DRAFT

Lebanon

Public Expenditure Review of the Social Sectors

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Chapter 1

Introduction and Executive Summary

Overview of expenditures

Lebanon's investment in human capital is impressive. Its health and education indicators correspond to those of other lower-middle income countries — a major accomplishment in spite of the setbacks from the civil war. The Government has shown its commitment to the provision of social services to the population. It has allocated significant shares of its recurrent and capital budget to the social sectors. The Council of Development and Reconstruction (CDR) undertook rapid rehabilitation of schools, health centers, and hospitals shortly after the war. Almost all public schools have benefited from these investments.

As a nation, Lebanon spends about 19 - 20 percent of GDP on health and education alone. The public sector's proportion amounts to 5 percent of GDP against the international average of 11 percent. The Government of Lebanon allocates 26 percent of its expenditures (excluding debt servicing) to these two sectors. An additional 4 percent is allocated to safety net programs which means that a little under one-third of the government's budget is consumed by social programs. (See Table 1.1.)

Lebanon's social sectors are unique when compared to the rest of the world due to the heavy involvement of the private sector. Private financing of health and education expenditures is 12 percent of GDP as against the world average of 5 percent. This large difference reflects the structural characteristics of the sectors — heavy private sector activity, significant government subsidies to private providers, and minimal government regulation. Private contributions to welfare programs are believed to be substantial and far greater than public welfare expenditures, though this is difficult to quantify due to lack of data. Non-governmental organizations have a strong presence in all fields of activity whether welfare or developmental.

Implications of existing sector policies

This report assumes that the Government's objective is to extend essential health and education services in a cost efficient manner to all Lebanese. In order to achieve this objective, not only are technical efficiency gains (such as lowering unit costs) required, but also changes in the Government's policies and regulations. There is no assumption made in this report that the public sector should be expanded to deliver services to the population. The strong preference underlying the reform proposals is that Lebanon build upon its existing public and private institutions in order to extend coverage and improve the quality of services.

The two broad findings or observations that result from the review of the social sectors are as follows:

- As a nation, Lebanon is spending too much on health and education.
- Inequity will increase under the existing health and education policies with the affluent having access to quality services while low income groups become increasing excluded from the benefits.

Table 1.1
Government Expenditures on Health, Education, and Social Services

	1992	1993	1994	1995	1996	1997	1998
			(in current LL billion)				
Grand Total Expenditures on Social Sectors	412	531	707	997	1,009	1,530	1,583
Education	211	274	406	510	432	610	963
Ministry of National Education, Sports, and Youth	207	178	234	322	314	388	456
Ministry of Vocational & Technical Training	-	19	25	40	33	40	33
Ministry of Culture and Higher Education	-	60	80	105	61	150	195
Other ministries	-	-	-	-	-	-	276
CDR	1	13	63	40	21	29	-
Council of the South	4	4	4	4	4	4	4
Health	132	102	140	303	386	513	379
Ministry of Health	89	101	136	177	206	239	240
Budget Reserves	0	1	4	5	5	12	21
Other ministries	33	-	-	103	150	208	110
NSSF Contributions	9	-	-	18	25	55	7
Social Services	69	155	162	183	191	407	241
Ministry of Social Affairs	-	38	53	69	89	95	94
Ministry of the Displaced	-	4	6	7	6	7	9
Grains and Sugar Beet Office	69	113	103	107	96	177	138
Central Fund for the Displaced	-	-	-	-	-	64	-
Council for the South	-	-	-	-	-	64	-
			(in percent of GDP)				
Grand Total	4.3	4.0	4.6	5.5	4.9	6.6	6.1
Education	2.2	2.1	2.6	2.8	2.1	2.6	3.7
Health	1.4	0.8	0.9	1.7	1.9	2.2	1.5
Social Welfare	0.7	1.2	1.1	1.0	0.9	1.8	0.9
		(in percent of public expenditures excl. debt servicing)					
Grand Total	24.3	23.2	18.2	22.3	19.9	31.3	30.1
Education	12.4	12.0	10.4	11.4	8.5	12.5	18.3
Health	7.8	4.5	3.6	6.8	7.6	10.5	7.2
Social Welfare	4.1	6.8	4.2	4.1	3.8	8.3	4.6
Miscellaneous items:							
GDP mp	9,499	13,122	15,305	18,028	20,417	23,034	26,121
Government expenditures excluding debt servicing	1,700	2,285	3,891	4,467	5,079	4,888	5,254

Source: Ministry of Finance and staff calculations.
Note: "-" indicates that data were not available or could not be collected by the mission.

Lebanon is spending about 80 percent more than other countries on health and education as a share of GDP, but available evidence does not indicate that the outcomes are comparatively superior. This high level of expenditures on the social sectors comes at the expense of other productive investments that could promote economic growth beyond the current level of about 5 percent per annum. Through better management of public and private resources, the country can achieve even better outcomes than it presently obtains. The Government has a critical role to play in setting policies and introducing (and enforcing) regulations that would encourage the public and private sectors to invest in and deliver cost-effective services.

The Government plays an important role in ensuring that all of its citizens have equal access to opportunities to build (or maintain) their human capital. In the arena of welfare services, this means that the vulnerable have the instruments and mechanisms to participate in the fruits of the country's growth (such as prosthetics for the disabled). If groups of individuals are excluded from consuming health and education services, the long-term impact can be severe. For example, if the poor only have access to low quality education, then implications for their long-term productivity and wages are not optimistic — and the cycle of poverty will be maintained. The Government through its expenditures and policy actions can play an balancing role to ensure that inequality does not grow in the future.

Problems affecting government interventions

The sectors of health, education, and welfare all have significant government financing and/or provision of services. The investments in these sector are particularly labor intensive since the physical facility is by itself insufficient to promote welfare. There are three areas that the Government may want to focus on in order to improve the effectiveness of its social sector interventions in general. Not only will this result in improving the welfare of the population, but it will also bolster the Government's credibility as an entity that can ensure the delivery of key services to the population.

The first issue is the **lack of adequate forecasting of operating costs of public investments** prior to undertaking them. The focus in the past has been to rehabilitate destroyed or deteriorated facilities. However, prior to making new investments, it would be worthwhile for the line ministry, CDR, and the Ministry of Finance to reach an agreement on the project's long-term affordability. All investment projects have operating cost implications which may or may not be affordable under the existing fiscal situation. A good use of resources would suggest only to undertake those investments which the government will be able to support fully. Thus, building health or social development centers, without an *ex ante* analysis of whether or not the country can afford the implied increase in recurrent expenditures, may lead to future under-funding of the operating costs - and therefore poor service delivery. The Government may want to consider introducing mechanisms which avoid similar situations by having the three parties reach an agreement regarding future funding of the implied operating costs *prior* to beginning any investment. The presence of poorly operating public facilities may undermine the Government's credibility among the population.

The second problem that Government may want to address is the **lack of an agreed upon sector strategy** by the line ministries involved. Though the Government's relative presence in service provision is small when compared to the private sector, its policies have a major impact upon the sector's development. In some cases (health and social welfare), the line ministries are pursuing two contradictory policies — of improving the system of public financing of private services while increasing their public investment in those areas. In the case of education ministries, a strategy needs to be developed to address issues such as the role of public schools vs. private

schools, the implication of public financing of private education, and the over-supply of teachers. Without a roadmap for these sectors, each of the line ministries will be forced into reacting to events with the strong possibility that events will overtake them leaving them to deal with larger problems in the future. The presence of a proposed strategy will also facilitate building a national consensus regarding the complementary roles of the public and private sector.

The third problem faced by the Government is that **some donor financed investments hurt rather than the help the country in the medium-term.** The most obvious would be that though projects' capital costs are covered by donors, the operating cost have to be financed out of the Government's recurrent budget. Thus seemingly free or inexpensive funds become a burden on the country due to high recurrent costs of operating the project - such as of a hospital. Second, even when the project's recurrent cost implications are not large, they can displace other priority projects which need funding for operating costs. Thus, being selective on what donor financed investments the country accepts, will help retain domestic financing for national, including sector, priorities.

Options for reform

The following chapters provide a series of options for the Government to improve the effectiveness of public expenditures and sectoral policies. The options range from minor improvements to major structural changes — all based upon the existing institutional context of the sector.

Education expenditures in Lebanon are well above the world average: 9 percent of GDP compared to 5 percent. Though government expenditures at 3.7 of GDP are less than the international average of X percent, Lebanon has an active private sector which is heavily involved in the provision of education at all levels. There are several steps that the Government could take that would help to increase the provision of lower cost education while improving the quality of services. They are:

(a) Seek ways to improve the efficiency — especially to lower unit costs — of the public education sector. This may require putting a moratorium on teacher hiring.

(b) Revisit its decision to discourage the expansion of the subsidized private schools.

(c) Improve the quality of public education through decentralizing management to the local level.

(d) Introduce a voucher system for education from grades 1 – 12.

The health sector warrants special attention because the rate of growth in public health expenditures at 15 percent appears to be faster than GDP due primarily to the growth in transfers to private hospitals. Government expenditures of 1.5 percent of GDP underestimates total government health spending due to large arrears to private hospitals (equal to 0.8 percent of GDP) by the Ministry of Health, army, and internal security. In order to contain escalating costs and improve the effectiveness of government interventions, the Government may want to:

(a) Revisit its public investment plans for public hospitals and health centers.

(b) Initiate a systematic effort to curtail MOH reimbursement to private hospitals which do not meet minimum capacity (100-200 beds) and safety levels.

(c) Fast track strategies to implement global-budget contracts with private hospitals to contain growth in MOH reimbursement.

(d) Undertake comparative analysis of pharmaceutical prices as a basis for developing strategies to reduce prices and make prescribing more cost-effective.

Though the Government has several different programs to improve the welfare of the population, they can be categorized into regular and emergency programs. The programs supported by the Ministry of Social Affairs fall into the first category since they target vulnerable in society such as the disabled, elderly, and orphans. They also help to provide social development services such as adult literacy, health care services in low-income areas, etc. The main emergency relief programs are the grain and sugar beet subsidies, the Ministry of the Displaced, Central Fund for the Displaced, and Council for the South. In 1997 the "regular" welfare programs constituted about one-quarter of the total welfare expenditures of the Government. In order to improve MOSA's services, the Government may want to consider the following actions:

(a) Provide adequate financial support to MOSA for extending the institutional arrangement of the Rights and Access Program (for the disabled) to other beneficiary groups such as orphans, elderly, and delinquents.

(b) Encourage MOSA to build a track record in successfully managing existing social development centers within current resource allocations prior to expanding the network.

(c) Expand and standardize procedures to improve the accountability of service providers including NGOs which receive government grants, welfare centers, and social development centers.

(d) Per diems paid to NGOs for boarding and care for orphans, elderly, disabled and other vulnerable groups should be indexed to the CPI and revisited every 2 – 3 years.

Chapter 2

The Education Sector[1]

The Lebanese population has a long tradition of investment in education. Not only does one find a strong willingness to pay for the education of children, but also that this willingness continues far beyond compulsory education, up to university and post-graduate studies. Certain of Lebanon's education indicators compare favorably with upper middle income economies, but less so with OECD countries. Net enrollment ratios at primary and secondary levels are estimated at 83 and 52 percent respectively against 87 and 47 percent for the MENA region. The average number of years a 5 year old can be expected to attend school is 12.6 years compared to 15 years for OECD countries.

By all international standards, Lebanon's education system is atypical due to three distinguishing features: (i) the coexistence of several independent sub-systems; (ii) the substantial presence of private spending; and (iii) the subordination of schools to specific religious and ethnic communities resulting in multiple schools serving the needs of different communities present in the same locality.

Lebanon spends an unusually high share of GDP — 9.3 percent — on education with private expenditures alone representing 5.6 percent of GDP. The high level of national income devoted to education makes Lebanon an outlier on two grounds. First, Lebanon is spending almost 3 percentage points of GDP more than OECD countries (5.9 percent on average). Second, the relative contribution of private sources (mainly households) is almost 5 times the OECD average. These features immediately raise fundamental questions: (a) are these funds effectively spent; (b) is the burden of expenditure equitably distributed; and (c) what is the role of the state in the education sector? (See Table 2.1.)

Overview of the sector

About one third of the Lebanese population is involved in the education sector with over 950,000 students and 83,000 staff. The majority of students in grades 1-12[2] are enrolled in private schools (56 percent), followed by public schools (31 percent), and subsidized private schools (13 percent). All schools, irrespective of the degree of government subsidy, charge fees. Though legally, subsidized private and public schools are not allowed to, they do impose fees because government transfers are insufficient to cover their operating costs.

General Education

The public school system plays a complementary, though secondary, role to private education. Though government schools still lag behind private schools in terms of quality of education, their lower fees make them affordable alternatives to private education. Thus, it is not surprising that public schools are more active in rural rather than urban areas and attract more students from low income households. The recent sudden increase in public school enrollment of 40,000 students

[1] Although each sub-sector of the education system had been considered at the outset of this work, the report focuses on general, pre-tertiary education, where the most fundamental issues have been found.

[2] The schooling system in Lebanon is 5 years primary education, 4 years complementary, and 2 years upper secondary. At the end of the complementary level, there is an exam called Brevet d'Enseignement du Premier Cycle (BEPC) which must be passed in order to enter secondary school. At the end of upper secondary, there is the Baccalaureat exam.

Table 2.1
Total Expenditure on Education by Type and Source of Funds in 1998

Type of funds	Source of funds	Expenditures (in LL bl)	Share of GDP (in percent)
Public expenditure	Three ministries of education	662.5	2.5
	Other ministries	276.4	1.1
	CDR & Council of the South	26.9	0.1
Private expenditure	Households	1,398.0	5.3
	Private employers	70.1	0.3
Grand Total		2,433.9	9.3

Source: Government of Lebanon

(X percent) is considered by some to be a response to the current economic situation which makes it difficult for households to pay the high private schools fees[3]. Others, however, perceive it as a partial restoration of the public trust vis-à-vis the State, and its capacity to provide better education services.

The subsidized private sub-sector is slowly shrinking due to the 1991 legislation which halted the Government recognition of new private schools eligible for public support. All subsidized private schools function only at the primary level and enroll 22 percent of primary students. These schools receive per pupil grants from the Ministry of Education, Youth and Sports (MOEYS). The grant is linked to the minimum national salary (125 percent of the salary) and currently is LL 312,500. This amount is low particularly when compared to the average cost of running a public school or private school fees. For example, it is 18 percent of the average unit cost of a public school and 20 percent of the average fee paid in private schools (*Administration Centrale de la Statistique*, 1998). Therefore, the Government allows these schools to charge a maximum additional fee of 1.3 times the minimum salary, namely LL 325,000 in 1998.

The majority (320) of the 391 subsidized private schools belong to NGOs, which frequently operate both unsubsidized and subsidized private schools. Given that the government grant is inadequate for covering operating costs, NGOs must seek additional sources of funding. They obtain revenues from three major sources: (i) profits from their purely private schools; (ii) donations from local-fund raising or from foreign countries with the same religious affiliation; and (iii) income generated by their real estate holdings or other commercial activities.

Due to historical reasons, the Lebanese education system is also characterized by a second differentiating factor, namely that schools are run by specific communities. Some areas are rather homogenous; others are not, with different communities living close to each other, or even integrated. It is common to have several schools serving the needs of the different communities present in the area. Such a situation, combined with the breakdown of schools into three sub-sectors (private, semi-private and public), has led to two major problems. First, the country is unable to take advantage of potentially promising economies of scale. Second, the complex school mapping which has resulted from this system, generates substantial transportation costs for students to attend different confessional schools.

Vocational and Technical Education

The vocational and technical (VT) training sub-sector in Lebanon is under-developed. The private and public sectors both prepare workers for two levels of qualifications — qualified worker and technician. The public sector has 35 centers in which 16,000 students are enrolled. The 280 private sector centers enroll 42,000 students and provide training mostly in service fields, leaving capital-intensive training to public institutions. From a quantitative point of view, the Government is committed to doubling the present size of the public sector, in order to attract about 40 percent of students leaving complementary education[4].

The two main weaknesses of this sub-sector are (i) the curricula which are not properly adapted to the requirements of a modern economy; and (ii) the weak linkages of the VT centers to enterprises. The Government has begun to address these problems by revising the curricula and introducing the dual system of combining theory and practice. It has already created linkages

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[3] About 43 percent of the minimum wage for enrolling child in a non-subsidized private primary school and 54 percent in a non-subsidized private secondary school.

[4] A vocational and technical education project has been recently prepared; the project document lays out the main issues in this sub-sector.

with 75 enterprises and *begun revising the list of trades*. Nevertheless, the sector is still perceived as a second best solution for low achievers as it does not lead to tertiary education since VT students are unable to pursue their school career in general education. A further problem is that higher technical training is still undeveloped, which would fit the needs of training higher technicians between the levels of engineer and ordinary technician.

Higher Education

Higher education is undoubtedly a significant asset of the Lebanese education system. When Lebanon is compared against other countries at similar level of economic development, its higher education sector is above average in both quantitative and qualitative terms. Tertiary education is provided by one public university — the Lebanese University — and 18 smaller private universities. The Lebanese University enrolled 47,000 students in 1997/98, and an estimated 40,000 were enrolled in the private sector. With 46 percent of its student population enrolled in private tertiary institutions, Lebanon is similar to Jordan and the Netherlands, and is overtaken only by a few countries such as Japan, Korea, India and Belgium[5]. One fourth of the students are non-Lebanese, which indicates the attractiveness of the sector in neighboring countries.

Evidence regarding quality of tertiary education is limited, but it is generally believed that the most prestigious private universities (the three or four top ones), are close to Western standards. This is a remarkable achievement since this corresponds to the number of highly rated United States' universities (adjusted for population size). The Lebanese University does not have a similar reputation, and its internal efficiency is low, as reflected by the significant proportion of students who drop out prior to obtaining a diploma.[6] The Lebanese University has programs in all academic fields, and has developed regional branches in several regions of the country.

Public expenditures

Aggregate government expenditures on education for 1998 are estimated to reach LL 966 billion or 18.4 percent of budgeted expenditures (excluding debt servicing). Total public expenditures represent 3.7 percent of the GDP which is below the world average of 5.1 percent. About 69 percent of government expenditures are allocated through the three education ministries. The remainder is channeled through various other line ministries, the budget reserves, the Prime Minister's budget, CDR, and the Council for the South. The bulk of the budget is allocated to recurrent expenditures. The share of capital in total education expenditures is about 8 percent, slightly above the international norm. However, this is to be expected given the reconstruction requirements following the war. (See Table 2.2.)

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[5] See World Bank, 1995. Indeed, the frontier between public and private institutions is rarely clear-cut, as most private institutions receive state subsidies. This is why several criteria are usually combined to assess the degree of "privatization" of a university such as status of teaching staff, methods of accreditation, and origin of research funds.

[6] Students in the Lebanese university are probably –on average—from lower socio-economic status; and selection at entry is also likely to be less severe.

Table 2.2
Consolidated Government Education Expenditures

Government Agency	1992	1993	1994	1995	1996	1997	1998
				(in nominal LL bl)			
TOTAL EDUCATION EXPENDITURES	211	274	406	510	432	610	963
Ministry of Education, Youth, and Sports	207	178	234	322	314	388	456
Ministry of Technical and Vocational Training	0	19	25	40	33	40	33
Ministry of Culture and Higher Education	0	60	80	105	61	150	195
Other ministries	-	-	-	-	-	-	276
CDR	1	13	63	40	21	29	-
Council of the South	4	4	4	4	4	4	4
TOTAL RECURRENT EXPENDITURES	204	227	243	412	366	523	889
Ministry of Education, Youth, and Sports	204	161	166	295	291	361	446
Ministry of Technical and Vocational Training	0	10	12	19	20	24	27
Ministry of Culture and Higher Education	0	56	65	99	55	139	140
Other ministries	-	-	-	-	-	-	276
CDR	-	-	-	-	-	-	-
Council of the South	-	-	-	-	-	-	-
TOTAL CAPITAL EXPENDITURES	7	47	163	98	66	87	75
Ministry of Education, Youth, and Sports	2	17	68	27	24	27	10
Ministry of Technical and Vocational Training	0	10	13	22	12	16	6
Ministry of Culture and Higher Education	0	4	16	7	6	11	56
Other ministries	0	0	0	0	0	0	0
CDR	1	13	63	40	21	29	-
Council of the South	4	4	4	4	4	4	4
				(in percent)			
TOTAL EDUCATION EXPENDITURES	100	100	100	100	100	100	100
Ministry of Education, Youth, and Sports	98	65	58	63	73	64	47
Ministry of Technical and Vocational Training	0	7	6	8	8	7	3
Ministry of Culture and Higher Education	0	22	20	21	14	25	20
Other ministries	-	-	-	-	-	-	29
CDR	1	5	16	8	5	5	0
Council of the South	2	1	1	1	1	1	0
TOTAL RECURRENT EXPENDITURES	100	100	100	100	100	100	100
Ministry of Education, Youth, and Sports	100	71	69	72	79	69	50
Ministry of Technical and Vocational Training	0	4	5	4	6	5	3
Ministry of Culture and Higher Education	0	25	27	24	15	27	16
Other ministries	-	-	-	-	-	-	31
CDR	-	-	-	-	-	-	-
Council of the South	-	-	-	-	-	-	-
TOTAL CAPITAL EXPENDITURES	100	100	100	100	100	100	100
Ministry of Education, Youth, and Sports	34	36	41	27	36	31	13
Ministry of Technical and Vocational Training	0	20	8	22	19	18	8
Ministry of Culture and Higher Education	0	8	10	7	8	13	75
Other ministries	0	0	0	0	0	0	0
CDR	16	28	39	41	32	33	-
Council of the South	50	7	2	4	5	4	5

Source: Ministry of Finance and staff calculations.
Note: "-" indicates that data was unavailable or could not be collected by the mission.

At present, 67 percent of the three education ministries' consolidated budget is spent on primary and secondary education, 28 percent on higher education, and 5 percent on vocational and technical education. During 1991 - 1998, an increasing proportion of these expenditures were being allocated to higher education with pre-tertiary education, especially VTE, being the loser. University education receives a high share of education expenditures compared to the MENA region (20 percent in 1996)[7] and OECD (25.7 percent in 1992), indicating the Government's priority.

Recurrent expenditures

Whether assessed in constant currency or in dollar terms, public education expenditures have significantly recovered since the end of the civil war[8]. Two large wage increases of 70 and 150 percent were given to school (1995) and university (1997) teachers which increased the recurrent budget for the education line ministries by X percent over this period. Though teacher salaries are now close to international standards (1.4 times GDP per capita), they constitute a high share of the recurrent budget. For MOEYS and Ministry of Technical and Vocational Training (MOTVT), the share is 85 percent which is above OECD standards of 82 percent. (An unspecified share of the MOEYS's wage bill is allocated to teachers permanently "seconded" to other ministries and, thus, overstates the share of the total budget allocated to personnel costs.)

A small portion of the line ministries' recurrent budget is allocated for transfers to schools, centers, and universities. The MOEYS and MOTVT transfer 6 percent and 2 percent of their budget to private subsidized schools and training centers. The budget of the Ministry of Culture and Higher Education (MOCHE) is almost entirely transferred to the Lebanese University. In 1998 this transfer represents 94 percent of the ministry's budget. The university enjoys an autonomous status, and manages its own recurrent budget. In addition, during 1994-1997 MOCHE obtained a credit line (about 2 percent of its total budget) for providing scholarships to poor but talented students attending private universities. An additional large expense for the MOEYS is the rent payments for schools as the ministry does not own many of its facilities.

One of the unique aspects of the Lebanese system is the presence of education expenditures outside of the education line ministries' budgets. There are three types of expenditures: (i) government education allowances; (ii) salaries for education expenditures; and (iii) pension payments to former education staff[9]. The largest proportion of these recurrent expenditures is for education allowances or grants to public employees with children enrolled in school. The allowance amount is calculated as a proportion of education costs borne by households. This grant is higher for private schools than for public ones, on the ground that fees are significantly higher. The exact allowance differs by ministry. Security and defense personnel tend to have more generous schemes from their line Ministry than civilian staff, who obtain their allowance from the *Mutuelle des Fonctionnaires*, whose budget is appropriated by that of the Presidency of the Council of Ministers. (See Table 2.3.)

[7] With a wide range of variation, from 18.5 percent in Tunisia to 39 percent in Jordan.

[8] It is difficult to infer precisely the real increase, because the assessment of the purchasing power of the LL leads to contradictory results : if one takes into account the domestic inflation rate, the value of the Pound has declined. But if one takes the exchange rate of the Pound with other currencies, it has significantly appreciated during the same period, from LL 1732 for a US $ in 1992, to LL 1530 in 1998.

[9] It is found in section 32 of the budget, called budget reserves. Former education employees are not distinguished within other former State employees. It has been assumed that this proportion was equivalent to that of the present share of education staff within public employees, namely 25 percent.

Table 2.3
Recurrent Education Expenditures in other Line Ministries in 1998

Budget Sec. No.	General Title	Purpose	Amount (in LL bl)
3	Presidency of the Council of Ministers	Salaries of education inspectors	2.5
3	Presidency of the Council of Ministers	Civil servants education allowances managed through the *Mutuelle des Fonctionnaires*	40.0
3	Presidency of Council of Ministers	State Security staff education allowances	0.8
6	Ministry of the Interior	General Security staff education allowances	7.2
6	Ministry of the Interior	Interior Security staff education allowances	32.3
8	Ministry of Defense	Military staff education allowances	68.4
32	Budget reserves	Pensions for former education staff	125.0
	TOTAL		276.2

rce: Ministry of Finance

Capital expenditures

Capital expenditures for public education facilities are channeled through five budgets: the three education line ministries, CDR, and the Council of the South. During 1992 – 1998, the average annual capital expenditures were LL 77 billion of which the line ministries were responsible for LL 50 billion, CDR for LL 23 billion, and the Council of the South for an estimated LL 3.5 billion[10]. During this same period, the Council of the South built 127 schools and rehabilitated 44. Investments by CDR have benefited about 1,300 schools, *i.e.*, almost all public schools.

Though efforts for upgrading primary and secondary schools continue, they have slowed considerably given that major rehabilitation projects have been completed. CDR activities have followed the same pattern, such that the current emphasis has shifted to the Lebanese University. There is an ambitious project to establish three new campuses for the Lebanese University, which is presently spread over 40 different locations. Given that CDR's strength in the education sector is in rehabilitation, this shift towards constructing university campuses suggests the need for better and continuous consultation with education specialists, especially at National Education Council for Research and Development (NECRD), MOEYS (the ultimate user), and MOCHE. Such consultations are a prerequisite for capital expenditure to be adequately programmed (using reasonable and standardized norms) and properly implemented, equipped, and staffed.

Private expenditure on education

There are three major sources of financing of school fees and other related costs of education: parents, public employers, and private employers. Parents make the largest contribution. On average, households pay LL 1.27 million — or 12 percent of the average annual household budget. This is exceedingly high by international standards which are usually between 1-3 percent of the household budget.

Fees are the largest education expense for households. Unsurprisingly, private school fees are three times higher than those charged by subsidized private schools. In addition to fees, there are other direct costs such as school supplies, textbooks, and transportation. Anecdotal evidence suggests transportation costs, especially for students attending private schools are quite high in order of LL 250,000 per year for a secondary school pupil. This is a direct result of the complex school map resulting from the prevalence of schools catering to specific communities. (See Table 2.4.)

While all families with children attending school incur expenses, some households receive education allowances from their employers. About one-third of all children receive financial assistance. Public sector employees receive on average LL 1.12 million per child annually for education expenses while private sector workers receive *LL 1.56 million* for their employers. The public scheme covers 19 percent of all Lebanese pupils (or 150,000 students) while the private employers assistance covers 6 percent of students (45,000 children). In addition, 8 – 9 percent of students receive financial aid from other sources, usually the school itself. The public sector is more generous than the private sector in terms of paying fees, especially for children attending private schools.

[10] Schools built by the Council represent about 13 percent of the number of schools which has been handled by the CDR. Unit costs are assumed to be 5 percent higher in the South than in the rest of the country, due to additional transportation costs for building material, and more difficult working conditions.

Table 2.4
Combined Education Expenditures per Pupil
by level of education and school status, 1997
(in LL '000)

Level of education	Schools		National
	Public	Private	Average
FEES:			
Pre-school	143	1299	1090
Primary	111	1328	942
Junior secondary	134	1740	1101
Vocational (first level)	190	1464	1026
Upper secondary	180	2379	1442
Vocational/technical (second level)	254	1644	1194
Tertiary	218	6517	3250
Average	*147*	*1817*	*1269*

Level of education	Schools		National
	Public	Private	Average
OTHER EXPENDITURE:			
Pre-school	143	298	271
Primary	160	381	311
Junior secondary	222	465	368
Vocational (first level)	371	427	408
Upper secondary	317	560	457
Vocational/technical (second level)	515	585	562
Tertiary	633	1039	863
Average	*274*	*446*	*391*

Source: Administration Centrale de la Statistique, 1997

Major issues

Public schools are significantly more expensive than private schools on a cost per student basis[11]. At the primary/complementary level, public schools are 20 percent more expensive than private schools and 57 percent more expensive to operate than subsidized private schools. While secondary public schools are 35 percent more expensive than private schools. (See Table 2.5.)

Even when compared with international standards, both public primary and secondary schools are exceeding expensive. For example, when comparing the unit cost as a percentage of GDP with OECD countries, the ratio for public secondary schools is 40 percent against the OECD average of 26 percent. However, using this measurement, private secondary school unit costs in Lebanon are in line with OECD countries.

Unit costs in Lebanon are affected more by the type of educational institution (public, private, subsidized private) rather than the level of schooling. This, combined with high costs at the primary level, is also reflected by the fact that expenditure does not sharply increase with the level of education. This latter pattern is more akin to the one observed in OECD countries than in developing and, in particular, MENA countries.

The Lebanese education system has high repetition and drop-out rates, especially in public sector, which results in a heavy burden on the government budget. Repetition and drop out rates measure the internal efficiency of the education system. In Lebanon, the public sector is less efficient than the private sector. A 1995 survey found that 33 percent of students failed to complete primary school and 25 percent dropped out from the complementary and secondary levels.

Repetition rates in particular are indicative of the financial burden placed on the system. In Lebanon, repetition rates are 28 percent in public, 12 percent in subsidized private, and 5 percent in private primary schools. Thus, over one-quarter of the students in primary public schools are repeating a grade and costing the government for that extra year of education. The impact of high repetition and drop-out rates is not solely on the budget, but they also damage the reputation of public education among the population.

Another measure of low internal efficiency[12] is the age structure of students. An estimated 37 percent of primary pupils are at least one year older than the expected age for their grade. This proportion increases to 52 and 46 percent respectively in complementary and secondary schools — mostly likely due to repetition. Thus, what should be exceptional cases (repeaters) are rather the norm. One possible explanation is that the language of instruction is not the mother tongue which means that average or low achievers require a longer period of learning. (In many countries where the native tongue is not the vehicle for instruction, the pre-tertiary curriculum is 13 years long.) There could also be other reasons, however, the end result is most children need

[11] In order to make a fair comparison with private schools, it is essential to include a capital cost, by utilizing the average of capital expenditure during the 1992-1998 period, namely about 8 percent of recurrent costs. The comparison with the private sector in this respect is not perfect, as far as no discount rate is introduced for amortizing public buildings, while the private sector may have to consider this aspect, especially if it has to borrow money for capital investment. The last problem lies in the absence of enrollment data for the past two years, 1996-97 and 1997-98. As a consequence, one is obliged to calculate unit costs by using budgetary data from 1998 and enrollment data from 1996, which is unfortunate, but generates a lower bias than taking budgetary data from 1996, in so far as many changes have occurred, in particular in the field of teacher salaries, which have a big impact on unit costs.

[12] Internal efficiency is related to cost-effectiveness. Outcomes of the education system such as drop-out rates, repetition rates, and students' cognitive and technical skills are used to gauge the effectiveness with which resources (inputs) are utilized. An education system is considered internally efficient if it produces maximum output for a given input of resources.

Table 2.5
Unit costs, by source of finance, level of education and sector
(in LL million)

Sectors	Source of finance /1	Primary/ complementary	Upper secondary	Vocational/ technical	Tertiary
Public sector	Public	1.674	2.779	1.815	2.970
	Private	0.532	0.532	0.532	0.851
	Total	2.206	3.311	2.347	3.821
Subsidized private sector	Public	0.256	-n/a-	-n/a-	-n/a-
	Private	0.680	-n/a-	-n/a-	-n/a-
	Total	0.936	-n/a-	-n/a-	-n/a-
[illegible] subsidized private sector	Public	0.000	0.000	0.000	0.000
	Private	1.760	2.145	2.145	5.617
	Total	1.760	2.145	2.145	5.617

Note: 1/ Grants included in private category

more that 12 years to complete the curriculum. Not only does this raise the real cost of producing graduates, but it penalizes the children from the pedagogical standpoint and the parents from the financial angle.

Student performance is better in private — subsidized and unsubsidized — schools than in public schools indicated differences in the quality of education services provided. In order to assess the efficiency of resource utilization, one possible method is to compare the quality of the final product, i.e., pupil performance. This approach has to be based on standardized tests, preferably developed internationally[13]. Though Lebanon has not yet participated in such studies, it may want to consider doing so. In spite of the absence of such studies, the reputation of the Lebanese education system is strong in the region. The most prestigious universities are close to international standards, which suggests that the standards developed in pre-tertiary education are in accordance with these norms.

Recent surveys completed by NCERD measure pupil competencies in different fields of study with respect to the type of school attended by children. The comparisons do not reflect favorably on public schools. At the primary level, even low cost subsidized private schools perform markedly better than public schools. Private schools are systematically better — more efficient — than other schools. This is particularly true in foreign languages, but even for the Arabic language, which is more commonly utilized in public schools. The global passing rates on these tests in private schools (4th and 9th grades) were 50 and 158 percent higher than in public schools. (See Table 2.6.)

A standard argument for this large difference is that public schools enroll more children from low-income households who are less likely to perform well. Though this may appear plausible, it does not explain the large difference in performance between children attending subsidized private schools and public schools. Subsidized private schools have the lowest level of school inputs and charge fees comparable to public schools yet perform remarkably well (except in French language). This suggests that it is not the socio-economic background of the students that determines performance but rather the quality of the education itself. It is clear that for public schools to fulfil its promise to provide children with a good education, internal efficiency needs to improve dramatically.

The public sector has an oversupply of teaching staff who are ill-equipped to deliver quality education. Several different measures appear to indicate that Lebanon has too many teachers. One survey estimates that 8.8 percent of the labor force works in the education sector which is high compared to the 5.4 percent OECD average. The share of non-teaching staff at 23 percent is relatively modest, compared to 31 percent in OECD countries. Therefore, overstaffing can be suspected, but primarily on the teaching staff side.

The conventional way to assess whether there is an oversupply of teachers is to use the student-teacher ratio. For general education as a whole, the overall average ratio is 12 (that is, twelve students per teacher). Differences are particularly striking between public and private schools. The student-teacher ratios range from 8 in public, 14 in private, and 22 in subsidized private schools. Also within the public school system, the ratio is 9 and 5 at the primary/complementary and secondary levels respectively — exceedingly low by any international standard. Furthermore, though this ratio is too low to be cost-effective, if it led to outstanding academic achievements, one could justify it. However, in the case of public schools, the high student-teacher ratio does not appear to yield perceptible benefits in terms of improved student outcomes.

[13] And this sort of international comparative assessment is developing rapidly, in particular thanks to the International Educational Achievement network (IEA), with the active present support of OECD.

Table 2.6
Quality Indicators of Education by School Category
(in percent)

Passing rates at end of Grade 4

Subject	Public	Schools Private subsidized	Private unsubsidized	National Average
Arabic language	56.0	72.0	82.0	71.3
English language	32.1	70.5	94.6	65.4
French language	3.2	7.9	57.1	36.6
Mathematics	46.9	67.6	70.2	60.6
Sciences	52.0	68.7	79.9	64.4
Practical knowledge	46.2	54.0	53.3	52.9
All fields	50.4	64.8	77.1	65.4

Passing rates at Grade 9

Subject	Public	Schools Private subsidized	Private unsubsidized	National Average
Arabic language	86.3	- n/a -	91.6	90.0
English language	16.5	- n/a -	60.1	49.7
French language	11.5	- n/a -	56.5	42.0
Mathematics	21.5	- n/a -	58.3	44.8
Sciences	53.6	- n/a -	73.8	72.7
Practical knowledge	61.2	- n/a -	60.7	60.9
All fields	27.8	- n/a -	71.8	55.6

Source: NCERD, 1996

The over-supply of teachers in public schools is well known. It is common knowledge that there are public school teachers without specific teaching duties. Though their numbers are difficult to assess, NECRD data found that one out of five public teachers have a teaching load of less than 10 hours per week. School visits confirm that some schools miss personnel, while others are crowded with staff. This phenomenon has its roots in the displacements of persons during the war, and cannot be easily solved. The MOEYS is progressively tackling, though slowly, the issue given its social and political sensitivity[14].

The issue of teachers goes far beyond purely quantitative and budgetary aspects. It is likely that the quantitative oversupply is mixed with a qualitative deficit: only 34 percent of the total staff (teaching and non-teaching) of the sector holds a higher education degree. The MOEYS is particularly concerned with the existence of allegedly poorly trained contractual teachers, who lack the status of protected civil servants. One option under consideration is to replace these teachers on contract by better trained tenured civil servants, in order to increase education quality in public schools. The cost-effectiveness of this project has not been properly assessed. Teachers in private schools are not necessarily better trained, but are simply held accountable for their performance.

Government education allowances have an uncertain impact upon the education system. The Government is well aware of the counter-productive impact of its education allowances. The system provides a large education subsidy to primarily the middle class in Lebanon and on those grounds cannot be seen as promoting equity. Furthermore, these allowances create strong incentives for public employees — including teachers — to send their children to private rather than pubic schools, because they increase in proportion to fees. The Government is considering a new scheme of eliminating most allowances — including for education — while increasing wages by a corresponding amount. Though this proposal has many strong merits, its impact on the education sector has not been adequately examined and may have undesirable consequences.

The new system would change the present pattern of education financing in Lebanon. The substitution of allowances with higher wages would mean that households could spend their extra income as they wish and not necessarily on education[15]. The critical questions for the country are (i) will education expenditures continue to grow; and (ii) which of the three segments (private, subsidized private, and public) will benefit and lose from this new scheme?

There are three possible consequences that may be of particular concern to the Government. *First,* the program will decrease the demand for private education, though to what extent is indeterminate. This would adversely affect a sector which has the ability to provide good quality education at internationally competitive costs. *Second,* if public sector enrollment expands, the country will produce an increased number of poorly educated adults. Though quality can be improved in the public schools, it will take bold measures and systemic changes that will need time to implement. The consequence of the delay would be a lost generation of students — and workers. Therefore, sequencing of reforms can have important long-term consequences for development. Furthermore, it remains an open question of whether public schools — even after major improvements — will be competitive with private schools in terms of quality of education services and unit costs. *Third,* the net fiscal impact of increased enrollment in public schools is uncertain, but it will entail an increase in the direct government expenditure on education. Quality improvements may also come at a price which would also result in higher fiscal outlays to the education line ministries.

[14] A specific study on this issue is being completed as an input to the preparation of a Bank-financed project
[15] Which would differentiate it from a voucher system.

The MOEYS's active management of individual schools is at the expense of giving adequate attention to strategic issues. Development of a strategic vision for the education sector requires the involvement of ministries of finance and planning (or its equivalent), and technical ministries. In Lebanon, at present, the ministries of education lack the necessary trained staff, resources, and tools for planning and projecting the evolution of the education — public and private — sector. Furthermore, the current involvement of high-level ministerial staff in the daily operation of the education system directs their attention away from strategic issues and general guidance of the sector. In order to shift the ministries' emphasis to more important strategic issues, it may want to consider relinquishing its direct control of each individual school.

A pre-requisite for developing a strategic vision based upon the situation in Lebanon requires the collection of basic data in order to build various scenarios, simulate their fiscal impact, and propose alternative policy options to the Government. Reliable data are missing for many key variables such as enrollment, passing, repetition and drop out rates, of achievements, of staff recruitment and promotion, and of financing. This is true for all sub-sectors — public, private, and subsidized private. This lack of reliable data is a serious obstacle to the transparency of the sector and to informed decision-making.

Options for reform

This section presents several different reform measures that the Government may want to consider. Some options offer incremental improvements, whereas others require radical changes in the education system. However, all of them propose to move the education sector in a direction of greater fiscal sustainability without sacrificing quality or coverage.

The Government may want to seek ways to improve the efficiency — especially to lower unit costs — of the public education sector. One major and obvious source of high costs is the low student-teacher ratios in the public sector, especially at the secondary level. It is possible that the shift of students from private to public schools may continue such that the number of teachers will approach internationally acceptable standards. There is some discussion to increase the number of teachers which would be unwise given the current oversupply.

In order to determine the best way to lower costs, the Government could as a *first* step rationalize the management of the teaching staff, through a precise inventory of personnel by field, skill, and region; better control of movements; and a redeployment of teachers to schools where their skills are needed. *Second*, the Government may want to clean up the budgetary situation created by the assignment of teachers to line ministries outside of the education sector as this prevents an accurate estimate of unit costs. The teachers working in other line ministries should have their salaries integrated into the budgets of those line ministries. *Third*, the Government may find that even with the increase in public school enrollments, it may be necessary to consider retrenching teaching staff. Possible methods of doing this are by (i) not rehiring contractual teachers at the end of their contracts; (ii) terminating teachers who do not show up for work on a regular basis; (iii) shrinking the teaching staff through attrition by not filling positions when persons retire or leave the MOEYS; and (iv) offering attractive severance packages to teachers who work in over-staffed schools.

An additional method of lowering unit costs is to reduce the burden of rented facilities, especially when the latter are ill-conceived for education purposes; rehabilitate and, if needed, extend existing facilities and equip them. However, this should be considered after the Government has

developed a strategic vision for the education sector or at the very least only build new schools when the existing public school have low unit costs and adequate demand for education services.

The Government may want to revisit its decision to discourage the expansion of the subsidized private schools. Available evidence indicates that these schools provide quality education at modest costs. They have the lowest unit cost of any of the sub-sectors (X percent of public schools). Out-of-pocket expenditures for families are relatively low and comparable to fees charged by public schools. Furthermore, the quality of education is superior to that provided by public schools at this time.

Concern has been voiced that the organizations running these schools are profiting from their operation. However, since the government transfer per student is extremely low (X percent of unit cost), it is very unlikely that these schools provide any profits to the NGOs operating them. Other concerns are related to the curriculum begin taught which may not reflect Government ideals. However, the Government could devise a system where the specific amount of the grant per student will depend upon what share of the State's regulations the schools follows. It is of course the State's prerogative to identify what regulations are important from its view, such as curriculum, norms, secularization, criteria of enrollment, teacher skills, outcomes, etc.

Improve the quality of public education through better management. Restoring public schools quality and their perception among parents will take time. The Government has already taken the first important steps of improving the curriculum and textbooks. One of the least cost ways of improving the public schools is through better management of existing resources. The Government could improve management through (i) shifting responsibilities of school management to the local level which would benefit not only the central administration, but also the schools themselves and their stakeholders (parents and municipalities); and (ii) increasing accountability and transparency at the local level to avoid clientelism and inaction.

As a prerequisite to the above changes, the central administration at the MOEYS would require (i) a simple management information system to provide data on each individual school; (ii) a clear delineation of which aspects of school operations (and finances) to be transferred at the local level would be carefully listed and distinguished from those to remain under the direct control of the ministry; and (iii) a system of quality control and evaluation of institutions and their staff on a regular basis.

The Government may want to consider introducing a voucher system for education. The new system of financing education would be based upon a flexible voucher program, name a system of per student public subsidy calculated as a proportion of the unit cost. The allocation of the vouchers would be given to schools based upon two principles. The first would link the value of the voucher to the degree of the school's compliance to State regulations and quality of education.

The second principle would be based upon the application of some sort of normative unit cost in order to avoid using tax payer money to pay for high unit costs for certain elitist schools. The normative unit cost could be determined in different ways. One possible route would be to use a scale based on a percentage of the GDP per capita; the norm would be obtained by taking the average of both developed and developing countries since Lebanon falls somewhere between these two groups[16] from the education point of view. Any given school would be eligible to a

[16] For instance, 15 percent of the GDP for primary education, 20 percent for secondary, and 40 percent for tertiary education. In the present Lebanese situation, these percentages would be translated into LL 1.2 million for primary education, 1.6 million for secondary, and 3.2 million for higher education.

voucher which would be calculated as a variable percentage of the normative unit costs, depending on how closely it follows State regulations.

One can assume that State objectives aim at harmonizing as much as possible the different existing sub-sectors, community-based, in the Lebanese education system. One of the advantage of the proposed system is that it will preserve the unusually high willingness to pay partly education cost by Lebanese families, although in a more equitable way than today. Finally, the system could be economically sustainable. For instance, if all pupils were enrolled in schools applying the above unit costs, and if all schools had signed an agreement making them eligible to the 80% voucher rate (80% of the normative unit cost unit cost), the public effort for education would amount, with present numbers of pupils, to 4.6% of the GDP. Many other simulations could be made, but this one is reasonable in the context of Lebanon. Indeed, such a system would also lead to a serious upgrading of the MOEYS capacities to ensure quality assessment.

Next Steps

Additional measures the Government may want to consider are listed below. These measures should not be regarded of secondary importance, since some are essential steps to improving the effectiveness and equity of the education system.

(a) improve data collection, gather data allowing international and temporal comparisons, improve data reliability and ensure their regular production along standardized and permanent definitions; make the data available to each layer of the structure, as well as to the users of the system; organize data for a sound management information system (MIS);

(b) staff the ministries in charge of education with a core of high-level personnel responsible for the general guidance of the overall sector and helping decision makers to shape linkages between sub-sectors, relationship amongst the three segments and consistency with the overall governmental policy (budget issues, labor market issues); equip this staff with adequate programming and planning tools; and upgrade skills of the staff in general administration;

(d) prepare a sector-wide strategy, involving all segments and levels of the education system, detailing the linkages between the public sector and the two private sectors, and laying out the costs and expected benefits of the actions to be taken;

(e) target the population of school-aged children who never went to school or dropped out early, and design special programs to reach them out and enroll them in primary schools;

(f) increase inter-sectoral cooperation between the public sector and the private and subsidized sectors, to rationalize school mapping, avoid duplication, and minimize transportation costs.

Chapter 3

The Health Sector

Despite the destructive impact of the civil war on the country's health and sanitation infrastructure, the health status of Lebanon's population is average for a lower middle income country. However, seven years after the war, the health sector in Lebanon is in near crisis. The high real growth in public expenditures on health, the increased investment in hospital and health infrastructure, and continued growth in the number of doctors has led to a system with low prospects for long and, possibly even, medium term sustainability.

Lebanon spends 10-11 percent of GDP on health care which is high by international standards. The public sector share at an estimated 20-23 percent is relatively low while out-of-pocket payment by patients provide a significant proportion. The limited data available indicate that public and private spending on health care is growing several percentage points faster than GDP due to such factors as medical price inflation and utilization growth experienced by the private insurance sector. During 1993 – 1997, the average annual growth rate in actual public health expenditures was 15 percent. (See Table 3.1.)

The system Lebanon is building today is unlikely to meet to the country's needs in the 21st century unless fundamental structural changes are made which address the twin problems of cost escalation in health care and inadequate coverage of the population. The increasing allocation of national resources towards health care does not represent an improvement in the population's welfare since unfortunately many of these resources increasingly appear to be being spent on cost ineffective services.

Overview of the sector

The health care system in Lebanon is complex and fragmented due to the large number of players both in the financing and provision of services. Though the civil war may have set back the public sector's ability to provide health care services, it is the current open-ended reimbursement practices of the Ministry of Health (MOH) and other financers that have inadvertently encouraged increased private provision of high cost and technologically sophisticated services. As a result, Lebanon now appears to have excess supply of many types of health infrastructure as well as doctors. In order to place the government's role in context, this section will provide an overview of the existing health care providers, financiers, and services.

Provision of health services is dominated by the private (for-profit) sector and NGOs. In 1996 the 18 public hospitals out of a total of 158 hospitals provided 5 - 10 percent of beds, but a lower share of hospital admissions. Public health centers provide perhaps 2 - 3 percent of doctor visits. Public health facilities have difficulty providing effective services due to the wide differentials existing between public and private sector remuneration. Doctors working part-time in the public sector tend to refer their public sector patients to their private practices for treatment.

Lebanon's health care system is also witnessing a rapid proliferation of tertiary units providing a range of high technology investigations and treatments. By 1997 there were 12 open heart surgery

Box 3.1
Some interesting statistics on the health sector

- Hospital bed occupancy is only 56%, compared to OECD norms of 80-85%, yet there is major investment in expanding hospital capacity.
- Around two thirds of hospitals have less than 80 beds; most planned new public hospitals have 40-75 beds, yet international evidence indicates that acute hospitals need a minimum of 150-200 beds to provide efficient care and assure quality.
- There are around 100 health financers for a population of only 4 million, though international evidence indicates that strong, consolidated financers are more effective at containing health care costs.
- Private insurers have very high overheads - 50% or more of premiums.
- Public financers have weak cost control - 15% real growth a year on average since 1993 for the Ministry of Health.
- Around one third to a half of the population are uninsured, though able to go to the Ministry of Health for reimbursement of hospitalization and high cost health care. The uninsured are more likely to be old, poor or outside the work force.
- Two thirds of households earning less than 500,000LL a month report financial problems which lead to medical problems not being treated.
- Pharmaceuticals account for a high share of health expenditure – around 20-30% - and margins paid for wholesale (10%) and retail distribution (22.5%) are high.

Table 3.1

Sources of Finance for Health Expendiutres in Lebanon, 1997

Sources of Finance	Estimated expenditures (in LL billion)	As share of total (in percent)
Ministry of Health /1	251	10-11
Civil Servants' Co-op /1	42	1.6-1.9
Army /1	82	3.1-3.7
Security forces /1	69	2.6-3.1
Govt-financed mutuals /1	15	0.6-0.7
National Social Security Fund /1	200	8-9
o/w GOL pays 55 LL bl		
Household out-of-pocket /2	1,199	46-54
Private insurance /1,2	360-683	16-26
Private mutuals /1	13	0.5-0.6
Donors /3	7-65	0.3-2.5
TOTAL	2,238 - 2,619	100

Sources:

(1) Data collected by Ministry of Health from the agencies and their responsible ministries; assumptions to be published in Ammar, Mechbal and Azzam, loc. cit. forthcoming 1999

(2) Estimates of private insurance and out-of-pocket expenditures from *Conditions de Vie des Menages en 1997, Etudes Statistiques No. 9, Administration Centrale de la Statistique,* Beirut

(3) Donor and NGO estimate derived from DCDR data on donor financed construction, and from assumptions used in Sabri, Burns, Guedira and Mechbal in *Health Sector Reform in Lebanon,* Report of a WHO Preparatory Mission, June 1996

units, 19 cardiac catheterization units, 39 centers for renal dialysis, and 54 CT scanners, 12 MRIs, and 12 in-vitro fertilization centers — all for a population of about 4 million persons. There is evidence that in some specialties, small tertiary units with low volumes of cases per hospital or per surgeon are likely to have poorer treatment outcomes.

Primary care — in the sense of first-contact, generalist services acting as a gatekeeper to more expensive specialist health care — is not a well-established model of service delivery in Lebanon. In general, people self-refer to specialists and shop around for care among different generalists and specialists in private practice. Other secondary sources of primary and ambulatory services are health centers, hospital outpatient departments and emergency rooms, and dispensaries.

Though health centers provide lower-priced services, they appear to account for only 10-20 percent of doctor visits.[1] There are 184 - 194 public health centers of which MOH has 60 – 70, Ministry of Social Affairs (MOSA) 89, and the army 35. Many of the MOH's health centers are partially staffed and under-utilized: the busiest centers see about 50 patients per day, while others see only 5-10 patients per day, or are simply non-functioning.

The health work force is characterized by too many doctors, especially specialists, and too few nurses. As a consequence, doctors end-up providing services when nurses would more than suffice. At present, there are 2.1 – 2.4 registered doctors per 1,000 persons which is higher than some high income countries with older populations that have greater medical needs. In addition to the large stock of existing doctors (estimated at 8,250 – 9,500), there are an additional 500-600 new doctor registrations per year of which 250 graduate from medical schools in Lebanon alone. Registered doctor numbers in the Lebanese Order of Physicians in Beirut (to which three-quarters of all doctors belong) has been growing at 9 percent a year on average since 1993, far ahead of population growth of 1.5-2 percent a year. About two thirds of doctors are specialists. Most general practitioners have no post-graduate training.[2] By contrast, nurses are in short supply at around 3,500 nurses and nurse aides which are equivalent to about 1 per 1000 persons. Nursing shortages are reported to be greater outside Beirut and in public hospitals.[3]

The multiplicity of financers in the Lebanese health system is striking especially since only a maximum of 60 percent of the population carries health insurance. Of the approximately 90 financiers, 80 are private insurers and mutuals covering 8 percent of the population. There is one semi-public fund, the National Social Security Fund, which covers 30 percent of the population by providing insurance primarily to employees in the formal sector and contracted staff in the public sector. The three largest government financers — Civil Service Co-operative, the army, and internal security — cover the majority of public sector employees and provide coverage to 15 percent of the population.

[1] *Beirut: A Health Profile 1984-1994*, Ed. Mary Deeb, (AUB, Beirut 1997) found only 10% of doctor visits in the greater Beirut area were to a health center. In rural areas, however, health centers are likely to account for a larger share of consultations - MOH estimate perhaps one third.
[2] Estimates supplied by the Lebanese Order of Physicians of Beirut, with the assistance of Dr Ghattas Khoury and Dr Antoine Comair.
[3] CDR, March 1998.

Uninsured Lebanese citizens, comprising 40-52 percent of the population, are theoretically able to obtain reimbursement from the MOH for high cost services. An estimated 13 percent of households receive aid from the ministry for health care each year.[4] Insurance coverage is higher in greater Beirut and Mount Lebanon (50 - 55 percent are insured) than elsewhere in the country (23 - 36 percent are insured). There is some evidence to suggest that the uninsured are more likely to be elderly, unemployed, or from a low-income district.[5]

Lebanon is also unusual given the high proportion of health costs covered by out-of-pocket payments by private consumers. The primary sources of finance for health expenditures in Lebanon are household's out-of-pocket payments (46–54 percent), the Government (21-23 percent) and private insurance (17-26 percent) with donors playing a small role. The uses of household expenditure on health services, which accounts for around half of total health expenditure.[6] (See Table 3.2.)

Public expenditures and the public sector investment

The Government's health budget for 1998 is LL 380 billion or 7 percent of budgeted expenditures (excluding debt servicing). Two-thirds of health expenditures are allocated to the MOH and the remainder to public sector social insurance funds and contributions to the NSSF. The amount that the Government will spend in 1998, however, is likely to be significantly higher based upon past expenditure growth and the lack of any structural changes in the system. (See Table 3.3.)

The average real growth in budget *allocation* from 1993-1997 is under 1 percent a year compared to the average real growth rate in *actual* expenditure from 1993-1997 which was 15 percent per year. This rate of increase is well above average real GDP growth of 5.6 percent during the corresponding period. In the light of the high level of health spending relative to GDP, and the constrained fiscal position, this rate of growth may be unsustainable.

Real growth in budget allocations has varied widely from year to year over this period, with the MOH accumulating debt to private hospitals equal to the shortfall relative to accrual expenditure. In some years, the MOH has received substantial additional allocations from the Budget Reserve – LL 20 billion in 1994, LL 6 billion in 1995, LL 76 billion in 1997 - to reduce prior years' debts to private hospitals. As at the end of 1997, debt to private hospitals was estimated to be in the range LL 80-100 billion, after payment of debt outstanding from 1996 and previous years. Other public sector financers, principally the army and internal security - have also accumulated significant debt to private hospitals in 1996 and 1997, estimated to amount to a further LL 125 billion at the end of 1997.

Public spending is dominated by reimbursement of private hospitals and other providers, which accounts for over 75 percent of total public health expenditures. Reimbursement for pharmaceuticals accounts for a rising share. Expenditure on public hospitals and health centers is not identified

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[4] *Conditions de Vie des Menages en 1997, loc. Cit.* is the source of the higher estimate of numbers uninsured and reliant on MOH reimbursement; Ammar, Mechbal and Azzam, *loc. Cit. I*, forthcoming 1998 is the source of the lower estimate.

[5] *Conditions de Vie Des Menages en 1997.*

[6] *Conditions de Vie Des Menages en 1997.*

Table 3.2
Household spending on health by type of service, 1997

Service category	Household expenditure per year (in LL thousands)	Share of all households paying expenses of this category /1, 2 (in percent)	Total household expenditure (in LL million)
Private insurance	**1,719**	**15**	**214,133**
Out-of-pocket payments			1,198,902
Hospitalization	1,167	29	282,884
Pharmaceuticals	556	83	388,417
Doctor visits	358	74	221,470
Lab tests, xrays	249	46	96,196
Therapy	520	8	33,701
Dental care	705	30	176,234
TOTAL			1,413,035

Source: *Conditions de Vie des Menages en 1997, Etudes Statistiques No. 9,* Administration Centrale de la Statistique, Beirut

1/ Average annual household expenditure for households incurring this type of health expenditure.

2/ Total households are 841,677

Table 3.3
Consolidated Government Health Expenditures

Government Agency	1992	1995	1996	1997	1998
		(in nominal LL billion)			
Total Health Expenditures	**132**	**303**	**386**	**513**	**379**
Ministry of Health	89	177	206	239	240
o/w transfers to private sector		*137*	*167*	*197*	-
Budget Reserves	0	5	5	12	21
Other ministries	33	103	150	208	110
NSSF Contributions	9	18	25	55	7
Total Recurrent Expenditures	**126**	**286**	**366**	**510**	**371**
Ministry of Health	84	160	187	236	232
o/w transfers to private sector		*137*	*167*	*197*	
Budget Reserves	0	5	5	12	21
Other ministries	33	103	150	208	110
NSSF Contributions	9	18	25	55	7
Total Capital Expenditures	**5.8**	**17.2**	**19.3**	**3.1**	**8.3**
Ministry of Health	5.8	17.2	19.3	3.1	8.3
Budget Reserves		-	-	-	-
Other Government ministries		-	-	-	-
NSSF Contributions		-	-	-	-
			(in percent)		
Total Health Expenditures	**100**	**100**	**100**	**100**	**100**
Ministry of Health	68	58	54	46	63
o/w transfers to private sector		*45*	*43*	*38*	-
Budget Reserves	0	2	1	2	6
Other ministries	25	34	39	41	29
NSSF Contributions	7	6	6	11	2
Total Recurrent Expenditures	**100**	**100**	**100**	**100**	**100**
Ministry of Health	67	56	51	46	63
o/w transfers to private sector	*0*	*48*	*46*	39	-
Budget Reserves	0	2	1	2	6
Other ministries	26	36	41	41	30
NSSF Contributions	7	6	7	11	2
Total Capital Expenditures	**100**	**100**	**0**	**0**	**0**
Ministry of Health	100	100	100	100	100
Budget Reserves					
Other Government ministries					
NSSF Contributions					

Source: Ministry of Finance and staff calcuations.

separately, but these services account for under 10-15 percent of the budget. Primary care and public health expenditure appears to account for no more than 10 percent of the budget.

Capital expenditure is a small and falling share of the total public health budget. In recent years, most capital expenditure on public health facilities has been donor-financed and managed by CDR. Twenty three percent of the planned investment program, by value, has been completed. Fifty five percent of the program is still in the planning and preparation stage.

Major issues

The major problems affecting Lebanon's health sector revolve around two over-arching themes: (i) cost-escalation in health care services and (ii) inadequate health care coverage of the population. The Government's experience in the last few years with an increasing share of the budget allocated towards health care speaks for itself. However, this outcome was predictable given the opportunities available to the private sector to profit from the MOH's open-ended reimbursement policies, especially for high-cost services. In addition, the Government also inadvertently gave incentives to consumers as well as providers to substitute high-cost health care for low-cost outpatient care.

Though about half of Lebanon's population is covered by a public or private insurance scheme, the remainder are technically covered by the MOH at least for high-cost services. In practice this means that over half of the population is not covered for primary or ambulatory care. Furthermore, since the MOH insurance coverage is not explicit, there are high transaction costs for households in obtaining reimbursement from the ministry for health services.

(a) Hospitals

The Government is pursuing two fiscally incompatible strategies for improving hospital services. There is a need to agree on a single coherent strategy for the health sector which resolves conflicting concepts of the future role of the public sector in health service provision. At present, investment plans for public hospitals are premised on the view that the MOH should replace its contracts with private hospitals with public sector provision of hospital services. To make this public sector-based strategy work, there would need to be political will to stop the uninsured using private health care where public capacity is available, and to countenance income losses and hospital closures in the private sector. This strategy also relies upon a very challenging, sharp improvement in the capacity of the public sector to manage health services and attract staff and patients to its facilities.

The MOH is also pursuing another strategy of strengthening its capacity to contract with the private sector for health services. This requires the MOH to develop strategies to control costs, and to strengthen co-operation with other public financers to increase purchaser-power. To make this strategy work, there would need to be political will to crack down on fraudulent claiming, and to terminate contracts with private hospitals with poor quality and/or high cost services. The public hospital expansion plans pose some risks to this strategy by diverting scarce MOH resources, and exacerbating conflict between private hospital interests and public sector interests.

The expansion of the public hospital capacity is unwarranted given the existing over-supply of hospital beds. Currently, only 56 percent of all public and private hospital beds in Lebanon are

being used. Despite this over-supply of hospital beds in Lebanon, a major public investment program under CDR is rehabilitating and building new hospitals. This program would increase public hospital capacity by over 200 percent by adding at least 1,758 additional beds to the existing 858 beds. In addition, the private sector also proposes to increase the number of hospital beds by over 20 percent in the next four years. Without upgrading and rationalizing the system as well as providing sufficient resources to cover the recurrent budget, much of the hospital capacity is likely to be sub-standard.

If all of the planned new and rehabilitated hospitals were to become fully operational, recurrent costs would be of the order of LL 180 billion per annum, which would represent a 70 percent increase in MOH's budget. The 1998 budget makes provision of only LL 6 billion to assist new public hospitals to meet recurrent costs. The inadequacy of the recurrent budget is already apparent: a World Bank mission identified recently completed facilities that are not functioning due to lack of operating funds.

The majority of hospitals in Lebanon are too small to be efficient or safe. The Government proposes to build more small hospitals. In order for a hospital to be efficient, it needs a minimum 100 - 200 beds. In Lebanon, two-thirds of hospitals have less than 80 beds and only eight hospitals have more than 200 beds. Most public hospitals in the urban and rural areas have less than 75 and 45 beds respectively. The government hospital plans include two public teaching hospitals of 360 - 540 beds, 17 hospitals with 40 - 75 beds.

As is apparent, much of the planned public hospital investment is in facilities that are too small to achieve economies of scale and appropriate clinical quality for acute care, given trends towards greater specialization in medical practice in the last twenty years. In addition, some challenging and costly changes to pay and management in public hospitals would be required before the MOH could staff and manage these facilities effectively and attract an adequate flow of patients to them. The Law of Autonomy for public hospitals is intended to address some of the pay and other restrictions that impede effective management of public hospitals and health centers. However, a number of issues remain to be resolved before a new law could be implemented effectively.

Aggregate bed numbers is not the only issue of potential concern about Lebanon's hospital sector and investment program. Over the last 20 years, increasing specialization in hospital care and declining average lengths of stay have changed the optimal size and configuration of hospital services. It would be inappropriate to expand hospital services in Lebanon on the model of the 1970's. Today's technology requires fewer, larger hospitals. The appropriate role for small, community hospitals with 40-75 beds in acute health care is likely to be much more limited than it was 20 years ago. Lebanon's small public hospitals and many small private hospitals cannot be expected to function efficiently or safely as acute hospitals.

Growth in payments to private health care providers is the main factor responsible for the unsustainable growth in Government health spending. During 199x – 1997, the rate of growth of transfers to private hospitals was X percent per annum and now makes up x percent of the ministry's budget. The MOH reimbursement policies for private health care are also skewing health spending towards areas of lower cost-effectiveness, limiting the scope to shift resources to cost-effective public health initiatives and development of primary and community health care.

The MOH is developing detailed mechanisms for controlling costs in a fee-for-service reimbursement system. It is improving administrative, financial and medical controls, introducing prospective case-based payment for surgery, developing utilization protocols, and promoting same-day surgery. These measures should improve value-for-money, but it will take some years to implement them fully, and they are not likely to control growth in spending on a long term basis unless they are combined with global budget limits on hospital spending.

(b) Financing

The multiplicity of health insurance funds leads to escalating health care costs due to high administrative costs and low bargaining power. Administrative costs of health care are high due in part to government taxes. Less than half of private insurance premiums are estimated to be spent on patient benefits. Stamp duty and an 11 percent premium tax account for about 20 percent of costs. A second factor leading to high costs is that financing agents have weak institutional and administrative capacity to manage costs and utilization of health care services. Thus, they are unable to identify claims due to fraud or over-prescription by hospitals and doctors. A number of private insurers, mutuals and self-insuring employers achieve economies of scale by contracting with a third party administrator to administer claims and manage utilization on their behalf. The largest such organization, Mednet Liban, administers claims for some 170,000 beneficiaries.

The lack of bargaining power by any one of the 90 plus funds as well as their lack of coordination has led to cost escalation in the private health care services. This results in private hospitals and doctors charging high prices with the knowledge that insurance companies and the Government will pay them. Though organizations such as Mednet Liban represent large numbers of health care consumers, they still lack sufficient market power to impact cost escalation in health care. Even third party administrators have been unable to slow down the increase in cost per day of hospital or even hospital admission rates which have been growing at 12.6 percent and 4.5 percent during the last five years.[7]

There are significant financial incentives for a greater share of health care costs to be shifted to the government, both by private insurance funds and individuals. Consumers can avoid paying for private health insurance and still be covered for health care by the MOH without contributing any money. This is due to the MOH's policy of 100 percent reimbursement for high-cost health care through MOH without any contribution. The financing structures also lead to poor targeting of Government health expenditure: The MOH is not able to limit reimbursement to services for low income people or those who are unable to obtain insurance.

The financing system creates incentives for over-use of high technology, under-use of primary and ambulatory care, and cost-shifting to the MOH. As doctors begin to prescribe more technologically sophisticated services, costs begin to outpace benefits. Some insurers no longer cover some of the high technology services which are reimbursed 100 percent by the Ministry. Even where they do cover them, there are reports that people with less than 100 percent coverage prefer to claim reimbursement for these services from the MOH rather than their own insurance company. While

[7] Estimates supplied by M. Mounier Kharma, CEO of Mednet Liban.

the uninsured can access basic primary care services and essential drugs from NGO or public health centers at low out-of-pocket cost or apply for discretionary aid from the *Minister of Health*, they can also obtain high-cost health care services free by getting the MOH to pay on their behalf.

(d) Primary health care and pharmaceuticals

The existing primary health care system does not act as a break to increasing health costs. One of the major purposes of a primary health care system is to act as a "gatekeeper" to more expensive specialist health services. Ideally persons requiring medical attention should first seek the advice and permission of a primary care practitioner to determine whether more sophisticated — and expensive — care is needed. Most people in Lebanon use private medical practitioners and private pharmacies rather than health centers for primary care, and incur high levels of out-of-pocket costs for these services. There is anecdotal evidence of poorly trained practitioners, and inappropriate diagnosis and prescribing. Consumer protection from poor quality or over-priced services is lacking in the private ambulatory care sector.

Though it would significantly help to contain costs if people sought low-cost primary care, the MOH has not been able to institute incentives to discourage consumers from by-passing health centers. Despite the lack of popularity of public health centers among the population, under CDR oversight, an investment program to build 21 new public health centers and rehabilitate 11 existing centers of the MOH.[8] In addition, the MOSA has submitted plans seeking approval and funding to CDR to develop its centers into a network of 85 larger social development centers and 208 satellites, incorporating health services. Constructing health centers in and of itself will not increase the population's utilization of these facilities, and particularly if they are inadequately funded for operating costs.

Pharmaceuticals are over-priced in Lebanon penalizing the average citizen. Pharmaceuticals appear to account for a high share of total health expenditure in Lebanon — perhaps 25-30 percent, and are predominantly met by out-of-pocket expenditure averaging an estimated LL 460,000 per household annually.[9] There is evidence of poor value-for-money for consumers in this area of spending. Some importers of pharmaceuticals can obtain supplies at lower prices than those submitted to the MOH, which are used to set regulated retail prices. Margins paid for wholesale (10 percent) and retail distribution (22.5 percent) are high, compared to efficient distribution systems such as the UK where comparable figures are 5 and 15 percent respectively.[10] There is anecdotal evidence of deep discounting to pharmacists (25-30 percent discounts are said to be readily obtainable), which regulation prevents being passed on to consumers.

Price regulation and pharmacy ownership regulation prevent price competition and restrict the scope for rationalization of retail outlets. There is no established market for generics. This is attributed in part to the need for a better-developed safety regulation system for generics, but is also likely to be due to remuneration of pharmacists via percentage mark-ups on the costs of prescription drugs.

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[8] CDR, March 1998.

[9] Nandakumar 1996, *loc. Cit* estimates 30 percent or more. A lower estimate is arrived at based on estimates of household expenditure from *Conditions de Vie des Menages en 1997*, and reported 1997 by public and semi-public guarantors.

[10] UK data for 1997 supplied by Alliance Unichem Ltd.

Options for reform

High and rapidly growing health spending in Lebanon is not a sign of strength. Fragmentation of financing and service provision is resulting in inefficiency and compromised quality. Costs are rising at uncontrolled rates in both the public and the private sectors. There is no evidence that rising real public spending on health is reducing the burden of out-of-pocket expenditure, since public spending growth is mostly on hospitalization and high technology, while out-of-pocket spending is mostly on ambulatory care and pharmaceuticals. While incremental progress is occurring through institutional strengthening in the MOH, a coherent national strategy would be a means for addressing the widely recognized problems in the health sector.

In order to successfully begin addressing the structural problems affecting the system, the Government can introduce measures which would markedly improve the efficiency of the system — not only without sacrificing quality of care but improving it. There are six main short-term actions the Government may want to consider which would lead to systemic improvements in the near future.

(a) The government should develop a single, consistent policy for the role of the public sector in service provision and financing in order to resolve divergent views. Currently the MOH is expanding public facilities *and* strengthening its capacity to contract with private providers. The consequences of doing nothing — that is, following both of these two strategies — would result in continuing the health care system down the path of unsustainability. In order to take the bold steps necessary to introduce key changes, especially to transfers to private hospitals, will require consensus building among the major stakeholders such as private hospitals, insurance funds, the Government, and consumers. However, it would serve the interests of the largest stakeholders to participate in discussion since bankrupting the system would not be optimal from the providers point of view.

However, Lebanon may want to consider other health sector models from the perspective of financing. Administrative costs could be reduced and purchaser power increased by establishing a single health fund, offering universal cover, and financed by some combination of compulsory employer and employee contributions, levies on the self-employed and contributions from other tax bases. Most countries which operate a single-financer model raise finance predominantly from taxation (such as the Nordic countries and the UK). This group of countries include those which achieve good population health outcomes at lowest share of GDP spent on health. This type of option would require a very radical change in institutional arrangements in Lebanon, however.

Other options could be considered which would build on existing institutions in a more incremental way. Countries which have adopted the "Bismarkian system" of social insurance, such as the Netherlands, Luxembourg, Belgium, Austria and Germany achieve economies of scale and comprehensive cover using a number of large social insurance funds (with or without competition) and retaining a role for regulated private insurance. These countries have had variable success in achieving purchaser-power and effective cost-containment, however. Some health systems in middle income countries (including some of the transition economies, and the proposed health reforms in Turkey) raise finance for health care from multiple sources of contributions, but then achieve purchaser-power and scale economies by unifying funds from these sources into a single purchaser or network of single regional purchasers.

(b) The Government should revisit its public investment plans for public hospitals and health centers. This would make sense given that the Government needs to decide which model it intends to follow for health sector development. However, even disregarding that issue, there is a need to assess the cost-effectiveness of present plans. Key issues to be taken into consideration are aggregate bed numbers required relative to demand; the appropriate size and configuration of hospitals; and the ability of the Ministry of Finance to meet the implied recurrent costs of the investments. As noted earlier, the present bed occupancy rates were low both in the public and private hospitals.

If the Government continued with its plan to expand hospital capacity, there are three scenarios that could result, either singly or in combination: (a) the MOH budget is increased by up to 70 percent; public and private sector hospitals operate with even lower occupancy rates (and current occupancy is low by international standards). (b) The MOH ceases to contract with private hospitals, to make budget savings of around 180 billion LL to offset the recurrent cost of new public hospitals, resulting in likely closure of a number of private hospitals. (c) The new public hospital capacity is under-financed such that the facilities are built but do not operate.

(c) There should be a systematic effort to curtail MOH reimbursement to private hospitals which do not meet minimum capacity and safety levels. As discussed earlier, small hospitals with less than 100-200 beds are not only inefficient due to their inability to achieve economies of scale, they also tend to have lower safety standards. This arises due to the inability of hospitals to afford maintaining the necessary services associated with each bed particularly when occupancy rates are very low. Furthermore, the lower the volume of patients, especially in hospitals with tertiary (specialized) units, the greater the likelihood of poorer treatment outcomes.

In the past, the MOH has considered strategies of restricting contracts to a smaller number of larger hospitals (cutting contracts for small numbers of low-occupancy beds), terminating contracts where there is a history of excessive billing, and stopping referrals to private hospitals where public hospital beds are available. Political pressure from private hospital interests has to date overturned decisions to use these strategies. The MOH contracts also set limits on total payments to private hospitals, but these have not been enforced.

(d) The Government should fast track strategies to implement global-budget contracts with private hospitals to contain growth in MOH reimbursement. Global budget solutions — which limit total expenditure on hospital and other health service contracts each year — provide more powerful incentives for controlling growth in payments to private hospitals than case-base-payment accompanied by utilization controls. A number of health systems have developed contractual models for allocating funds, managing cost and volume risk within a global budget limit. The Australian State of Victoria, for example, contracts with hospitals each year for a case-mix adjusted volume of procedures, supplemented with a payment for each hospital's share of over-contract volume from a limited pool of funds.

While it is desirable to develop comprehensive tools for relating global budgets to case-mix, it is not necessary to defer use of global budget contracts until such tools are in place. A number of countries have implemented global budget contracts initially with relatively simple mechanisms for measuring and costing output, and made these contracts more sophisticated over time. These "fast-track" options could be considered in Lebanon, if stakeholders accept the urgency of controlling growth in

health care costs, and if these options are pursued as part of an accepted medium term strategy for tackling problems in the health sector.

(e) The MOH could undertake comparative analysis of pharmaceutical prices as a basis for developing strategies to reduce prices and make prescribing more cost-effective. In the short term, there is a case for exploring the scope to reduce prices paid for pharmaceuticals, in view of the evidence of high costs cited above. Systematic comparative analysis of drug prices might form the starting point for development of a strategy. A range of policies undertaken in other countries to manage drug prices and improve cost-effectiveness might be considered, including options for developing the market for generics, and changes to the regulation and reimbursement of pharmacists to remove the financial incentive to dispense higher cost drugs.

Medium-term reforms

Medium-term initiatives could include:

(a) Development of a national strategy for financing reform firstly to consolidate fragmented financing arrangements, for example through Third Party Administrators. H.E. Mr. Franjieh, Minister of Health, has proposed a way of moving towards this type of model in Lebanon. His Health System Reform Draft Proposal advocates unifying public sector financing systems, through contracting out functions of the MOH and other public funds to a Third Party Administrator, or small number of TPAs. The MOH is taking incremental steps towards standardization, by establishing linkages and sharing information with other public insurers. It would be possible in the longer term to contract out health care coverage to health-maintenance organization, whose development could be encouraged. Consolidation in the private insurance industry might be fostered through legislation (already planned) to enforce adequate capitalization or reinsurance. Cost-shifting to the public sector might be reduced through regulation to require comprehensive, renewable cover.

(b) A second stage of financing reform could be contemplated to reduce the uninsured proportion of the population and expand the contributions base. It may be possible in Lebanon to extend insurance coverage and expand the contributions base by increasing the opportunity and incentive for the uninsured to obtain coverage with private insurers or NSSF, or by making insurance or NSSF membership mandatory for additional population groups (such as the self-employed), and by more stringent targeting of access to MOH reimbursement. Any strategy which continued to operate with multiple financers would need to incorporate robust mechanisms to identify and verify eligibility for insurance cover for all of the Lebanese resident population.

(c) Development of a national strategy for high quality primary care and a gate-keeping (referral) system capable of controlling costs without heavy reliance on out-of-pocket payment, and which extends to the private sector, as well as public and NGO health centers. For the medium term, issues of quality and affordability in private primary and ambulatory care warrant a place on the policy agenda. Consumer protection from poor quality or over-priced services is lacking in the private ambulatory care sector. A strategy is needed to advance MOH aspirations for primary care development in the private sector as well as in health centers. Implementing a broader primary care strategy is likely to be a long term project, since reliance on out-of-pocket payment cannot be reduced

until there are changes to the way doctors and other professionals are paid, and until administrative systems are in place.

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Chapter 4

Social Services

The Government of Lebanon starts from the unique position of designing many of its programs from scratch. The civil war impeded the development of the public sector, but also provided the opportunity to Lebanon of building a modern government which was not hampered by the inertia of an entrenched and large bureaucracy. This advantage can be exploited in all the social sectors, but especially in welfare activities.

The delivery of welfare services to the population is dominated by the NGO sector in Lebanon, though the Government plays an important role in the financing of selected services. The Government's main channel for providing welfare assistance to the needy is through the Ministry of Social Affairs (MOSA). In addition, the Government allocates resources to emergency programs which assist persons affected by the war. In 1997 total public expenditures amounted to 1.8 percent of GDP of which 23 percent were allocated to the MOSA. (See Table 4.1.)

The MOSA funds three major types of activities: (i) NGO service delivery to the most vulnerable groups (i.e., orphans, disabled, and elderly); (ii) Social Development Centers (SDCs); and (iii) social and health centers run in partnership with NGOs. The ministry is considering expanding its network of SDCs and health centers to directly provide literacy, training, and health care services to the poor.

The ministry potentially has a significant role to play in meeting the demands of vulnerable groups, especially those whose needs are not addressed by other government agencies. The MOSA can provide an avenue for these people to take advantage of existing public services and increase their participation in society. However, if the ministry decides to expand the services it delivers to other groups in need, at this junction in time, this may serve to dilute its effectiveness rather than to increase its relevance to the population.

The Government's role in welfare activities

The mandate of the MOSA is overwhelming. It is asked to serve a variety of groups by providing and financing a wide range of services. Fundamentally, the mandate is so broad and its resources are so limited that it may be worthwhile to revisit its role in the Government — possibly by narrowing its mandate to increase the ministry's effectiveness. The ministry itself sees its role broadening especially as private health and education services are becoming beyond the reach of many low income households. However, at the same time, MOSA is the only government body which represents the interests of the truly vulnerable groups such as the disabled, orphans, and elderly.

The budget of the MOSA is indicative of the role it plays. The majority of the budget — 98 percent — is transfers to various programs and categories of services. The remainder of the budget is allocated towards the operational costs of the ministry itself and its 146 permanent and contractual employees. The recipient of the transfer funds are primarily NGOs, the MOSA's centers, joint MOSA-NGO projects, and a variety of smaller programs. The three largest categories of spending (including central administration) are financing non-profit organizations to aid orphans, elderly, and social cases (66 percent of the budget); social development centers (13 percent); and the social and health projects with associations (9 percent). (See Tables 4.2.)

Table 4.1
Consolidated Government Social Services Expenditures

	1994	1995	1996	1997	1998
			(in nominal LL bl)		
Total Social Expenditures	**162**	**183**	**191**	**407**	**241**
Ministry of Social Affairs	53	69	89	95	94
Ministry of the Displaced	6	7	6	7	9
Grains and Sugar Beet Office	103	107	96	177	138
Central Fund for the Displaced				64	
Council for the South				64	
Total Recurrent Expenditures	**160**	**182**	**191**	**407**	**241**
Ministry of Social Affairs	52	68	88	95	94
Ministry of the Displaced	6	7	6	7	9
Grains and Sugar Beet Office	103	107	96	177	138
Central Fund for the Displaced				64	
Council for the South				64	
Total Capital Expenditures	**1.460**	**0.880**	**0.150**	**0.005**	**-**
Ministry of Social Affairs	1.460	0.880	0.150	0.005	
Ministry of the Displaced					
Grains and Sugar Beet Office	-				
Central Fund for the Displaced					
Council for the South					
			(in percent)		
Total Social Expenditures	**100**	**100**	**100**	**100**	**100**
Ministry of Social Affairs	33	38	46	23	39
Ministry of the Displaced	4	4	3	2	4
Grains and Sugar Beet Office	63	58	50	44	57
Central Fund for the Displaced				16	
Council for the South				16	
Total Recurrent Expenditures	**100**	**100**	**100**	**100**	**100**
Ministry of Social Affairs	32	37	46	23	39
Ministry of the Displaced	4	4	3	2	4
Grains and Sugar Beet Office	64	59	50	44	57
Central Fund for the Displaced				16	
Council for the South				16	
Total Capital Expenditures	**100**	**100**	**100**	**100**	**0**
Ministry of Social Affairs	100	100	100	100	
Ministry of the Displaced					
Grains and Sugar Beet Office					

Source: Ministry of Finance

Table 4.2
The Ministry of Social Affairs' Activities
(in 1998)

	Beneficiary Group	No. of Beneficiaries
Social Affairs	Total	35,612
	Orphans and Social Cases	24,546
	Advanced Training	5,286
	Level 1 Technical Training	3,797
	Infants	1,268
	Elderly	645
	Delinquents and high risk cases	70

	Type of Center	No. of Centers
Social Development Centers	Total	292
	Main	86
	o/w functional	44
	Branches	206
	o/w functional	43

	Type of Project	No. of Projects
Social and Health Projects w/ NGOs	Total	251
	Social and health centers	161
	Social services	32
	Day care	33
	Miscellaneous services	25

Source: Ministry of Social Affairs

Through its transfers to NGOs, MOSA currently funds the care of about 30,000 persons. The majority of these cases are "social cases" which includes children from dysfunctional families as well as from poor though normal ("functional") families. In 1996, the ministry made these transfers through 163 NGOs of which 72 were located in the Greater Beirut area. Of the 28,000 persons helped, 23 percent were "orphans" (including children whose mothers were alive), 3 percent were elderly, and 74 percent were social cases. For children (orphans and social cases), education and frequently boarding expenses are paid for by the ministry. The NGO receives a per diem for each case the MOSA approves for funding. The per diems for beneficiaries are quite detailed so that more difficult cases and those that receive boarding are higher.

The second largest category of funding, social development centers (including branches) receive LL 11.9 billion. This amount funds the recurrent costs of the 292 centers – including wages and benefits of administrative and technical staff, medicines, training material, utilities, and transportation. An estimated 800 persons are employed full-time at the centers, though according to the MOSA, to be fully operational the centers should have a total of 3,400 permanent administrative staff in addition to several hundred technical staff (such as doctors, trainers, and daycare teachers). At present, according to MOSA's own estimates, less than 33 percent of SDCs are functioning at full capacity.

The third largest category receiving funding from the MOSA are the social and health projects undertaken jointly with NGOs. In these projects, MOSA provides 70 percent of the budget while the NGO provides the remaining 30 percent of which only 10 percent must be in cash. In end 1997, there were 251 projects funded through 177 different NGOs. Though projects receive funding for only one year irrespective of the length of the project, most are more or less automatically renewed every year. All project employees are appointed by the General Director of the MOSA based upon a list of candidates suggested by a joint MOSA and NGO committee list. The ministry's regulations also require that all project employees are paid government level wages and social insurance. This latter amount increases the project's wage bill by 30-40 percent.

The organization of the budget is program based rather than line-item based. This encourages transparency about which activities and priorities are being funded, though not necessarily about how the funds are being spent. Yet even the program-based budget advantages are under-exploited. The first is that once an NGO or project receives funds from the MOSA, its contract is almost always renewed. Therefore, the ministry in reality only has control over new projects requesting financing. Even then, its control is limited due to political considerations. (See Table 4.3.)

The second reason that the system fails to deliver is that inadequate resources are available for monitoring of funds channeled through such organizations as NGOs and social centers. This results from lack of adequate number of personnel, training, standardized forms, and agreed upon standards and norms. Thus, the ministry's role in ensuring that proper services are delivered to the final beneficiaries is limited in part due to its capacity as well as the organizational arrangements under which the contracts are agreed upon.

Given this situation, it is not surprising the MOSA is interested in pursuing the expansion of its SDCs. There are several attractive features to this program. First, the ministry would have greater control over the centers in its ability to finance programs it sees as important and modifying them to reflect the changing needs of the communities being served. Second, MOSA's

Table 4.3
Disaggregated Recurrent Budget of the Ministry of Social Affairs, 1998

	Amount (in LL million)	Share of Budget (in percent)
Grand Total	**94,134**	**100.0**
Central Administration	**2,179**	**2.3**
Transfers	**91,950**	**97.7**
Financing of non-profit organizations (Aid to orphans, elderly, social cases)	62,034	65.9
Social development centers and branches	11,930	12.7
Social and health projects with associations	8,500	9.0
Allocation for social training centers in Haddas	2,000	2.1
Development of training programs of protection, and training of delinquents	1,000	1.1
Funds for insuring the rights of the handicapped	1,000	1.1
Nutrition/food programs	1,000	1.1
Funds for volunteer camps	800	0.8
Labor Unions	630	0.7
Funds for model health and social centers	600	0.6
Funds for joint project with UNFPA	563	0.6
Investment in artisan house	500	0.5
Funds for special events in Lebanon	430	0.5
Community for adult illiteracy campaign	300	0.3
Project to support families	200	0.2
Funds for handicapped centers	100	0.1
Contributions to projects in the devt media and communications with the citizens	100	0.1
Investment in center for carpet making	150	0.2
Funds for projects of development and services	94	0.1
Membership fees to national and international org.	20	0.0

Source: Ministry of Finance

SDC's could act as a safety net for the poor in terms of providing essential health, training, and social services. Third, it could act as a "one-stop shop" for people with needs who could then be guided to the relevant public and private institutions or organizations providing assistance.

However, on the negative side, given the MOSA's own track record, few of the existing SDCs function to a level that it itself finds satisfactory. In 1997 44 out of 86 main SDCs were fully operational and 43 out of 206 SDC branches were functioning. Nevertheless, there are unquestionably some successes — but possibly because those SDCs are operated like NGOs with little interference from the ministry and received additional funding from other sources such as international donors.

The MOSA is following a dual strategy for promoting welfare — financing NGO services *and* increasing its network of centers which could deliver similar services. Issues arise regarding the efficiency of this approach since SDCs could be considered as competitors to local NGOs. In an era of large fiscal deficits, should the Government be taking on more responsibilities — more expenditures — when the private charitable organizations are willing to provide services to the population. Also, the more practical issue is whether the Government has the necessary capacity to directly provide services to communities given its limited flexibility. The inability of the Government to pay competitive wages results in SDCs having difficulty in attracting and retaining good quality personnel. Also, the inability to hire and fire personnel would constrain the ability of SDCs to respond to changing needs.

The ministry has great potential given its national position in helping NGOs coordinate activities, establishing standards of service delivery, ensuring coverage, monitoring implementation, — and most importantly making sure that the needs of the most vulnerable groups in society are given a voice and are not overlooked in the process of nation building. The MOSA has an important role to play — one which it has already played — in establishing institutional arrangements which promote transparency and accountability. This not only improve service delivery to the population, but also it enhances the Government's reputation.

Major issues

The needs of vulnerable groups — especially orphans, the disabled, and the elderly — are not adequately met. There are several reasons why this occurs in Lebanon. First, though many NGOs are involved in providing assistance to these groups, recent declines in charitable contributions and Government per diems (in real terms) to NGOs have led to a reduction in service quality and/or quantity. Second, the lack of national standards in what minimal care and services should be provided to these groups has led to a variation in the quality and type of services rendered. For example, in some orphanages, 50 –100 children are supervised by one person. Third, the lack of "consumer" awareness for various problems as well as solutions leads to lack of action. For example, assistance to the disabled is curtailed due to the lack of family awareness on services availability (in the form of training or specialized apparatus).

The MOSA under-exploits its comparative advantage in establishing institutional arrangements to increase coverage of vulnerable groups. The ministry's program for the disabled, "The Rights and Access Program", is a model institutional arrangement for addressing the needs of the disabled. The committee is composed of ministry officials, NGOs assisting the disabled, and the disabled themselves. (See Box 4.1.) This cooperation between the representatives of key stakeholders in the decision-making process leads to improving the responsiveness to the user

BOX 4.1

THE NATIONAL COMMITTEE FOR THE DISABLED

The National Committee for the Disabled (NCD) constitutes an important organizational achievement as exemplified by its accomplishments, its mandate, and its productive engagement of Government, NGOs, and beneficiaries. The NCD — a semi-public body — was established by Law No. 243 in July 1993 as a response to the needs of the disabled in Lebanon. The mission of the Committee is to define a policy in favor of the disabled and to guide and monitor the execution of that policy by the Ministry of Social Affairs. It is the ultimate reference within the Lebanese Government to all affairs related to the disabled.

The Committee consists of 13 members: 5 government representatives from the Ministry of Social Affairs, 4 disabled persons representing four types of impairments (motor, mental, hearing, and visual), and 4 institutions (NGOs) representing each type of impairment. To date all members of the Committee have been appointed by the chairman, the Minister of Social Affairs, for an initial period of 3 years. The Committee is seeking to amend the law to allow for the election of the non-governmental members.

Through the Rights and Access Project, the Committee seeks to serve all disabled Lebanese regardless of their social, political, or religious affiliation. The project's overall objective is to integrate the disabled into the society. In order to achieve this, the steps involved are identifying the rights of the disabled, facilitating access to these rights, and by transforming the relationship between the disabled and the private sector (institutions and individuals) as well as the public sector. This latter point would require shifting from a relationship based on "belonging" to a group to a relationship based on "rights". This is to be achieved through a variety of measures including the promulgation of specific laws and decrees; issuing disability cards; and through an inquiry into the specialized institutions providing services to the disabled. Initially the project would address only severe and obvious impairments, while less severe disabilities would be included at a later stage.

The Ministry of Social Affairs is responsible for executing the project through a three member Executive Committee which includes the Director General of the Ministry, the Director of the Social Services Unit of the Ministry, and a representative of an NGO working with the disabled and also a member of the National Committee. Members of the Executive Committee of the project, jointly or individually, are empowered and responsible for initiating all preliminary studies; seeking financial support; selecting the appropriate centers to execute the activities and buying the necessary equipment; and recruiting specialized staff.

At the operational level the project is carried out by specialized committees dealing with the legal, medical, research, and budgetary aspects of the project. To date, the project has been able to operationalize five centers where various activities are carried out simultaneously such as orientation for the disabled and their families, entering and updating data, and issuing disability cards. The disability cards cover the total costs of the holders: (i) medical treatment and medication, (ii) disability assistance and equipment, (iii) hospitalization and surgery,, and (iv) specialized care. At the same time, researchers were able to publish a book listing all institutions working with and for the disabled according to geographical location, alphabetical order, types of aid programs, and types of disability. This is the first publication which provides a comprehensive overview of almost all NGOs working to help the disabled in Lebanon.

while increasing transparency and, therefore, accountability of all actors. This arrangement which has minimal fiscal costs (LL 1 bl in 1998), builds upon the strengths of the Government's abilities to bring various players together and ensures a coordinated approach to improving coverage of the affected population groups. The Government is also the only body which has the mandate to monitor the activities of organizations, especially those that receive transfers from it. At present, the allocation of the MOSA's budget and employee time goes minimally towards this key activity though at least 65 percent of the ministry's budget is transferred directly to NGOs.

The ministry's proposal to increase the number of Social Development Centers would result in high fiscal costs to the Government. The MOSA would like to expand its current network of SDCs. It proposes that each main SDC have 31 permanent employees (this excludes technical personnel such as doctors, trainers, and literacy teachers) and each branch office 17 employees. Each main and branch SDC implies an additional cost of LL 134 ml and LL 73 ml in annual permanent employee costs alone. These figures exclude the wages for essential technical employees and non-wage recurrent costs (such as medicines, books, paper, and transportation). In order to even fully staff the existing SDCs, the wage bill would have to increase from the LL 3.4 bl to 26.7 bl — over a 600 percent increase. Thus, it is obvious that the ministry's desire to be a service provider (such as training and health care) with a national presence would come at a very high cost to the budget. (See Table 4.4.)

The joint social and health projects with NGOs have too much MOSA interference and too little MOSA oversight. In its co-financed projects, the MOSA plays a large role in personnel issues such as approving employees working in the project and setting their wage and benefit levels (based upon government pay scales). One complaint is that the low wages set by the MOSA result in attracting low quality personnel. Though the ministry's presence is heavily felt in this area, once the project is approved, there is minimal oversight to ensure that the project functions well and serves a large beneficiary group. There is also little standardized assessment of whether the project is serving an adequate number of beneficiaries to be cost-effective and whether the beneficiaries receive proper services (such as the quality of medical care and childcare). Even at the application stage, the MOSA does not require a proper beneficiary assessment in order to determine the need of the project's services. The lack of MOSA monitoring of these projects may in part be the result that the ministry itself is understaffed: of the 470 positions only 31 percent are presently filled.

Providing transfers per beneficiary to NGOs without an agreed upon and/or enforced standards leads to unexpected negative consequences. The most glaring problem that arises is the increasing institutionalization of children in orphanages even when the child is not an orphan. The majority of these children have at least one parent alive (usually a mother) and most come from functional (i.e., "normal") families. More parents are trying to get their children into these orphanages due to the high cost of private education and the decreasing availability of subsidized private schooling. In the last few years there has been a sharp increase in the number of persons who have applied to have their child placed in an orphanage — most requests are now being made by the poor. The NGOs have difficulty turning children away, especially the poor. Furthermore, NGOs can also achieve economies of scale by increasing the number of children the take in and thus, the amount of the total transfer from the MOSA/MOF. Yet this increase in the number of non-orphans in institutions may have long-term developmental effects on children which are not recognized at present.

Table 4.4
Estimated Costs of Expanding Social Development Center Network

	No. of SDCs	No. of permanent employees	Cost per permanent employee (in LL ml per year)	Total Permanent Employee Cost (in LL ml per year)
Existing network				
All SDCs	292	800	4.32	3,456
Main	86		4.32	
Branch	206		4.32	
Upgrading SDCs to full capacity				
All SDCs	292	6,168	4.32	26,646
Main	86	2,666	4.32	11,517
Branch	206	3,502	4.32	15,129
Extending the SDC network				
New SDCs	75	1,625	4.32	7,020
Main	25	775	4.32	3,348
Branch	50	850	4.32	3,672

Source: MOSA and staff calculations.

Options for reform

The MOSA should be assisted in expanding the institutional arrangements of the Rights and Access Program (for the disabled) to other beneficiary groups such as orphans, elderly, and delinquents. In general, the MOSA and NGOs do not have a common understanding about what are the essential services that need to be provided to vulnerable groups. NGOs receive per beneficiary transfers for providing care and frequently boarding to orphans, elderly person, and disabled. However, what that entails is left undefined. Therefore, the quality of services delivered to the vulnerable varies.

The Rights and Access program established an institution which helps the MOSA, NGOs, and disabled persons engage in dialogue on what needs to be done to improve the situation of the disabled. Furthermore, this body helps to set policy in matters which affect the disabled. By duplicating this arrangement for other groups, the basis for establishing standards of care and services would be created. It would also help to ensure better coverage of those in need. The MOSA is already considering expanding this model and should be encouraged and supported. If additional funds are needed, the government should consider providing these programs with its full support.

The MOSA should build a track record in successfully managing existing SDCs within current resource allocations. The MOSA at present has an estimated 292 main and branch SDCs of which only 30 percent are fully functioning in mid 1997. Prior to considering plans to expanding the network of centers, the Government may want to improve the operations of the existing facilities. Due to fiscal constraints the options of substantially expanding resources to the centers may not be possible thus, the MOSA may want to consider other options for improving the functioning of existing centers. Though the following options for upgrading the SDCs within the existing budget may sound bold, new and ambitious responses are necessary to introduce significant and visible change. Simply expanding the bureaucracy is unlikely to solve the problem since the Government, like any large organization, lacks the flexibility to adapt quickly to changing environments.

There are several different options that the MOSA could consider — all of which would require redeployment of staff and resources to fewer well-functioning SDCs. *First*, the MOSA could consolidate the number of SDCs down to 60 main centers.[1] This would allow the MOSA to stay within its 1998 existing budget for SDCs of LL 11.9 billion while fully staffing each of the 60 centers. A *second* alternative would be to identify the best 10-20 SDCs and reallocate resources to them from other centers which are presently only partially functioning. The centers which already show some promise would thus obtain needed funding from those which are providing only limited services. *Third*, the MOSA could "privatize" come of the most poorly functioning SDCs by contracting out the operation to the private and NGO sector. (The MOSA already has some agreements with NGOs to operate some centers.)

Though there are several different ways of proceeding, the success and credibility of any of these options would depend upon a transparent selection process, a quality control system, and a monitoring system with explicit targets to determine whether centers have been successful in achieving results on the ground. In order to ensure that this would occur, the MOSA would need to establish a list of objective criteria such as selecting (i) centers which have exhibited the ability

[1] This amount is calculated as follows. The number of permanent employees per main center is 31 and the average compensation package is LL 360,000 per month. We then assume that these employees' cost represent 70 percent of the total recurrent budget of the center.

to deliver services to the community (possibly measured by case load per employee); (ii) SDCs located in communities with the greatest needs, especially low income neighborhoods; and/or (iii) centers located in areas where there are no NGOs present that provide similar services. Finally, SDCs will be more successful if the central administration is willing to take a hands-off approach, by not interfering in their operations and decisions but rather focussing on their results.

The MOSA should expand its monitoring role and establish standards for services to the vulnerable in order to increase transparency and accountability. At present the MOSA is simply a channel for funds to NGOs and social and welfare centers. Once an NGO obtains funding from the ministry, its "contract" is likely to be renewed every year – unless the NGO terminates it. Though there may be political constraints to changing this system, there are ways to improve the accountability of NGOs receiving government funding. First, there needs to be an agreed upon set of minimum service standards the NGOs have to meet. Therefore, if an NGO says that it will provide boarding and education to 100 orphans, there should be a set of criteria that all NGOs providing care to orphans need to follow such as the ratio of a "foster-mother" to children for each age group, the type of diet the children receive, access to medical care and check-ups, etc.

Second, the MOSA should have an adequate number of trained staff (e.g., social workers) that monitor the NGOs to ensure that they meet the service standards. If some NGOs are showing signs of difficulty in meeting these standards, a mechanism should be instituted to help improve their operations. This may involve partnering a successful NGO with the problem one (learning through association) or other intensive advice and oversight by the ministry staff. However, the biggest problem that may arise in some cases is the ability of the MOSA to enforce action against an NGO which consistently is unable to meet service standards. In this case, the Government will need to find mechanisms to halt the funding.

Per diems for boarding and care for orphans, elderly, disabled and other vulnerable groups should be indexed to the consumer price index. This way they can be automatically updated to reflect the higher cost of living expenses. It will reduce the perceived arbitrariness in the system and give it greater credibility. Also, it will help NGOs to plan their revenues for the following year. The ministry should of course revisit the per diems every few years to determine whether structural changes have occurred requiring more substantial modification of the per diems.

Medium-term reforms

The MOSA may want to consider the following issues:

(a) Establish its strategic priorities and how it intends to achieve them. At present the ministry is playing several — possibly contradictory — roles such as financing NGOs to provide services while providing similar ones itself. Depending upon what role it intends to play, there are major financial implications. For example, expansion of the SDC will mean much heavier recurrent costs. Whereas greater dependence upon NGOs to deliver services will require less financial investment, but more sophisticated tools and staff in the central administration involved in monitoring and quality control.

(b) The MOSA should find ways of improving the functioning of services through the social and health projects it co-finances. These projects receive 70 percent of their funding from the ministry. However, the NGO which manages and operates the project pays the price of less independence. The problems which affect these projects are similar to those of SDCs due to the

heavy government involvement in these projects (e.g., pay scales, benefits, ministry approval of employees). One possibility that the ministry may want to consider are giving lump-sum contracts for these projects with an agreed set of deliverables and instituting a quality control and monitoring mechanisms.

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