Reform follows failure:  
I. Unregulated private care in Lebanon

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This first of two papers on the health sector in Lebanon describes how unregulated development of private care quickly led to a crisis situation. Following the civil war the health care sector in Lebanon is characterized by (i) ambulatory care provided by private practitioners working as individual entrepreneurs, and, to a small extent, by NGO health centres; and (ii) by a fast increase in hi-tech private hospitals. The latter is fuelled by unregulated purchase of hospital care by the Ministry of Health and public insurance schemes. Health expenditure and financing patterns are described. The position of the public sector in this context is analyzed. In Lebanon unregulated private care has resulted in major inefficiencies, distortion of the health care system, the creation of a culture that is oriented to secondary care and technology, and a non-sustainable cost explosion. Between 1991 and 1995 this led to a financing and organizational crisis that is the background for growing pressure for reform.

Introduction

Many European countries have been or are presently going through a process of reform of the health care sector. The impetus for such reform comes from the inability to control costs, criticism of bureaucratic rigidity, and the impression of getting poor value for money (Dekker 1994). Most attention goes to the supply side, and the reform debate is dominated by a focus on administrative/financial and organizational issues (Oevretveit 1994). There is a characteristic shift towards market-derived incentives in pursuit of micro-economic efficiency (Saltman 1994) and control of expenditure.

Developing countries are increasingly interested in following similar approaches in order to control costs, but also, and this is much more a central issue than in Europe, in order to correct obvious government failures in financing and provision of health care (World Bank 1993). As in Europe, reliance on the private sector and managed markets is supposed to enhance provider efficiency through competition and the substitution of direct management with contractual relationships.

A growing number of developing countries are now embarking on reforms in which contracting out clinical services – and specifically hospital care – is a key element. The speed with which these approaches have been endorsed in development circles is in sharp contrast with the lack of actual experience and empirical evidence for success (Carr-Hill 1994). The do’s and don’ts, the approaches that work and those that do not, have not been clearly identified in the industrialized world (Petchey 1995; Saltman 1994), let alone in developing countries. What little evidence there is to date indicates that in developing countries the conditions for successful introduction of such reforms are often not in place (Broomberg 1994). Appropriate regulation technologies and capacities need to be developed. Reforming the health care sector in developing countries is indeed subject to specific constraints that centre around the government’s regulatory capacity and the strength of its
bargaining position (McPake and Hongoro 1995). If ultimately reform has to be evidence-based, documentation of present pragmatic efforts is essential.

In most developing countries the original impetus for health care reform comes from a reaction to the government’s failure to deliver health care, combined with a crisis in the financing of the health sector. Scaling down public delivery of services and the introduction of private sector competition in the provision of health care with retention of public financing is usually seen as the way to address public sector inefficiencies whilst retaining a tool for ensuring equity (Birdsall and James 1992). Privatization is further to be seen in an ideological context of shift from welfarism to monetarist macro-economics (Price 1989) but, as in the industrialized world, the debate is now moving from ideological positioning to operational questions (Belmartino 1994). In practice, reform mainly addresses urban health care systems where it focuses on introducing purchaser-provider splits so as to induce supply-side efficiency through competition, whilst keeping the State in a monopolistic power position.

In Lebanon the impetus for health care reform also starts from the recognition of an unchecked growth of expenses for medical care. In contrast with many developing countries, however, it is not a reaction against the government’s inefficiency in delivering services. In Lebanon, indeed, the State has only a marginal role in delivering health care, and a purchaser-provider split exists de facto. Both ambulatory and hospital care are almost exclusively private. Ambulatory care is essentially provided through private clinics financed through out-of-pocket payments. Hospital care is provided through (small) private (for-profit and not-for-profit) hospitals. For about half of the population, hospital care is covered by private or public insurance schemes. For the rest of the population, it is purchased by the State. Private hospitals are thus heavily dependent on public funding. This arrangement has proven highly inefficient, the absence of self-regulation of the private system being compounded by the absence of adequate public sector regulatory mechanisms and capacities.

This first paper documents how, in a very short time-span, unregulated privatization has created an inefficient and distorted health care system, and a non-sustainable cost explosion. The Lebanese case illustrates the strategic importance of the regulation, planning and policy setting functions of the public sector. It shows that public financing per se, without the institutional capacity and proper attention for the mechanics of regulation, does not provide sufficient leverage to avoid predictable market failures. Although the starting point for the Lebanese health care reform is different from most other developing countries engaging in reform (down-scaling public care provision is not an issue), the question of the regulation of a partly publicly financed private sector is of wider relevance.

Lacking regulatory authority – and essential reliable information – the Ministry of Health (MOH) was forced to adopt a reform strategy wherein the problems of financing of the health sector are not dealt with head-on. Tackling the organizational problems of health care delivery first provided an opportunity for building up alliances and pressure that should allow it to tackle finance at a later stage. A second paper documents the way pressure for reform has built up, and identifies the key elements on the reform agenda (Van Lerberghe et al. 1997).

**Health care delivery and the civil war**

Once a prosperous, upper-middle-income country, Lebanon declined during the war of 1975–1990. About one-quarter of the population emigrated during these 15 years. A 1992 study, two years after the end of the war, classified 450,000 individuals as displaced (Feghali 1992). This is a very large number considering the relatively small population of the country—approximately 3 million. Reliable demographic figures are politically sensitive and hard to come by: the last population census in Lebanon dates back to 1932. Furthermore there are some 900,000–1200,000 unregistered foreign workers (mainly from Syria), and some 400,000 Palestinian refugees. Economic activity is picking up fast again following the cessation of internal fighting, and GDP increased from around US$1500 in 1992 to around US$2300 in 1994 (different sources mention different figures). In real terms, however, the per capita income is still below the pre-war level.

The war was a period of an accelerated urbanization: 85% of the population now lives in towns. It was also a period of demographic and epidemiological transition. Only 9.6% of the population is younger than five years, as opposed to the 12–13% that is common in the region. Infant mortality increased from 48 per 1000 in 1975 to 75 in the middle of the war, but then dropped to 44 in 1990. By 1992 it was down
to 34, concentrated in a limited number of areas. Preliminary results of the 1996 PAP-Child survey show an infant mortality rate (IMR) of 28 per 1000. Infectious and parasitic diseases are on the decline. The pattern of demand for care is now dominated by chronic diseases and problems related to the urban environment. For example, the most consistent finding in an analysis of the reasons for encounter in health centres in Lebanon was the high frequency of diagnosis and treatment of hypertension and diabetes (Adib 1994).

With a culture of trade and commerce, and delicate religious and denominational balancing acts that determine politics and administration, Lebanon has a strong tradition of individualism, self-reliance and private initiative. The private sector – with private-for-profit (PFP) and community-linked not-for-profit non-governmental organizations (NFP-NGO) – dominates in most fields, including health and education. Although traditionally considered reasonably competent, effective and even an attractive career possibility, public administration in Lebanon has never played a dominant role in the health sector.

Public services in Lebanon were severely affected and weakened by the war (Kronfol and Bashshur 1989). Buildings and equipment were destroyed, looted or damaged. Trained and capable people left the country (Kronfol et al. 1992), whilst those who stayed had to struggle to survive on inadequate salaries. There has been little opportunity for modernization of ideas, skills or style of work. For all practical purposes, the MOH disintegrated during the war. There was no clear policy, no means to implement it, no information to work on. The public health programmes that were active during the war period were donor driven – with major roles for WHO and UNICEF – and channelled through NGOs of various denominations. Considering the circumstances, this proved highly effective: NGOs proved to be highly flexible and able to deliver results – 89% vaccination coverage with an ongoing civil war. The MOH, however, had only a marginal role in all this.

The MOH activities were limited to contracting with private hospitals in order to deal with emergencies. This was in fact a continuation of the policy of contracting-out that already existed before the war, when the government paid the bill for some 40 000 acute care hospitalizations per year in the private sector. During the war, direct involvement of the MOH in direct provision of hospital care became marginal. By the mid-1980s, seven of the public sector hospitals had been destroyed. At some point the public sector could avail of only 200 beds in Beirut. The share of the public sector in national hospital bed capacity thus fell to less than 10% by 1984 (Anonymous 1987). By the end of the war public hospitals had only 700 partly operational beds left of the 1870 they had in the early 1970s.

In contrast, the private sector remained very dynamic throughout the war. For example, 56% of the present private hospital capacity was created during the war years. Most of this represented development of business opportunities by private entrepreneurs for whom the war provided fresh investment capital.

But the war was also a period of major expansion for NFP-NGOs. These set up a network of health centres and dispensaries, and carried out public health programmes. Lebanese and international NGOs undertook emergency programmes with the support of donors through financial grants designated for short-term emergency aid. International NGOs expanded from 28 to 171 services. There was also an exponential growth of national NFP-NGOs. These were mainly small-scale organizations, working in underserved rural and urban poverty pockets, with emphasis on Beirut and Mount Lebanon. They focused on emergency relief and humanitarian assistance, rarely on community development work. For example, in the mid-1980s, 43% of their clients were health service and 47% relief assistance beneficiaries (Ministry of Labour and Social Affairs and Norwegian People’s Aid 1985). Most NFP-NGOs depended on donations from foreign NGOs and support from political parties and factions. During the war these NGOs gained high visibility and credibility, although many were mere propaganda machines or even fronts for commercial organizations. After the war, however, this credibility was not translated into involvement in planning or policy discussions.

In summary, over the last 20 years the Lebanese health care system has developed in a largely unregulated way, following private initiative and investment. The public sector has been absent, but the country has a NFP-NGO health care delivery network with a public sector logic that has been developed on the basis of the relief operations during the war.

**Ambulatory care in private clinics**

Private practice has been the main source for ambulatory medical care for the Lebanese. Roughly
Health sector reform in Lebanon. I.

Figure 1. Doctor and hospital bed per population ratios in Lebanon and selected other countries*

Figure 2. Sources of ambulatory care

one out of five households identifies with one medical practitioner as its ‘family physician’, very much in a West-European fashion though with less reliance on house calls – less than 5% of contacts are house calls (Abyad 1994; Kronfol et al. 1985).

There is an ample supply of physicians: some 8–9000, i.e. a ratio that comes close to three doctors per 1000 inhabitants. This is higher than most of the rest of the world outside the formerly socialist economies of Europe (Figure 1). The doctor/bed ratio of 0.88 is also among the highest in the world, almost three times that of OECD countries. This relative over-supply of doctors makes ambulatory care a natural career perspective.

Most ambulatory care is provided in private clinics (Figure 2). Hospital outpatient departments capture 8% and health centres, whose number increased spectacularly during the war, have expanded their share to 10%. Most of these health centres are run by NFP-NGOs; the few public health centres and dispensaries offer services of poor quality and are barely used. Health care delivery by NFP-NGOs is strategically important since in many cases their health centres are the only accessible option for the poor. Also, they
remain a key vehicle for programme activities such as vaccination. The set-up of these health centres is very varied and flexible. There are major institutions with lots of staff, various specialities and extensive equipment; others operate out of a rented apartment and offer only essential amenities. Some of these health centres function poorly; others offer services of a better quality level than the average private practitioner – at a lower price to the patient.

On the whole, however, the profile of care offered by NFP-NGO health centres increasingly looks like that of private clinics. This is a consequence of the changes in the environment in which the NFP-NGOs operate. Since the end of the war they have been experiencing growing difficulties in securing funds. Inputs from foreign donors to Lebanon have diminished and the trend has been to redirect funds towards the government. Furthermore, political funding related to the various factions in the war dwindled. Consequently, the importance of ensuring cost recovery became paramount. Since there is an amply supply of physicians, the NFP-NGO health centres can afford to rely more and more on non-salaried part-time physicians: an average of 8.4 per centre. Proceeds of fee-for-service payments are split between the physician and the NGO, for example on a 50/50 or 75/25 basis. The NFP-NGO health centres are thus progressively transforming into an infrastructure that is rented out to private practitioners who carry out the NFP-NGO’s mission, but at the same time use the infrastructure to build up a private clientele. This phenomenon has now become so extensive – also in the government health centres – that some of the NGOs are looking for ways to limit the fragmentation of care that is the result of the multiplication of doctors who use the health centres as a recruitment basis.

When not working in a NFP-NGO setting, private practitioners function essentially as individual private entrepreneurs, most often with some specialist label, but without accreditation, control or regulations. There is thus a continuum between health centres and private practice that affects the way both function: practice in most NFP-NGO health centres becomes more ‘commercial’, while the PFP sector cannot ignore the de facto quality standards some of these NFP-NGO health centres are setting.

**Hospital care in subsidized private hospitals**

There are at present approximately 3.4 beds per 1000 inhabitants in Lebanon (Figure 1), more than in the rest of the region but less than in other countries with similar doctor/population ratios. The number of beds increased both during and after the war (Figure 3).
More than half of the private hospitals became operational during this period. At the same time the number of public beds shrunk, both in absolute and in relative terms.

The long stay hospitals belong to the NFP-NGO sector. The short stay hospitals belong either to the public sector (6% of the total number of beds), NFP-NGOs (22%) or for-profit (FP) private organizations: individual doctors or groups of businessmen that include doctors. Most of the expansion over the last 15 years took place in the form of small-scale private acute care hospitals: 87 out of 140 have less than 50 beds. Almost one-third of all acute beds are in hospitals of 50 beds or less (Figure 4). On the average, FP-NGO hospitals are smaller than those owned by NFP-NGOs or universities.

In the 1980s, 61% of patients were admitted to voluntary and teaching NFP private hospitals, 37% to other private hospitals and less than 2% to public hospitals (Kronfol et al. 1985). The latter have now become even more marginal; since 1992 the numbers of hospitalizations, outpatient consultations, x-rays, laboratory examinations, etc. have declined by 10–20% each year. Many of these public hospitals now have bed-occupation ratios of less than 5–10%. In the meantime, the smaller PFP hospitals seem to increase their market share. This evolution is linked to the way health care is financed in Lebanon.

Health expenditures in the 1990s

It is extremely difficult to know who spends how much on health care in Lebanon. Data are incomplete and contradictory. The 1992 estimate is of US$ 301 million, i.e. about US$ 100 per person per year (Posarac 1994). Triangulation of information from various sources on 1995 yields a range of between US$ 600–862 million (Table 1): US$ 200–300 per person. Around 60% of expenditures is private money in the strict sense of the word (out-of-pocket and private insurance), while one-third is paid for from public sources (MOH and public insurance schemes, i.e. the National Social Security Fund (NSSF), the army and the Civil Services Cooperative (CSC)).

Obviously the situation is changing very fast, not only in absolute terms (doubling in less than three years), but also as a percentage of GDP. Table 2 shows that in 1992 private health expenditures were at the same level, in terms of GDP, as in established market
Table 1. Who pays the health bill?*

<table>
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<tr>
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<tbody>
<tr>
<td>Public insurance</td>
<td>49.0 (16%)</td>
<td>71.0</td>
<td>-</td>
<td>130.8 (15–22%)</td>
</tr>
<tr>
<td>schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public funding: MOH</td>
<td>45.1 (15%)</td>
<td>62.8</td>
<td>72.1</td>
<td>98.2 (11–16%)</td>
</tr>
<tr>
<td>Lebanese NGOs and</td>
<td>29.0 (10%)</td>
<td>-</td>
<td>-</td>
<td>41.6 (5–7%)</td>
</tr>
<tr>
<td>international donors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private insurance</td>
<td>41.6 (14%)</td>
<td>-</td>
<td>-</td>
<td>151–207 (24–25%)</td>
</tr>
<tr>
<td>Out-of-pocket</td>
<td>136.4 (45%)</td>
<td>-</td>
<td>-</td>
<td>179–381 (30–44%)</td>
</tr>
<tr>
<td>Total</td>
<td>301</td>
<td></td>
<td></td>
<td>601–859</td>
</tr>
</tbody>
</table>

* US$ million; estimates adapted from Posarac 1994 and other sources

Table 2. Public and private expenditures for health (excluding donor assistance), as percentage of GDP

<table>
<thead>
<tr>
<th>Area</th>
<th>Total (% of GDP)</th>
<th>Public (% of GDP)</th>
<th>Private (% of GDP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lebanon (1992 estimate)</td>
<td>4.8</td>
<td>1.6</td>
<td>3.2</td>
</tr>
<tr>
<td>Lebanon (1995 estimated range)</td>
<td>6.4–9.1</td>
<td>2.4</td>
<td>3.9–6.6</td>
</tr>
<tr>
<td>Syrian Arab Republic</td>
<td>2.0</td>
<td>0.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Jordan</td>
<td>3.8</td>
<td>1.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Turkey</td>
<td>4.0</td>
<td>1.5</td>
<td>2.5</td>
</tr>
<tr>
<td>China</td>
<td>3.5</td>
<td>2.1</td>
<td>1.4</td>
</tr>
<tr>
<td>Middle East Crescent (weighted)</td>
<td>4.1</td>
<td>2.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Latin America (weighted)</td>
<td>4.0</td>
<td>2.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Sub-Saharan Africa (weighted)</td>
<td>4.5</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Asia (weighted)</td>
<td>4.5</td>
<td>1.8</td>
<td>2.7</td>
</tr>
<tr>
<td>India</td>
<td>6.0</td>
<td>1.3</td>
<td>4.7</td>
</tr>
<tr>
<td>Established market economies</td>
<td>9.1</td>
<td>5.6</td>
<td>3.5</td>
</tr>
</tbody>
</table>

economies, and higher than in most of the rest of the world. Public expenditures, on the other hand, were among the lowest. By 1995, overall health expenditure in GDP terms in Lebanon appears to close the gap with the established market economies; mainly through an increase in private expenditures but also by catching up in public.

Not all these resources are uniformly distributed. Figure 5 shows who paid for whom in 1992 and 1995. NFP-NGO and donor expenditures were assigned to the whole population. MOH expenditures were allotted to the uninsured population, except for the disbursements for cardiac surgery, kidney dialysis and cancer treatment, which benefit the entire population (see below). Expenditures of the various public insurance systems were allotted to the beneficiaries of these systems and their dependants. The same goes for the expenditures of private insurance schemes. No account is taken of the possibility that some may benefit from a number of insurance schemes at the same time. Nevertheless, in Figure 5, 25% of private insurance expenditures are arbitrarily distributed over both privately and publicly insured, to take account of the increasingly common practice of subscribing to complementary insurance. Both expenditure and coverage data are rough estimations, with a considerable amount of uncertainty, indicated by the arrows in Figure 5. This makes a precise interpretation of expenditure levels difficult. With this caveat, the figure nevertheless illustrates present trends in financing.
Between 5% and 17% of the Lebanese population have private insurance coverage—estimates range widely but there is a consensus that the sector is expanding. If one assumes that private insurance coverage has gone up from 8% in 1992 to 11% in 1995, average non-out-of-pocket expenditure for this part of the population in 1995 was around US$ 460 per person (but may be as high as US$ 950 according to some estimations). Of this, US$ 13.8 was donor money or NFP-NGO expenditure, and the MOH paid between US$ 10–14 (a conservative estimate: the real figure may be significantly higher) in hospitalization costs for cardiac surgery, kidney dialysis and a number of other specific conditions. The rest, over US$ 430 per person in 1995, nearly three times as much as in 1992, was accounted for by private insurance. The latter mainly covers hospitalization, but not exclusively.

Nearly half of the population is covered by one of the three public insurance systems: army, public service (CSC), and employees (NSSF). These insurance systems were created in the 1960s following European models (Kronfol and Bashshur 1989). They more than doubled their expenditures between 1992 and 1995 (Table 1), and now reach around US$ 74 per person per year. About 40% of their expenditures are for inpatient care. People in a public insurance scheme also may carry a complementary (private) insurance (estimated here, rather arbitrarily, to contribute US$ 29 per person), and benefit from MOH (low-end estimate between US$ 10–14) and donor-NGO inputs (US$ 13.8). Total expenditure would then be around US$ 129 per person (with a range of US$ 112–168).

The rest of the population is uninsured. The MOH spent around US$ 55 per person in reimbursements to private hospitals for inpatient care for the uninsured. It does not reimburse them for outpatient care. The only other non-out-of-pocket contribution to financing health care for this part of the population is that of donors and NGOs. Overall non-out-of-pocket expenditures for the uninsured were around US$ 69 (range US$ 58–89) in 1995: more than double the figure for 1992. Setting aside the de facto, but
limited, subsidies by NFP-NGOs, the uninsured have to pay out-of-pocket for all of their ambulatory care.

The overall impression is one of an explosion of expenditures that is most marked for the population with private insurance, but touches the rest of the population as well. If coverage for ambulatory care was eliminated, very similar expenditure levels would be expected for both the uninsured and those with public insurance, roughly between US$ 50–70 per person per year; for the privately insured, non-out-of-pocket expenditures are probably well above US$ 300.

**Financing**

Only one-fifth of the population relies mainly on third party payment for its ambulatory care: 16% through public insurance and 4% through private insurance (Figure 6) (Firsh et al. 1996). Ambulatory care is essentially paid out-of-pocket by 77% of the users. Ten per cent of the population rely on NFP-NGO run health centres where financial barriers can easily be overcome (low fees, possibility of free care); the rest of the population uses the services of (expensive) private practitioners. Out-of-pocket payment is the source of 74% of expenditures on laboratory services, 79% of those on drugs and 92% of those on dentistry.

Ambulatory care (slightly over half of total non-donor funded expenditure in 1992–93) is therefore fairly independent from public funding. Public insurance schemes contributed around US$ 40 million to non-hospital care in 1993. The rest was made up by private insurance, NGOs (whose contribution was estimated at US$ 6 million, probably targeting mainly the uninsured) and out-of-pocket payments. The latter have increased with the expansion of the supply of doctors, whereas the MOH was nearly completely absent (Figure 7).

The situation was very different for hospital care. The share of the public sector in directly providing hospital care is marginal. The State, however, makes use of non-public hospitals through three mechanisms. The first is the various public insurance schemes. These have arrangements to reimburse
itemized expenses made at outpatient consultations and for hospitalizations in private hospitals. They are independent from the MOH.

Secondly, the MOH pays, through its budget, for particular categories of treatment (cardiac surgery, kidney dialysis and cancer treatment). A political decision in 1990 led the MOH to pay for such interventions in the private sector for all Lebanese citizens. This now mobilizes between one-third and half of MOH expenditure for reimbursement of inpatient care: low-end estimates range between US$ 10–14 for 1995, up from US$ 8.5 in 1992. It is not known whether beneficiaries of this MOH financing are concentrated among a particular class, or equally distributed.

The final mechanism is contracting with private hospitals that provide for reimbursement of hospitalization costs of the uninsured population. Such treatment in the private sector, paid for by the government, concerned around 40 000 patients per year during the war, and rapidly increased afterwards: 64 200 patients in 1990, 65 800 in 1991, 80 000 in 1992, 90 000 in 1995. The MOH earmarks a number of beds for subsidized patients. Each hospital is graded, and a room rate and tariffs of charges for tests, drugs, use of the operating theatre, etc. are agreed. The MOH has to give authorization for admission – based on a very cursory referral note. After hospitalization of an authorized patient, the MOH will receive an extremely detailed bill, which it has to pay without being able to exercise any control (up to 1993–95) over the justification of the cost items. There are probably no or very few countries in the world that have a billing system that is both as complicated and as uncontrollable as the Lebanese system. Misuse is rife, but although public insurance has in two instances cancelled contract arrangements with hospitals, the MOH has never been in a position to do so.

Almost half of non-donor-funded expenditure is for hospital care. The public sector provides some US$ 12 per person per year for the (affluent) privately insured through reimbursement of heart surgery, kidney dialysis and cancer treatment. It spends US$ 50–60 per person per year for the publicly insured (employees and military with their dependants), and around US$ 55 per person per year for the uninsured. All in all, public insurance and the MOH paid about US$ 80 million for hospital care provided in private hospitals in 1992, and almost twice as much in 1995. The rest came from private insurance and from the users through out-of-pocket payments. In 1992–93, 65% of private hospitals' income came from MOH and public insurance, 18% from four private health insurance schemes and only 15% from
out-of-pocket payments. Donations account for 3% of their income (Figure 7) (Posarac 1994). A study of 82 hospitals in 1994 (Jurjus 1994) and detailed data on four hospitals in 1995 (Ramaddan 1996) confirm this pattern (Table 3).

Health care delivery, both hospital based and ambulatory, is thus essentially private and unregulated. Ambulatory care has developed outside public financing considerations. Hospitals, on the other hand, depend very much on public financing. Reimbursement of hospitalization expenses by public and private insurance schemes, and by the MOH, has been the motor of the expansion of the private hospitals. Without it, the survival of the smaller hospitals would probably be immediately endangered.

### Institutional bargaining capacity

The dependency of private hospitals, and especially of the smaller ones, on public funding should put the MOH in a strong bargaining position. Nevertheless, the MOH has been unable to restrain the growth of the cost of the hospital care it contracts for in the private sector. Hospital care is putting an increasing strain on its budget, as it does on public insurance (Abyad 1994). Before the war, payment of hospital care accounted for roughly one-third of the MOH budget. This then increased considerably, and since the end of the war hospital care has consistently mobilized more than three-quarters of the budget, including salaries. That is considerably higher than the OECD mean share for hospitals, excluding ambulatory care, in total public recurrent health expenditure (54% in the 1980s). Out of 60 low, middle and high income countries (Barnum and Kutzin 1993), only Malawi allocates as high a proportion of recurrent public spending to hospitals. The MOH’s reimbursement to hospitals has tended to grow over the years, both in absolute and relative terms (Figure 8). In the 1970s this made up one-third of the MOH budget. Since 1991 hospitals have absorbed over 80% of the budget, peaking at 86% in 1994 – rising from US$ 18.6 million in 1990 to US$ 62.5 million in 1994 and US$ 82.4 in million in 1995. The scope for developing the other activities of the MOH within this budget frame is limited and shrinking.

The MOH is having increasing problems in obtaining the budgets to keep up with the growing requests for reimbursement of private hospital care. Public insurance schemes are also experiencing problems in securing the required government contributions. On the other hand, the MOH is unable to exert the necessary pressure to control the amounts paid to private hospitals, neither through rationing nor through the pricing mechanisms.

In theory Lebanon’s MOH could have leverage over what happens in the field of hospital care, through its crucial role in the financing of hospital income (Figure 7). This leverage is, however, limited by the fact that the MOH has no authority over public insurance. It can only use its own inputs and technical authority as a basis for influencing hospital care in the private sector. In practice it has very little effective influence, for technical, administrative and political reasons, and coordination in this matter only started timidly in 1996.

Technically, the asymmetry of information available to the purchaser (MOH and public insurance) and the provider (the private hospitals) makes it difficult for competition, in the form of preferred contracting, to occur. Lebanon’s MOH has no inside knowledge on the functioning of the hospital sector. The complexity of the payment mechanism and the absence of adequate technology and trained personnel make it

### Table 3. Sources of income of four hospitals in 1995

<table>
<thead>
<tr>
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<th>MOH and public insurance schemes</th>
<th>Private insurance</th>
<th>Out-of-pocket payments</th>
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<tbody>
<tr>
<td>82 hospitals in 1994</td>
<td>67.1%</td>
<td>17.6%</td>
<td>15.3%</td>
</tr>
<tr>
<td>Hospital 1, 1995</td>
<td>88.4%</td>
<td>6.1%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Hospital 2, 1995</td>
<td>76.1%</td>
<td>16.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Hospital 3, 1995</td>
<td>46.0%</td>
<td>25.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Hospital 4, 1995</td>
<td>51.0%</td>
<td>30.8%</td>
<td>18.2%</td>
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impossible even to identify blatant misuse or inappropriate billing (Kronfol and Bashshur 1989), let alone issue guidelines for standard treatment protocols or costing norms. This deprives the MOH of control over the pricing mechanism, which, as European experience shows, is a critical tool for balancing supply and demand in regulated markets (von Otter and Saltman 1992).

The MOH thus has little information on which to base a regulation or control function. This is compounded by the fact that the MOH budget offers little scope for a personnel policy that would increase its capacity. In terms of purchasing power, the 1994 personnel budget is only 67.5% of the 1990 level. This also represents a shrinkage in relative terms: from 15.3% of the budget down to only 8.9%. With such a budget (an overall average of about US$ 3600 per employee for 1994), it is obviously difficult to retain, and near impossible to attract new, qualified staff, let alone maintain any illusion of setting up a health care provision system based on public sector employed staff. As such, the budget for personnel would be sufficient to hire staff to fulfil a regulatory role. However, this would require the MOH to rid itself of excess staff presently assigned to health care delivery, which is politically difficult. A 50% increase (in US$ terms) in the budget for salaries in 1995 brought purchasing power back to 1990 levels. This, however, does not fundamentally alter the situation, given the administrative constraints on hiring personnel in the public service.

Politically, the MOH is being urged to further promote expansion of hospital capacity rather than regulate it, and to refrain from showing preferences between potential provider-hospitals. The choice of hospitals to be contracted is basically a question of denominational and political considerations. The MOH thus cannot restrict market entry on technical
grounds. When a new small hospital starts activity, it is near impossible for the MOH to impede this, especially since it cannot provide alternative public hospital care possibilities.

Furthermore, non-market pressures and concerns with continuity of care and accessibility prevent hospital closure or stopping of reimbursement arrangements, even when market conditions suggest otherwise. Only once has the NSSF, over which the MOH has no control, had the political clout to stop purchasing care in a hospital for reasons of persistent false billings. In the Lebanese context, where denominational and political balances are all-important, the MOH itself has never been in a position to do this. Even a hospital that constantly overcharges by 60% or more remains contracted by the MOH. Theoretically the MOH has the administrative authority to intervene, but it does not have the technical means or information to make a case. The lack of technical prestige and credibility of a public service that has been absent from health care delivery and policy making for the last decade or more, further weakens its capacity to resist pressure on technical grounds. Both participation in and exclusion from the health care market are thus politically constrained. In such circumstances, it is unavoidable that there is little control over the size of costs, over their justification and over quality of care (Maynard 1991).

Without financial leverage, Lebanon’s MOH has even less control over what happens in the field of ambulatory care. Even though there has been a slight improvement over the last five years, the MOH still spends less than 4% of its budget for technical activities and programmes. Primary health care accounted for only US$ 21,000 in 1991. Their share of the budget has since increased to US$ 1,500,000 in 1995, but this remains a marginal amount compared to the bill for hospital treatment. As is the case in the field of hospital care, the MOH does not have technical authority since it has not been a significant actor in health care delivery over the last decades. And its administrative authority is extremely limited and almost impossible to carry through in a context of political interference and delicate denominational balances.

The MOH is thus left with (i) a budget that does not provide 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.

Incentives for inefficiency and distortion

In the aftermath of the war, the switch from emergency relief to health care delivery was to be based on a self-regulated system of private care providers, fuelled by public funds, where competition would ensure quality of care and affordability. Within five years the assumption that the sector would self-regulate (provide good quality care in an affordable and efficient way) proved false. There is ample anecdotal evidence that technical quality of care is wanting, especially in many of the smaller hospitals. There is no real evidence of growing consumer dissatisfaction as yet, but this can be expected as soon as problems with sustainability become more evident. Indeed, the mechanisms for regulation of the health sector (or rather their absence) act as incentives towards inefficiency and distort rational organization of health care delivery. They promote, and are reinforced by, a specialist-centred and secondary care oriented culture among both professionals and the public.

There are no incentives to expand the private provider’s or health centre’s responsibility for care beyond that of responding to immediate demand. Continuity of care is absent: for example, less than 2% of the contracts with private practitioners are revisits. Many health centres offer specialist consultations, but, in contrast, leave prenatal care to hospitals. This implies a tendency to medicalize, irrational use of drugs, and reliance on technology at the expense of communication. Hospital pharmacies have an average of 514 different items, up to 8000 in one hospital. Public funds pay for half of the 1.5 million X-ray acts made in Lebanon every year (Jurjus 1994). There are more health centres or private clinics with ECG services than with family planning activities. Little or no work is done in the field of health promotion, such as prevention of smoking. The priority given to kidney dialysis is in contrast with the absence of diabetes programmes (diabetes being the underlying aetiology for over one-quarter of kidney failure patients); the priority given to open heart surgery contrasts with the lack of primary preventions.
NFP-NGOs are presently offering an alternative of reasonably cheap and, in cases of need, free access to care for the poor. They, rather than government services, make up the social safety net for the poor in Lebanon. Their way of operating has led them to accept comprehensive responsibility for the care of certain population groups. This situation is now changing. Since their traditional sources of funding are withering, NGOs increasingly copy the work-style of private practice: exclusive focus on those activities that have immediate income generating potential. The financial predicament of NGOs, combined with a de facto restriction of their mission, results in erosion of the social safety net as well as in gradual elimination of examples and models of better practice at primary care level.

These changes are clearly dependent on the absence of public funding to sustain structures accessible to the poor, and on the inability of government to influence or rationalise the way the private practitioners operate. The lack of guidelines and regulation is fuelling prescription patterns that merely respond to demand, without elements of rationalization or constraints other than the patient’s ability to pay. This is preoccupying, for example, in the field of treatment of hypertension and diabetes, which was donor-sponsored for the last few years. The government is now contributing US$ 1.5 million per year to this programme, but still without treatment policy guidelines that would make it possible to control rising costs.

The lack of tools or levers for rationalizing ambulatory care is compounded by the type of political and financial incentives for hospital care. Hospitals and first level care in Lebanon are completely unrelated subsystems, both operationally and in the way they are financed. Since quality or cost-effectiveness are not determinants for purchase of hospital care, there is no real competition among hospitals. On the other hand, public subsidy for hospitalization, but not for ambulatory care, results in a de facto competition for patients between hospitals and first line services. This distortion carries an opportunity cost in terms of missed possibilities for efficiency gains through a division of labour between complementary first, second and tertiary care levels.

The expansion of the hospital network has taken place in an inefficient way, sacrificing overall sustainability for short-term return on singular investments. The creation of a large number of small private hospitals has resulted in an excess bed capacity in relation to the level of demand, as evidenced by a low bed occupancy (56%, compared to an OECD average of 81%), a short average length hospitalization stay of 4.8 days (less than half of that of OECD countries) (Jurjes 1994) and a hospitalization rate of 13.9 that approaches the OECD median of 16.1. A large proportion of hospitalizations in the small hospitals have no medical justification.

Lebanon now has three times more physicians per inhabitant than the average for the other countries in the Middle East. This can be expected to further fuel the growth of expenditure and the increase in hospital beds: new hospitals are already under construction. Most are so small that economies of scale are difficult. This results, for example, in under-utilization of equipment: CT scans in the smaller hospitals perform only between three and eight (often unnecessary) examinations per day. Kidney dialysis facilities could handle double the present patient load (Jurjes 1994), though the 400 dialysis patients per million inhabitants is already above the OECD median of 360.

Although manpower imbalances (e.g. only 2000 qualified nurses compared to 8–9000 doctors) will make it difficult to sustain proper functioning, hospitals aim for a level of technology that is way above that of many developed countries. The financing structure provides an incentive for the private hospitals to invest in heavy technology, since its operation will be preferentially subsidized by public funds. This has led to very rapid expansion, with little technical or economic justification. There are now five MRI in Lebanon, all located within a few kilometres from each other. At 240 cases per week the total cost can be estimated at US$ 4 400 000 per year: the equivalent of 5% of the MOH budget. There are 27 CT scans, six centres for in-vitro fertilization, and ten centres for lithotripsy (Jurjes 1994). The fastest expansion is in cardiac surgery and cardiac catheterization, techniques that are automatically reimbursed by the MOH. Heavy medical technology is now more available in Lebanon than in many industrialized countries (Figure 9). Apart from the expected iatrogenic effects, this expansion of technology will further reinforce a culture of hospitalocentrism and fuel the cost explosion.

These considerable investments gamble on a continued growth of the health care market to ensure returns. Even compared to established market
economies, however, private expenditures are already high in terms of GDP (Table 2), and public expenditure is growing too fast for the government to sustain. The present predicament is that without proper regulating mechanisms, an unbearable strain will be put on the MOH and social security schemes, whereas rationing or regulating mechanisms would endanger returns on private investment.

References


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