5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

The challenge that Lebanon faces can be mainly divided into two branches. The first branch follows the public-private partnership in health, and the second tackles the shift into the epidemiological transition era. Bearing in mind the long years of civil war, and the depression that all sectors have faced, the ability of resurrection was limited to a certain extent, though less so in the private sector. It was not until 1994 that the policy paper of former Minister of Public Health Mr. Marwan Hemade, became the basic document for negotiations with the World Bank for the "Health sector Rehabilitation Project" that was launched no later than 1995. The striking contradiction between the needs and the actual plans, especially in the construction of public hospitals, showed the lack of political commitment towards the government's privatization strategy, if there was one, and the fact that there was a missing link between the policies and their implementation, which was no doubt of a political nature. In 1997, the former Minister of Public Health, Mr. Suleiman Franjieh's paper, came to launch a new concept based on intentions and insights into reform, which opened the door to public debate over the issue.

Though political issues govern both the issuance of the laws and their implementation, there exist some evidence-based recommendations that cannot but capture the attention of some policy makers. The NHA 1998 study proposed a series of recommendations that were of concern in setting up goals and plans for cost containment, the strengthening of the PHC by both capacity and resources, rationalizing expenditures on pharmaceuticals, and controlling capital investment in medical technology. Most of these issues were tackled by the succeeding plans of action of the MOH.

The National Household Health Expenditure and Utilization Survey (NHHEUS) of 1999, showed that inequities in access to health care do not appear to exist, except with regard to dental care. But providing quality basic health services for the poor might solve the burden of higher out-of-pocket expenditure on health for the low-income households. Although the MOH is the insurer of last resort for all uninsured, including the poor, but it covers hospitalization costs rather than primary care services. The NGOs role, in collaboration with the public sector, might verse in that respect, as the health centers that provide basic package of PHC services are now distributed all over the Lebanese territories.

Formal policy and planning structures, and scope of responsibilities

Although the final plan of action is put by the MOH, integration of other international organizations plans into the main plan serves to strengthen its putting into action.

Even though they claim that they tend to support government plans, some international agencies have their own agendas, and sometimes they tend to force, though gently, their programs into action through specific allocation of resources. The donor agencies' role might range from technical support to financial support, passing through training opportunities and capacity building. In planning and implementation the speed and efficiency might be impeded or well-timed depending on administrative horizontal and

vertical criteria. Some programs might depend on more than one governmental body, in addition to some private bodies, which would render the information cumbersome and the achievement delayed. The body that is formally responsible for generation of information and statistics in the country is the Central Administration of Statistics (CAS). The CAS is directly affiliated to the Council of Ministers. But, due to administrative conflicts and sometimes the lack of timely data, parallel generation of information might occur which renders the conflict between the CAS and other bodies, both private and public, inevitable. The highest fragmentation in the health sector exists at the level of financing. With six public funding agencies affiliated to five governmental bodies in the scene, the enhancement of the unified database will solve much of the issue of overlap in financing and management. In addition, the MOH, as part of its Four-year plan (2003-2006), will redefine responsibilities, lines of authority and reporting mechanisms in all MOH units to solve the issue of bureaucratic impediments.

Key legal and other regulatory instruments and bodies:

It is true that the MOH is the main body responsible for health in the country, but regulation of the sector is not solely in the hands of the ministry. For example, political issues always govern the supply of hospital beds; but fortunately the accreditation system of hospitals came to partially solve that concern through decreasing the number of contracted hospitals due to the lack of required standards. The discrepancy that exists in human resources, though, needs further enforcement as to the limits that are put on the establishment of new medical schools and the bettering of employment conditions of nurses and community workers. So far, private providers have been investing in areas to maximize profit, which calls for the role of the MOH to provide equal accessibility of the uninsured through contracting with providers in all regions, thus insuring equity. The collaboration between the MOH from one part and the Order of Physicians and the Syndicate of Private Hospitals from the other part should be enhanced on a transparent basis for the support of an equitable and better quality health sector.

5.2 Decentralization: Key characteristics of principal types

Within the MOH:

In the MOH, and at the central level, different departments have certain legal responsibilities as defined by law. In addition, the financial issues are tackled by the Accounting Department, which is part of the secretariat. Decisions of recruitment in the public sector as a whole are the responsibility of the Civil Service Board (CSB). Some recruitment is done at the level of the Minister, for short-term contracts covered by the special budget procured to the Minister. Delegation of powers range from the level of Head of Department, to the Director General, who is the top level employee, depending of the issue under decision.

Within the MOH central offices, there are four main bodies that have continuous relations to administrative authorities in the Mohafazat. Firstly, and in addition to their having a local representative, the PHC and Reproductive health team have routine contact with the centers as part of their administrative responsibilities; they also conduct training sessions whenever needed. Second, fall the inspector pharmacists and doctors that conduct rounds as per request of the Head of Department of Pharmacy and Head of Directorate of Curative Care, respectively, as a part of their control over local pharmacies and private hospitals. The third team consists of information technologists as part of the installation of the visa billing and database unification software at the district levels

where the visas for inpatient care are granted. And, finally comes the Epidemiology Surveillance Unit establishing links with Qada physicians, which is the second administrative local level, and local authorities as far as communicable disease reporting and as outbreak management teams. In addition, immunization campaigns are conducted at specific times of the year, and they are conducted by the central team at the Directorate of Prevention in collaboration with local authorities. Also, inspector doctors are assigned to private hospitals to grant first level permissions for treatment at the expense of the Ministry.

State or local governments

There are three administrative levels in Lebanon, The Mohafaza, the Qada and the village. The MOH central administration, which is located in Beirut, is represented till the second administrative level with five Health Chiefs in the five Mohafazas, and 25 Qada physicians. The decentralization in Lebanon is partially active in terms of local activities, like inspection for food and water hygiene, the medical consultations in the dispensaries, as well as school health programs and inquires in collaboration with the Ministry of Education. But, although the responsibility is full regarding gate keeping role between the Qada and the central administration, the authority remains minimal, not to mention the financial inflexibility. Qada physicians report to the Directorate of Prevention at the central level. The Directorate of Prevention grants small financial lump sums after approval of the Accounting Department. A prior request by the Qada physician is required through the Health Chief of the Mohafaza based on a specific program of action for the year ahead. Monthly reports are routinely submitted by the Qada physician to the Directorate of Prevention through the Mohafaza chiefs, in which activities as well as recommendations for future actions are provided.

Greater public hospital autonomy

The law of public hospital autonomy issued in 1996 is on its way for completion. There were 22 public hospitals actively working at the end of 2004. It is expected that at the end of 2005 there will be 32 active hospitals, in all six Mohafazat including Beirut, and all acting under the law of Public Hospitals Autonomy. The evaluation of the experience is currently to be launched as part of the Plan of Action of the MOH, which has for one of its goals the strengthening of public hospitals autonomy.

Private Service providers, through contracts

Private hospitals distributed throughout the Lebanese territory have contracts with public providers to render services for the population under different schemes. The disbursement of beneficiaries for services rendered might vary between direct payment to the hospitals and reimbursement after full payment (e.g. in case of ambulatory care and drugs). Inspector doctors are present in each hospital to grant permission of entry through making sure that the occupancy rate for the day permits. This is relevant for all public financing schemes. Bills are submitted by hospitals at the end of each month to the public financing agency for auditing and performing quality checks. In addition, inspector doctors perform rounds on hospitals to make sure that quality is offered at a contained cost.

Main problems and benefits to date:

Decentralization is not a strong feature of the system. Except for Primary Health Care, the experience with decentralization does not grant it a very strong position. Currently, a

new program was initiated concerning district (Qada) level information system. The program is at the pilot testing level.

Integration of Services

For so long the preventive services as provided through the dispensaries were part of the public hospitals that provide curative services. Both the dispensaries and the public hospitals had for central point of reference the Department of Hospitals at the Directorate of Medical Care at the MOH. The hampering of the public system during the war period has weakened this integration due to weakness of the system as a whole. Though it was accidental, the resuscitation of the system was easier through working it into parts. Currently, with the strengthening of PHC through specific health centers that have evolved, with all the basic package of services they provide and under the patronage of the Directorate of Prevention; Together with the development of the law of Public Hospitals Autonomy, the integration of services are being blocked. But the establishment of referral hospitals at the peripheries, together with the provision of basic curative services, like drugs and small surgeries, at the level of Primary Health Care centers could be considered as one step ahead in integration although at the administrative level separate authorities for preventive and curative services are in charge.

5.3 Health Information Systems

Organization, reporting relationships, timeliness

Maybe one of the factors that weaken the health care system is the lack of timely information and transparent dissemination of data. There are three major data categories flowing in the System. Preventive care data, Curative Care data and administrative data sets. Data collected by MOH ranges from demographic information about patients, to resource and quality management information, pharmaceutical and drug use, to very confidential information related to disease and epidemics reported by health care providers. The periodicity of reporting of information varies between reports, ranging from immediate reporting (in case of outbreaks, and certain communicable diseases), to on demand reporting, passing through weekly, monthly and yearly reports. Hospital bills of patients treated at the expense of the Ministry from private and public autonomous hospitals are to be reported monthly, as a hard copy and an electronic copy, for auditing and control before payment. The Epidemiological Surveillance Unit is responsible for the collection of information regarding communicable diseases from districts (Qada) and private hospitals and clinics, on an immediate and weekly basis, and insuring the timeliness of information. In addition, the Department of Statistics receives monthly reports of births and deaths, reported from local authorities of the Ministry of Interior, in addition to district reports through the Mohafaza health chiefs. Moreover, the Primary Health Care department receives monthly reports from district health centers regarding the administrative status, the medical consultations achieved and drugs dispensed; in addition to occasional drug requests upon need. With the diversity of information received, there exists no integration and full automation of data, not at the district level, nor at the central level. Currently, hospitalization data are under the attempt of full automation and a link exists between the districts and the central administration from one part, and the Ministry and other public funding agencies from the other. This Beneficiaries Connecting Database will be the first attempt towards a National Information System. The Preventive care data, though, is highly fragmented and should be unified to insure that no duplication of data exists and to improve the

connection between different departments at the ministry having data of common interests. At the MOH, still, the recent establishing of the Medical Human Resource management application will insure a human resource unified database in the country. By the fact that all medical personnel should get their license from the MOH before practice, all information about all personnel working in the health field can be accessed.

Health data generated outside the Ministry by other bodies, like those generated at the NSSF, CSC, Military forces schemes and private insurance; or those generated through research or compilation, cannot be accessed except through formal protocols.

Data availability and access

All the above-mentioned activities relating to the information systems at MOH are done internally. Dissemination of data is another issue. Concerns of privacy and data exclusivity still prevail. Not only this, but data generated at certain departments cannot be accessed from another department inside the Ministry without passing through certain bureaucratic protocols.

Whenever international agencies are involved, either financially or technically, progress reports are due according to predefined terms of reference. So, it's actually easier to access the data reports from international donor agencies than from the Ministry, especially when development programs are concerned. The private sector, though, deems data as of private nature and should not be disseminated.

The Central Administration of Statistics (CAS) is the official body responsible for acquiring and disseminating of information in the country. Demographic, economic, health related data, can be accessed by visiting the CAS website at http://www.cas.gov.lb

Sources of information

Although there exists a national body, the CAS that is responsible for collection of statistical data from different institutions, information should be gathered from different sources, including all Ministries. So far, sources of information consist of vital registration data as reported by the Ministry of Interior to the CAS and published on their website (http://www.cas.gov.lb) in addition to some studies and researches. Some studies constitute, currently, the basic sources of information in the health field. The Ministry of Social Affairs (MOSA) survey in 1996 managed to classify the estimated population of Lebanon as per Qada, while the "Conditions de vie des Menages" in 1997 and The National Household Health Expenditure and Utilization Survey in 1999 both done by CAS, constitute the sole sources for estimates of population statistics at the Mohafaza level, in addition to reported morbidity, utilization of health services and consumer satisfaction assessment among other things. The Pap Child survey, done in 1996 contains the sole Maternal Mortality ratio figure generated in the country as104 per 100000 live births. The Health Sector and Reform in Lebanon, done by Dr. Walid Ammar, Director General of Health in collaboration with WHO, and published in 2003, constitutes the first source of information about the health profile of Lebanon after the war. The single source of information about National Health Accounts, is the NHA 1998, published in 2001 and will, hopefully be updated this year for accounts of 2003. Moreover, a new population-based survey was achieved by CAS, for which the data is about to be published. In addition, some small-scale studies exist which cannot be considered national. Hence, sources of information are fragmented and incomplete, in addition to the lack of timeliness and prompt research that is still missing at the national level.

5.4 Health Systems Research

Institutions conducting research in the health field range from academic institutions to governmental bodies. Research is usually conducted based on private sector needs and needs assessment strategies rather than policy oriented. But, even though the initiation of research is not policy oriented, once completed it is sometimes used by policy makers to strengthen their viewpoint, whenever relevant. National policies are usually of political nature.

The funding for research comes either from University Research Boards, whenever academic institutions are involved, or from small private, local or international funds. The National Council for Scientific Research (NCSR) funds some research proposals, which are more of a clinical nature rather than public health per se. Currently, the NCSR is undergoing some administrative changes and re-budgeting to involve more public health research on its agenda. Research funded by the NCSR has to follow certain criteria of selection by a technical committee, and a final report has to be submitted. In the Ministry of Health, there exists a very small fund for research that is usually prone to constraints of ministerial budgeting.

Publications in national and international journals are not scarce, though the constraints of quality, publishable papers might hinder the submission for publication. In addition to local journals, like the Lebanese Medical Journal, there exist some local bulletins done by academic institutions whereby they disseminate all the research articles written by researchers in that institution. Nevertheless, if the research done is not of a certain quality, its dissemination is not of importance from a public health viewpoint.

5.5 Accountability Mechanisms

In the public sector, employees are held accountable through the Civil Service Board and the Central Inspection Administration. Employees who commit administrative or practice errors or misconduct, are subject to scrutiny by the Central Inspection Board (CIB) whereby their employment status might be challenged.

Recruitment is very rare and subject to many considerations, the political and religious being the most prominent. Employees are sometimes transferred from one position to the other in the same Ministry or from a Ministry to the other, based on administrative and technical needs.

Recently the OMSAR, in collaboration with the CIB, is initiating the Sectoral Key Performance Indicators project, from which not only selected health indicators are to be generated and controlled, but also the personnel responsible for the generation and the evaluation of those indicators will be evaluated s per achievement.

In the private sector, the accountability of the employees is easier, because they have specified terms of reference and more administrative constraints. The medical bodies, like the Order of Physicians and recently, the Order of Nurses, have profession-related ethical accountability, rather than sector-related, but they still are under the constraints of the law when misconduct is at stake.