).

The same group also has an agenda of reorientation towards PHC in response to pressure from their constituencies, e.g. for care for chronic patients. On this agenda they are in concordance with those within the MOH who have a more technocratic and managerial outlook. This agenda is supported by part of the medical establishment and academia: family medicine concepts are not dominant but do exist (Abyad et al. 1992). Reorientation towards PHC is also advocated by the NFP-NGOs (not-for-profit non-governmental organizations), and those within the MOH who promote it found allies in agencies like the World Health Organization (WHO) and, at a later stage, the World Bank.

The third agenda is that of control of the financing crisis. For the managers within the MOH the main impetus for reform has come from the budgetary predicament. As of 1992 the consequences of the political decision of unlimited reimbursement of certain types of care had become apparent.

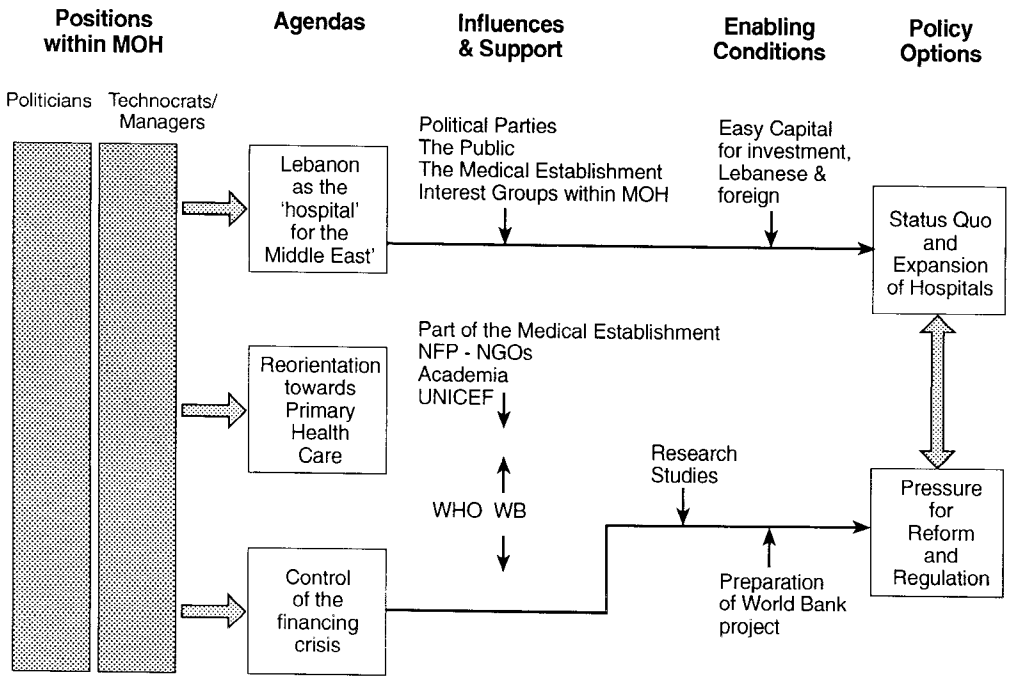

Figure 1. Agendas and conflicting policy directions with the Ministry of Health

This was not, however, the only element. The MOH also wanted to find a new and more rational equilibrium between primary, secondary and tertiary care, and to address the challenges of the epidemiological transition. Furthermore, some of these managers have a strong ideological tradition of public service, reinforced through their links with the NFP-NGOs during the war period. This makes the MOH one of the only organized groups concerned with equity and access, a concern reinforced through its links with WHO and academia.

The fusion of the second and third agenda items, reorientation towards PHC and control of the financing crisis, led to increasing pressure for reform and regulation. The challenge is to do this in a political environment with little awareness of the need and the stakes of reform, and with powerful interests pushing towards the status quo. Part of the private sector, for example, would like to get managerial control of the public insurance funds, as a way of streamlining bureaucracy and guaranteeing subsidies to hospitals.

The major constraint was the MOH's lack of recognized leadership, institutional capacity and authority to put the need for reform on the political agenda and to shape the orientation of the reform (Kronfol and Bashshur 1989). The MOH itself had little technical authority, limited political weight and few qualified professionals. Only a handful had an overview of the problems of the sector and a vision of possible ways out. Much of this had to do with the absence of information on what went on. It is revealing that even senior public insurance management staff are unable to provide a clear image of money-flows, and that the MOH has no updated inventory of health centres or hospitals in the country.

Despite its political and institutional fragility, the MOH has been taking the lead, being the body most immediately confronted with the financial consequences of the evolution of the last five years. For the MOH, both the way health care is delivered (with issues such as the equilibrium between hospital and community care, quality of care, access and equity) and the administrative-financial aspects of regulation, cost-containment and efficiency, were at stake. Very early on its priority option was one of regulation, rather than direct involvement in health care provision. This evolution was made possible by the fact

that the MOH had a better insight into the problems of the sector, which accelerated during the preparation of a World Bank loan for the reform of the health sector.

The need for information and alliances

In the first phase of putting health care reform on the agenda, research and information gathering have played a crucial role. This consisted essentially of documenting the extent of the cost explosion; the efficiencies and contradictions the health care system was heading for; and the extent of the problem of chronic diseases and ill health related to the urban environment. A flurry of research activities, funded through WHO, were contracted out to academic circles, but in close collaboration with the MOH. Besides providing information and evidence for the double agenda of organizational and financial reform, this research phase has had several important spin-offs.

First, knowledge provided the MOH with new leverage. It allowed the MOH administration to make the case for reform and, by the mere fact of knowing the sector, to progressively gain the authority to take a leadership position. Second, it fostered alliances outside the MOH and, within the ministry, a new sense of purpose. Third, this phase – with all the discussions with academia, NGOs and the international scene – allowed the MOH to make a basic strategic choice: it would aim to strengthen its policy-making and regulation functions rather than try to build a public sector delivery system.

This phase of awareness creation went on into 1994 and beyond. From 1994 onwards the MOH used the preparation of a World Bank loan as an opportunity to launch the process of reform. The aim was twofold: reorient the way health care is provided and rectify the financing structure. In order to do that the MOH had to improve its bargaining position and its policy leadership.

In current health sector reforms in industrialized countries the focus is on the pursuit of microeconomic efficiency on the production side, and on the allocation mechanisms that link finance to production (Saltman 1994). Most attempts start by concentrating on economic incentives and the financial operation of the health care system (Oevretveit 1994) in order to respond to fiscal pressure (Beaglehole and Davis 1992). Characteristic of the reform agenda in Lebanon is the sequencing of health care organization and health financing reform. Both are obviously interrelated, but the accent was put on health care reform first (with actual interventions), whilst in the field of financing, actions were limited to the preparation of future macro-level reform proposals.

Hospitals and the way they are financed are clearly at the heart of the problems of cost explosion and distortion of the Lebanese health system. This does not mean, however, that these problems can be tackled head on. The strategic role of public funding provides the MOH, *a priori*, with a good bargaining position towards the hospitals, and should allow it to eliminate major inefficiencies, control costs, and provide incentives for quality assurance. In particular, the smaller, inefficient private hospitals would be very vulnerable to financial incentives and disincentives. But the MOH controls only its own inputs, not those of public insurance, and moreover, although potential and willingness are there, it is too weak technically and politically to enforce changes in the financing structure on its own. There is some margin for controlling costs, and some steps have been taken in 1994–96, but a thorough restructuring requires stronger pressure and alliances.

Such pressure does not come from ambulatory private practice as it functions now. Lebanon has some tradition of family medicine (Abyad et al. 1992) that has been built up in academic circles, but over the last year hospitalocentrism, reduction of ambulatory care and technology consumption have become dominant. Public sector health centres are not a credible alternative, and few or no officials believe that they have the potential to become so rapidly, even with major resource inputs. One of the major impediments to improving quality of care at first contact level, and to using first contact level care as a lever to rationalizing hospital care, is the absence of an organizational model as an alternative to the present situation. For family doctors or general practitioners to put pressure on hospitals, they need first to start working in a different way themselves.

Currently, it appears that influencing the private sector will not be possible through mere financial mechanisms, certainly not in the short term. This would require massive state intervention, which is unrealistic given the budgetary situation and the weakness and lack of authority of the MOH. It will therefore be possible only to work through forms of pressure that are not exclusively dependent on MOH

Table 1. Interventions to prepare reform

Problem area	Interventions	Expected short-term results	Expected medium results
Hospital care: cost and quality	1994 onwards: Control billing and change price structure 1995: Autonomous public hospitals 1995: Feasibility study HMO	→Cost containment	Negotiated contracting conditions: gains in quality and efficiency
		→Regain credibility for public hospitals →Get more options	Ability to negotiate with private sector
First contact level care: quality and access	1993: WHO PHC Report 1995 onwards: Formulate programmes for control of chronic diseases 1995–6 onwards: Contracting NFP-NGO health centres: support in exchange for registration, minimum package and quality care	→Create demand for quality care	Pressure on private practitioners to improve quality
		→Accessible quality care →Capacity to manage responsibility for a defined population	Social safety net Fundholding type pressure in negotiations with hospitals
Regulation capacity	1992 onwards: Studies and research 1994 onwards: Control billling and change price structure 1995 onwards: Institutional strengthening 1996 onwards: Infrastructure coverage planning	→Alliances (especially with with social security system) and expertise	Ability to lead financing reform
		→Tools for regulation →Recognition of leadership and authority	Better control over system Ability to negotiate with private sector
Preparation of financial reform	1996 onwards: focus of studies and research on problems of financing	→Recognition of leadership and authority	Ability to market reform proposals
		→Knowledge on the functioning of the system	Ability to formulate a reform proposal
Pressure for sector reform	Capacity building (human resources documentation, information)	Favourable environment and increased control	Ability to formulate, to lead and to negotiate

administrative mechanisms: pressure from the medical community and pressure from user demand for accessible quality care.

Interventions to build pressure for reform

Pressure for reform in Lebanon built up through a series of parallel and phased interventions rather than through the marketing of an overall plan. A number of interventions were put in place in order to build a capacity, in terms of personnel and knowledge of the system, that would make it possible to create a favourable environment and gain some degree of control over the system. The aim is to provide the MOH with the ability to formulate, lead and negotiate overall proposals for reform. These different interventions are presented in Table 1.

In the field of hospital care, public hospitals became autonomous, and attempts are being made to improve their management. A major stumbling block is the absence of any links with the health centres. A feasibility study on establishing an HMO (health maintenance organization) in a Beirut suburb (Firkh

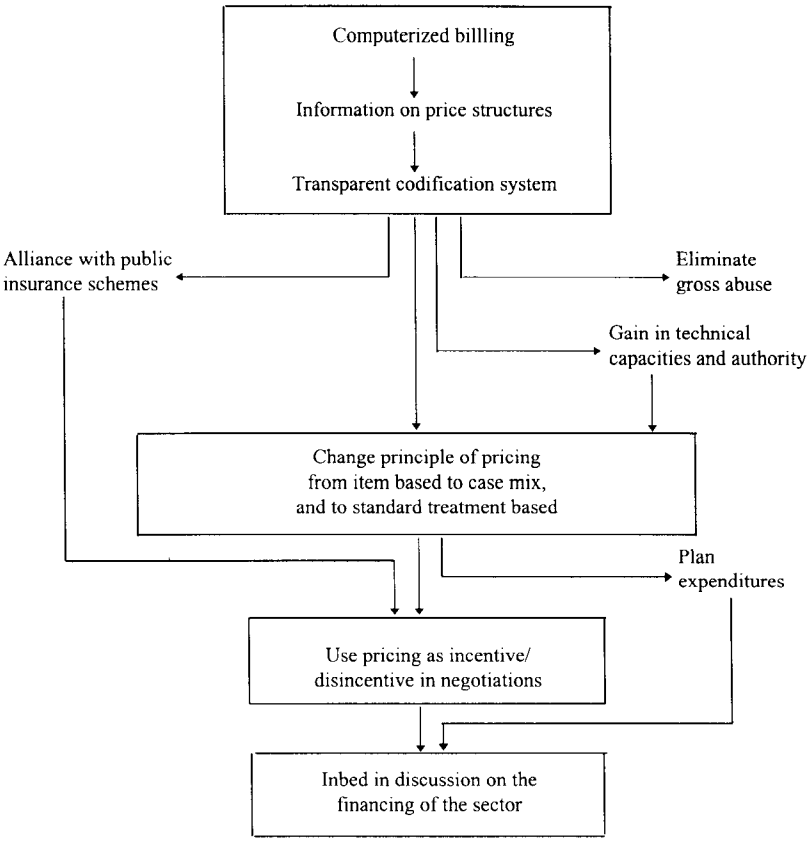

Figure 2. The strategy followed to control billing and pricing of purchased hospital care

et al. 1996) contributed in broadening the range of options that can be considered.

The key intervention, however, was the attempt at controlling the billing and pricing structure of purchased hospital care (Figure 2). Initially, this was a technical response to the budgetary emergency caused by increasing costs of purchasing care in private hospitals. A computerized system was created to allow identification of abuse and misappropriation, to get a thorough knowledge of the cost structure of hospital expenditure, and to transform the principles of reimbursement from an item-by-item to a case-mix basis. This, in turn, must make it possible to introduce elements of rationalization into hospital care (e.g. introduction of day-care) and to improve micro-level efficiency.

Transforming the pricing system requires technologies and capacities that were not available in Lebanon a few years ago but that are now being introduced gradually. It also requires the authority to follow-up on decisions made possible through this regulation technology, and to re-negotiate conditions of purchase of care in rational treatment norms – and despite its lack of authority, the MOH was able to negotiate a 13% rebate on the bills submitted for 1995. This new strategy has been crucial in creating an alliance with the NSSF, over which the MOH has no formal control, for a common position in the negotiation of prices with private hospitals.

A second area of intervention concerns ambulatory health care. The beginning of the 1990s saw the first studies on the health sector and initial attempts to formulate disease control programmes. A further, more radical step was taken in 1995–96, when the MOH negotiated contracts with NFP-NGO health centres. In exchange for logistic support (drugs, training,

equipment etc.) NFP-NGOs are supposed to provide an agreed package of care for their population (Bobadilla et al. 1994), and to introduce quality assurance in a planned way.

With these contractual arrangements the MOH hopes for a triple effect. First, accessible quality care would be assured for the health centre's population. This answers the MOH's preoccupation with maintaining a social safety net for the poorest. Second, providing quality care is expected to enhance demand for quality care, putting consumer pressure on private care providers. A climate of changed consumer-provider expectations would be the best bet for rationalizing health care provided by individual private practitioners. Third, gradual introduction of registration combined with support on a capitation basis would give the possibility of enabling health centres to make contractual arrangements for hospital care for their registered population. These health centres would then have a role similar to that of general practitioner fundholders in the UK or primary care gatekeepers as used by some health maintenance organizations in the USA (Enthoven 1991). Pressure for a rationalization of hospital care would then come not only from the MOH, but also from part of the health care community in the capacity of patient advocates.

With this strategy towards NFP-NGOs, the MOH has a first entry point in the ambulatory care market. An overall strategy towards regulating and rationalizing private ambulatory care is still missing. At this stage it is very much an approach of seizing opportunities and creating a favourable environment. As a strategy, however, starting with the NFP-NGO health centres offers only limited perspectives. NFP-NGO health centres only cater for some 10% of the first level contacts. Fundholding in the UK, however, only covered 3% of practices three years after its introduction, and major expansion was decided when only 15% of practices were enrolled (Petchey 1995). Thus, going by this example, even with a small section of the market it should be possible to wield significant influence.

LL17.6Registration of the population and capitation payment are likely to meet with considerable resistance (Blecher et al. 1995). The technical aspects of the contractual arrangements are crucial to the success of the strategy, and still need to be tested. Politically it will probably be difficult to introduce and enforce performance-linked incentives. Nevertheless, the plethora of doctors is a favourable factor. With the high doctor-population ratio (close to 3:1000; Van Lerberghe et al. 1997), a certain degree of proletarization, or possibly even pauperization, of doctors is likely. This would create a pool of doctors among which the MOH could find candidates for collaboration in a support-in-exchange-for-quality scheme.

The major bottleneck in creating a regulatory capacity and preparing the reform of health sector financing is the lack of institutional capacity and system intelligence. Drastic change is unlikely in a fragmented society such as in Lebanon, where everything is linked; incremental change, on the other hand, would not produce results without a strong sense of direction. The MOH has had to develop and provide that sense of direction.

The interventions concerning hospital and ambulatory care have provided the MOH with a first set of instruments to initiate sector regulation. In order to capitalize on the first successes, the MOH has had to recruit new, technically qualified staff, mainly with an NGO or academic background. These new recruits have brought technical expertise and a new managerial culture. There has been visible progress in streamlining MOH administration and in its performance in monitoring, evaluation and planning. Combined with the alliances the MOH has created during the research and documentation efforts of the first half of the 1990s, this accelerated modernization is starting to pay off. The MOH now has the best, if still very inadequate, knowledge of the situation. It is now technically capable of commissioning and leading studies that give an insight into the national health accounts, health expenditure and provider patterns. This increased system intelligence does not mean that the MOH has the capacity to plan and implement a comprehensive reform, but it is now in a position to mobilize pressure for reform and to push its own public sector agenda.

Seizing opportunities to prepare for reform

The strategy of the MOH is not merely one of muddling through (Bennet and Holland 1977; Lindblom 1959), but rather of seizing opportunities to make headway where progress or experimentation is possible. The major weaknesses of this approach are that there is as yet no clear view on the future of health sector financing and no vision of how to restructure ambulatory care. Delay in tackling the financing issues is also the major criticism made by the international community. This weakness, however, may

be the strength of the MOH strategy: the groundwork is being done, and there is time for experimentation and analysis. There will thus be less risk of importing ready-made solutions which are not adapted to the Lebanese situation. This is turn will increase chances that reforming health sector financing will not merely aim at cost containment, but will actually improve health care delivery. More important still, especially in Lebanon's fragmented society, there is time for creating the necessary alliances. By the time there is an overall vision of reform, not only of health care but also of the sector's financing, the balance of power will have changed.

The key issue in the Lebanese health crisis is that of the role of the public sector. Before the war this was limited to purchase of hospital care and lip-service to providing universal access (Hayek 1980). With the war, there has been the implosion of the MOH and the expansion of the private sector, presenting a situation which is becoming untenable: the extent of the problem in financing the present system is now such that it is increasingly difficult to justify further expansion for mere reasons of political equilibrium. It seems clear now that the public sector in Lebanon will remain a marginal health care provider but that there is some scope to redefine its role in financing and regulating the sector. There is thus hope that elements of public sector rationality will be injected into what is now, still, essentially a seller's market.

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