Republic of Lebanon
Office of the Minister of State for Administrative Reform
Center for Public Sector Projects and Studies
(C.P.S.P.S.)

Proceedings

of the Italian-Lebanese Conference

on Health Care Financing

Beirut, 16th & 17th of February 1999

الجمهورية اللبنانية
مكتب وزير الدولة لشؤون التنمية الإدارية
مركز مشاريع ودراسات القطاع العام

Edited by
Dr Saverio Pappagallo
Miss Aline Germani
Mr Roy Wakim

TABLES OF CONTENTS

FOREWORD

After seventeen years of war and an additional seven years of post war economic hardships, the health care system in Lebanon has suffered from fragmentation, lack of vision, lack of data to help formulate a health policy, inequities and prohibitive cost.

Health reform is eminent and is on top of the list of priorities of the present administration of the Ministry of Health. Because of the presence of several players on the health care platform, making it impossible for any one party to affect meaningful reform, the Ministry of Health is proposing the formation of a ministerial Higher Reform Council charged with adopting and implementing a sound and equitable, cost-effective health care system.

There is no "ideal" health care system anywhere in the world and at present, many governments are re-evaluating their systems to try to cut down on the increasing cost of health care delivery. Lebanon will study many of these systems and will either adopt the most appropriate and adapt it to its own needs or will formulate its own system based on lessons it learned from the successes and failures of others.

The Italian government has been very generous in sharing with us the information on its health care system and its willingness to assist us in our efforts to establish our own system by supplying us with expert and technical help and financial aide.

On behalf of The Ministry of Health and all the Lebanese people, I would like to express my gratitude and indebtedness to the Italian government, its Ministry of Health and all the Italian people for offering their help to and coming to the aid of a country in need of reform.

Karam Karam, M.D.
The Minister of Health
Lebanon

AKNOWELEDGMENT

The Directorate General for Development Cooperation (DGCS) of the Italian Ministry of Foreign Affairs has created , in collaboration with the Ministry of Public Health in Lebanon, the opportunity for this Conference as part of its effort to support the health reform program in Lebanon. The Central Technical Unit of the DGCS has extensively contributed to the organization and the success of the Conference.

We are especially grateful to HE the Minister of Health Dr. Karam Karam, HE the Minister of Health of Italy Mrs. Rosy Bindi and the Italian deputy Minister of Foreign Affairs Senator Rino Serri for having honored with their presence the Conference and highlighted the importance of pursuing international cooperation on health reforms.

We thank HE the Ambassador of Italy Dr. G. Cassini, the Italian Embassy Counsellor Dr. P. Dionisi and all the staff of the Embassy for their extraordinary support in realizing the Conference and the equally important events associated to the Conference.

Such event could not have happened without the cooperation from the Minister's Health Counsellors and the Ministry of Health Staff, and the assistance from Dr A. Aloi of the Central Technical Unit of the DGCS as well as the generous collaboration from the World Bank Project staff members.

We also thank all the participants, political leaders, academics, professionals and institutions and other agency speakers for their commitment to the Conference objectives and to frank and open debate.

Finally, thanks are due to all the individuals, secretaries and other support staff. Heir diligent work has been vital to the realization of the Conference and the production of these Proceedings.

EXECUTIVE SUMMARY

Dr S. Pappagallo

1. Calls for reform of the Lebanese health system have been increasingly voiced from different quarters over the last ministerial administrations.

The Ministry of Health (MOH) , and much less the different players of the national health system., have been under pressure to produce viable proposals for rationalising its internal system of payments, coverage and delivery of care . This, despite the fact that the contribution of the Ministry of Health to the financing and delivery of the health services is believed to be only a fraction of the total health care.

The special attention reserved to the Ministry of Health stems from the very fact that it is seen as failing to fulfil its institutional obligations of guiding the overall production and delivery of health services and care in the country. Concern over the poor control of its own expenditures has being growing.

There is a generalized feeling that the MOH needs stronger commitment to reshape its financing aims and administration. Many private and public hospital services risk financial collapse because of their exposure and dependence on the MOH's debt.

Furthermore, reform calls are often contradictory in their objectives and limited to either few magic bullets or to a long list of unclear actions.

Little attention is paid to the complex nature of the health system imbalances and to the roots of the current situation. Knowledge and awareness of the possible alternative approaches to the financial and delivery crisis of the entire health system are lacking among policy makers. Quite often they trail behind more active private providers' or payers' enterprises in devising nation-wide solutions of their own.

2. Government leading in the health service production, management and financing is increasingly contested as unduly intrusion in the market dynamics; at its worst, it is seen as extremely inefficient economic undertaking (e.g. welfare losses).

However, lack of national health policies has been considered an undesirable circumstance even in countries with the strongest feeling against government rulings. This applies more stringently to the health sector, where excessive deregulation ultimately affects the expenditure and finally jeopardizes important social and economic development.

It is, therefore, essential that the Ministry of Health and for all those purposes the Government in Lebanon achieves a solid guiding role in the national health policy development.

3. The Italian-Lebanese Conference on *Health Care Financing and Reform* was just one among the many opportunities for Lebanese decision-makers and stakeholders to get a first-hand knowledge of the changes other countries had to face in recent years to give an answer to their own financial problems.

It is a matter of fact that, in modern times, financing concerns are plaguing more than one country health system, whether private or public spending are considered. Debate on this issue is extremely intense among politicians, professionals, citizens and enterprises. Solutions may vary, though effects of globalization are forcing these debates into familiar tracks. Common themes are equity, coverage, choice, quality, dignified care, cost reductions, alleviation of poverty, technology management.

Cross-national comparisons, together with extensive internal and historical analysis, can help in preventing poor reform process, based on untested hypotheses as well as to find local "models" and a coherent set of policies, practices and processes. "Policy dialogue " may take different forms such as sharing of data, approaches and lessons on general and specific issues.

International exchange of experiences and approaches may only increase the likelihood of identifying a reasonable solution to local problems. Indeed, it can play a fundamental role for the diffusion of innovations, helps in anticipating obstacles in policy development and, given the high cost of research, is often the only means to obtain guidance. Studies of world health systems reveal trends in each of the major system components and, controlling for socio-economic conditions, facilitate the generalization of experiences.

4. The Conference on health care financing was definitely aimed at supporting this process, by offering as case study, the Italian reform. .

The Italian Health System is in many ways different from the Lebanese one. It shares, however, common concerns with many others, including the Lebanese health system.

The Italian National Health Service, requires from any citizen to be enrolled in the national health system, whether employed, non employed or self-employed. The enrollment is mandatory. The system is financed through a single fund. Universal and comprehensive coverage is, therefore, provided, comprising hospital, ambulatory, rehabilitative, preventive, long term, treatment and diagnostic services. The source of financing is based on a mix of general taxes (income taxes and indirect taxation), health taxes and, payroll contributions from employers and employees.

Underlying financing and delivering are the following principles: solidarity, equity, universality of the coverage as well as efficiency and cost-effectiveness of the operations. Private insurance is allowed and is underwritten mostly as complementary option rather than supplementary.

Finances from the national fund are transferred to the regional health authorities with equity criteria (not only historical ones) in mind. Regions have to allocate almost 50% of the budget to ambulatory and primary care. Programs of national interest, such as the control of non-communicable diseases, have specific national and regional budgets.

Hospital care are paid on DRG-like system, ambulatory care (specialist or not) on per capitation. General practitioners and specialists contracted in the first line network are assigned by the regional health authority, on the basis of specified vacancy lists, to cover a certain number of people. Citizens are free of choosing the doctor they want, within a given health sector. Referral to other hospitals in the region and in other regions may be accepted on the ground of emergency or prior authorizations. In that case, expenditures will be debited to the first region.

Small hospitals are increasingly reduced in number or facing aggregation and specialization. Large hospitals and teaching hospitals enjoy administrative and managerial autonomy: they cannot, however, set their own prices and policies. Budget and volume of activities must be negotiated with the regional health authority. The General Director of such a hospital is nominated by the regional authority and is accountable to it. Bonus incentives as well as strong sanctions are set to achieve efficiency and quality. Important annual budget deficit will entail his/her dismissal.

Hospital physicians are full-time or part timing salaried. For the latter, the private practice is possible in the hospital facilities, after the working hours.

The Italian health delivery system is largely public. Private hospitals, however, can be contracted. Private and public hospitals have to be accredited. Patients can be admitted against simple administrative formality. Out-of–pocket charges are applied on some items such drugs, laboratory tests and X-rays. Optical and dentist prostheses are not free of charge.

Some segments of the population would be exempted from the co-payments: unemployed, retired and single parent families.

Major problems faced by the National Health Service are the growing costs and the need to keep the government deficit within 3 % of GDP. Much of such rate of cost increase is to be attributed to demographic changes. Concerns about over-utilization, quality, rationing, fraud, physicians' dissatisfaction and waiting lists for elective surgery, are all part of the present political debate on the health care system.

The National Health Service has expenditures of about 110 trillion Italian liras (roughly 70 billion USD) and the 1998 deficit was about 4 billion USD. Such expenditures amount at about 8% of the GDP.

5. Against such background the Conference presented a challenging opportunity for comparisons and sharing learning.

Day-one sessions were centered on financing policies for the Italian national system, such as risk sharing and universal, mandatory insurance. The history of the Italian health reform is one of shifting from highly fragmented public insurance schemes, covering each social category (self-employed included), to a unified National Insurance fund.

Sources of financing, financing allocation mechanisms and health delivery systems were also extensively described. The importance that the National Health Institute plays in the Italian system by providing surveillance and research support to the Ministry of Health decisions was equally stressed.

The Italian Ministry of Health has progressively abandoned any direct involvement in delivering care and in managing resources, while increasingly playing a guiding role in resource allocation, in setting the requirements of the delivery system, and in specifying the relationships between all the stakeholders.

The Lebanese side produced parallel documentation on sources of financing and expenditures.

The most striking aspect of the Lebanese health system seems to be the limited size of the public sector against the national health expenditures, the concentration of such expenditures on hospital care, the growing rate of the MOH's debt (especially in financing high technology hospital care), and the weakness of the same (and for that purpose of the all public funds) in managing the funds and controlling the purchase of private hospital care.

Moreover, the fragmentation of the public funds has the effect of introducing imbalances and inefficiencies both in financing and delivering health services.

The growing rate of expenditures has little to do with demographic changes but rather with the uncontrolled induced demand, the proliferation of providers and technologies, and the great incentives for the beneficiaries to consume an unnecessary amount of care. Dental services represent a large portion of expenditures, demanding a strong action in prevention rather than in treatment. Out-of-pocket expenditures are said to represent 50% of the total national expenditures in the country, partially covering hospital services.

A largely overlooked issue in the Lebanese Health System appears to be the coverage by the Ministry of Health, of the population of "uninsured ". The size of such segment of the population is quite large (40%), and yet very little is known about them. Besides unemployed and retired seniors, such group may include also self-employed or employed with no insurance. For certain expensive services (e.g. heart surgery) the

Ministry of Health may take care of a section of the population shifted to it by other public and private insurance. How important is such transfer is a matter of guess, given the lack of reliable data on the insurance status of the population.

6. The second day was focused on policy topics relevant to a modern health care system, such as the rationing and allocation ethics and equity in the health care system.

The latter appears to be growing problems in industrialized countries. The longitudinal study from an Italian region underlines the importance of the mortality variability across social and economic groups. The size of the differential in the general and specific mortality was attribute to factors such as education, employment, income, rather than health resources distribution. Such gap was greater for some specific causes of diseases and in specific sex and age groups (e.g. lung cancer), suggesting the need for targeted disease prevention and control.

The importance of decentralization in the Italian health system was described. The regional health authorities have a prominent role in managing and administering the funds transferred to them, especially in what concerns the cost-containment, quality, accreditation, contract with private enterprises, management of the DRG and per capitation system.

In terms of management and administration of health funds, Lebanon offered the alternative experience of a private-for-profit third-party administration. This was said to have achieved better price-quality deals, appropriate service rationing, and decrease of over-utilization and induced demand. The advantages and disadvantages of such approach were widely debated.

The semi-autonomous status granted to the Italian hospitals provided the ground for considerations on the role of the Ministry of Health and the Ministry of Social Affairs in managing their own services and the growing feeling that the link between public goods and government bureaucracy may have to be severed. Structural adjustments may have to introduce a new "business like" health government. . Finally the all host of questions posed by the hospital payments mechanisms per case and pathology groups were examined.

7. It was more that natural, that such extensive "mirroring " efforts between the Italian and Lebanese participants, professional or otherwise, would have led to some further considerations on the available options to reform the financing (and the delivering) of the Lebanese Health System. Two panel groups were convened to produce important reflections, which in our opinion are worth mentioning.

A list of issues discussed by the two panels may constitute matter for consideration as well as for action. A comprehensive agenda for health reform may take the shape of a plan of action, whenever models, sequence, contents and processes are better clarified and scrutinized.

Suggestions are hereunder classified in terms of areas of potential interventions. Though they are not in strict terms, recommendations, they may prompt commitment for reform.

The list was not prioritized, because there is no agreement on what comes first. Whatever a potential reforms focuses on, this would represent an entry point to tackle finally the entire spectrum of the problems. We personally favor a stepwise approach starting from the restructuring of the fragmented, inefficient and qualitatively poor delivery system. Service provision needs vertical and horizontal integration among providers, centered on the key role of the physicians. Higher integration is important because health care effectiveness and quality is based on high degree of reciprocal interdependence.

However decided, it is also essential that options are preliminary tested in pilot project, in order to provide clearer evidence of their effects.

8. The panels stressed the importance of Government adoption of clear lines of political values in the health sector. The adoption of a chart of principles may represent a first important step to be promoted by the Ministry of Health. Such principles may cover the right of each citizen to have his/her health protected and restored, the right to be assisted when in need, irrespective of the capacity to pay.

Indeed, it was felt important that the Government adopts a health financing approach based on the principle of universal coverage, risk-sharing insurance and solidarity contributions. This shall mean that subjects at low risk of disease would contribute as those at high risk and mostly in need (e.g. young Vs senior, sick Vs healthy, rich Vs poor, employed Vs unemployed).

Other values to be reaffirmed in such a **Declaration of principles** are the concepts related to freedom of choice, comprehensive benefit package, equity in allocation of resources and expenditures, complementarily between private and public financing, efficiency and cost-effectiveness. Such principles may either be part of a separate chart or the introduction to a more comprehensive reform law.

9. It is self-evident that such aspirations may not be attained immediately. Furthermore, they have always to be assessed in the light of the available resources. However, they deserve to be adopted in a national chart, as they will represent the benchmarks against which to decide on the merits of public and private health policies. Their absence leaves the lawmakers in poor orientation and the stake-holders in a vacuum of direction.

A reform proposal entails, at its minimum, the re-assessment of the financing sources, the re-definition of beneficiaries and benefits, the choice of payments systems, the re-definition of expenditure control measures, the delivery system reorganisation, the MOH governance role, the public payers co-ordination.

Such reform can only be realised gradually. A number of preparatory actions need to be tackled such as the collection of essential data, needed to support or drive the political decisions. Such data (at minimum profiling of utilisation and expenditures by the public funds, mortality-morbidity across the country) not necessarily have to be extensive and strategic.

It is equally important that any proposal and agenda for reform, includes as a first step the mapping of different positions of major stake-holders, in order to achieve as much as possible win-win positions.

Forms of permanent consultation must be set between the MOH and other public payers, other government institutions (e.g. other ministries, commissions, regions etc.), providers and organized social groups.

10. The panels identified the following major aspects to be considered:

10.1 achievement of a larger and integrated public sector financing by:

- *Improving coordination or integration between the different public funds.*

  The need for such harmonization and final integration cannot be overemphasized. Public funds could purchase and provide better services, at lower prices, with less overhead costs and better control if they are unified. A gradual approach starting from quality control drives, data-bank sharing, disbursement and payments mechanisms harmonization (e.g. tariffs), as well as unification of financial decisions and fund management organization is one way to achieve it..

- *Improving mechanisms of exemptions and contributions by the "uninsured population", covered by the MOH.*

  The first step would be the identification of all beneficiaries (uninsured and insured alike) through a health card. Exemption categories (unemployed and retired personnel, low income below the poverty line) must be clearly identified, utilizing appropriate forms of means- testing. Efforts shall be exerted to enforce and extend employer obligations towards contributions, targeting the shadow, submerged economy.

- *Improving public fund financing.*

  The present state of financing from contributions and taxation must consider the need for expanding integrated patient and community care. Budgets must be realistic and reflect actual expenditures. The practice of financing under-estimated budgets, as it has been for years the case for the Ministry of Health, shall be revised.

  More reasonable allocations from general taxation, contributions, specific provider-and supplier taxation is necessary. Increase of tobacco and other goods taxes must be seriously considered.

  Much of the out-of-pocket payments must be reabsorbed to increase or to raise insurance contributions to cover ambulatory, preventive and diagnostic care.

10.2 **establish a more effective management of public funds:**

- *Identification of a unique fund management* entity leading, if so deemed, to a nation health fund. The MOH budget and the other public insurance schemes must generate such fund.

- More *rational budgeting and expenditures allocations*, reflecting needs and priorities (equity and effectiveness concerns). Planning shall be made on the basis of volume, activities and cost.

- *Decentralization of public fund management (e.g.* regional decentralization of health services provision and purchasing may be encouraged).

- *adoption and enforcement of global budgeting capping* at national, local, service, provider and program levels.

- *progressive separation in the MOH between financing, purchasing, and providing roles* e.g. hospital autonomy, establishing national (and regional , in the case of decentralization) non for profit purchasing agency.

- *adoption of adequate mix of different forms of provider payments* , which will prove to be effective in improving costs and effectiveness of care. Such mix will include a

combination of per capitation, DRG and fee for services for physicians, specialists and hospitals.

- *DRG and DRG-like systems* are not primarily devised to decrease expenditures or control the costs. They are aiming at controlling waste, inefficiency and unnecessary resource utilization. DRG must be validated and refined on continuous basis.

  An adequate information system must be in place to control trend in provider-purchaser and client behavior. Some forms of indicators must be adopted such as repeated admissions, ALOS, transfers, appropriateness of service delivered, quality criteria.

10.3 **provide stronger public sector coverage**

- *improving coverage in terms of comprehensiveness and benefits.* The MOH shall have as target the continuum of care for its own population as well as but for all the citizens in the country, starting with the people under public insurance coverage.

  The extension of benefits to uninsured and insured as for financing ambulatory care, PHC, program-objectives, alternative services is, therefore, a first line objectives in any proposed plan of real reform.

10.4 **promote better holistic and integrated patients and community services** by :

- *use and alignment of incentives for different levels of providers* capable of creating an integrated delivery system and having effective cost-control.

  An organized delivery system is a network of organizations that provide and arrange to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes as well as for the health status of the population.

  First referral hospitals, GP, specialists, nursing care, social services are such kind of organizations. The community of caretakers must be itself integrated in order to support the

development of the health care management system, in collaboration with public services.

Such integration encompasses contract and strategic alliances, as well as direct ownership of services.

If this is the case , the different components of the system must share economic incentives. The greatest potential for creating such alignment of incentives is the adoption of capitated payment or budget by all components of care. Full capitation places all providers in the delivery chain at risk. Without such form of risk-sharing or risk transference the traditional incentive to provide more health care that is clinically necessary would remain unchanged.

Full capitation will oblige providers to work together in cost-effective ways, to maximize the residual. It also provides incentives to place greater emphasis on disease prevention, health maintenance and health promotion. Capitation will improve clinical integration efforts and the shift towards forms of alternative care-givers.

- *coordinating health reform plans with other public funds and public providers.* Any reform action in terms of financing, re-organization of the delivery system , and re-consolidation of the beneficiaries can only be successful if they are coordinated with the other public funds and providers.

10.5 **strengthen Ministry of Health governance and authority:**

- *adoption of a National Health Service standard chart (Carte sanitaire).* Though such chart shall not be adopted in a perfunctory way, the standard will have to be directed towards the development of complementary and integrated care, services and providers and to avoid proliferation of high technology.

- *regulatory activity on accreditation, certification, quality control, portability, freedom of choice, liability and accountability of autonomous hospitals.* These are the core functions of a modern Ministry of Health and those which need, under the current circumstances, important upgrading .

- *unified or harmonized mechanism of price fixing, contract negotiations and competitive purchasing.* The Ministry of Health, and for that purpose any other public funds, shall be allied in searching for the best value for money. There are, however, doubts that the Ministry of Health, as well as other public agencies, are able to do so in an efficient pattern. Experience in some developed countries has suggested that specialised agencies (linked, autonomous or otherwise) are necessary (e.g. USA HCFA).

- *fraud control.* There is where the MOH shall develop specific intelligence. The adoption and introduction of any reform does not cancel out fraud, but just changes its features. The present system of preliminary authorization, admission, hospital, discharge and bill control by the public payers, besides being too cumbersome and prone to corruption, is too simplistic and understandable to prevent fraud. The size of such phenomenon is totally unknown. In USA is estimated at about 10-20 % of the national health expenditures.

10.6 **citizens' empowerment :**

- *patients' rights charts and guide to services shall be widely publicized.*

  Citizens' and beneficiaries are hardly informed on products, services , and care available, as well the ways to obtain them and the costs, their quality and their effectiveness. This is one of the reasons for economists to declare that the health market is not a perfect market. Clients do not have the element to make the most appropriate decision in selecting the services. This is also the reason why Government is obliged to step in a very heavy-handed way. Awareness of their own rights leads to participation in the process of producing "health". Lebanon is not exception.

- define in more transparent way the limits of citizens' *freedom of choice* in terms of selection of providers, institutions and portability. Financing systems (such the one presently available in Lebanon) prone to moral hazards may have to resume to clear-cut freedom policies.

- develop policies to target *inequities* in terms of geographical health resource distribution, socio-economic

inequities and outcomes. Citizens must be enabled to have equal outcome opportunities

- *private insurance regulation.* Private insurance may play in the future a more important role in the context of the health care financing in Lebanon. Regulation may be necessary to avoid excessive risk selection, since now. Forms of high-risk pool insurance shall be developed.

10.7 **develop policy support services to the MOH**

- issuing a *yearly national health plans*. This will allow all purchasers and providers to have a yardstick in their development of their own plans.

- issuing a *yearly national health report.* A profile, directory, and account of the health of the nation and of the Ministry of Health activities. An important tool for providers and purchasers.

- essential *information for decision making purposes. (in particular expenditures and utilization)*

- *research and demonstration project for financing and expenditure reform.* This is an essential step towards conflict resolution.

Speech of the Lebanese Minister of Health

Dr. Karam Karam

At the inauguration of Lebanese-Italian Conference on Health Care Financing
In the presence of
HE the Italian Minister of Health
At Issam Fares hall – AUB – Beirut
16/2/1999

Excellency Mrs. Rosy Bindi
Dear guests
Dear audience and friends

We are gathered here today, at the Lebanese-Italian Conference, to meet the scopes of Italian rehabilitation and financing programs in Lebanon and to set new perspectives for the Italian assistance to the Lebanese people.

What you will be experiencing, by seeing and hearing the 11 experts' interventions, during these two-day convention, will help you to be updated on reform, legislations and financing practices that are being developed in the Italian and Lebanese health care sector. Certainly this exchange will enrich both sides.

All the above, in addition to other administrative, financial and organizational initiatives, are being done to meet our moral and social concerns.

Lebanon will rely a lot on this fruitful and promising cooperation between our two countries, at the start of President Lahoud mandate. Such initiatives may meet the President's concerns and priority in guaranteeing health care for all Lebanese people, regardless to their place of living and their wealth.

In this frame the Italian Co-operation for Development, a specialized Office of the Italian Foreign Affairs Ministry, has mobilized its health experts to support and promote health reform in Lebanon, as it does with other Governmental and non-Governmental Organizations worldwide.

This is not the first time that the Italian Co-operation assists Lebanon in a such noble way. During the war period humanitarian aids were received especially for our people in the South and Jezzine area.

Later on, in 1992, the Italian Co-operation for Development signed the first protocol with Lebanese Ministry of Foreign Affairs.

This protocol has been renewed, in 1996, securing financial aids up to seven million American dollars in medical aids, shared between the health care centers in North and the Beirut Governmental Hospital at Quarantine.

Moreover, we have since 1997 an Italian expert in Public health and at our Ministry of Health,, cooperating closely with our Ministry Advisors.

Last year (1998), a new protocol has been signed between the Italian Co-operation for Development and Lebanese Foreign Affairs Ministry, in the perspective to secure to Lebanon additional resources in the field of human and material development. The protocol, in fact, includes sustainable training programs and equipment for the Public Health Laboratories, in collaboration of the Italian High Institute of Health, as well as further technical assistance to the Ministry of Public Health.

During recent years we have experienced a growing need at the Ministry of Health for research and studies aimed at promoting and implementing a general health reform in Lebanon. Training and upgrading of the Ministry Directorates and Departments are also necessary.

Italy has been ready to answer to all the above needs. It has also assigned Italian experts and it has started a scholarship program, allowing each year two Lebanese professionals to follow specialization courses in Italy, on health administration and financing.

Additionally, the Co-operation program is looking for the financing to the heart surgical department at the American University Hospital of Beirut.

The two-day Congress, looking for optimal health funding methods, will enable, certainly, the Ministry of Health to benefit from the Italian experience, in order to achieve optimal procedures and funding that will secure an efficient reform system of the Health Sector in Lebanon.

The Memorandum, moreover, that will be signed by the Lebanese and Italian Ministers of Health, will secure the Lebanese partners a safe experience in organizational reforms, specialized researches and medical new technology.

All the above will enable to achieve a better approach to reform the health care sector in Lebanon. This is essential to guarantee later respectable and decent health care services for Lebanese citizens and to ensure people a welfare system, sought after since long time. We thank, therefore, the Italian Government to provide us with such opportunity.

We highly appreciate the Italian Assistance through the Italian Ministries of Health and Foreign Affairs.

We highly appreciate the presence of the Italian Minister of Health among us. We are tankful to her, to her team and finally to all Italian guests.

We hope that the Conference proves fruitful and successful in meeting our peoples' expectations.

Speech of the Italian Minister of Health

Mrs. Rosy Bindi

At the inauguration of Lebanese-Italian Conference on Health Care Financing
In the presence of
HE the Lebanese Minister of Health
At Issam Fares hall – AUB – Beirut

His Excellency
The Lebanese Minister of Public Health Dr. Karam Karam

Dear Sir,

At first, I would express you my pleasure and honor to be invited by HE to come over Lebanon in order to sign a health cooperation agreement between the Italian and Lebanese Ministries of Health .

My brief visit allowed me to know more about the actual Lebanese difficulties and hopes. I have noticed how Lebanese people and institutions are determined to restore peace, stability, independence and to develop their country.

I have also noticed how much is appreciated the cooperation between Lebanon and Italy and what Italy is offering to promote the cooperation in the Health Sector.

I hope that above cooperation will prove fruitful in intensifying contacts in the Mediterranean area and strengthening the mutual efforts for grow and development.

The Lebanese-Italian Conference we are inaugurating today will certainly enhance the communication and exchange of expertise in strategic domains of the Health Sector.

Obviously, each country has its own experience and peculiarity in the health sector. Consequently issues such expertise exchange should not be taken lightly.

I am confident that this Conference will allow to go deeply in examining the similarities and differences of our health systems.

This will consent more understanding of the problems encountered and will particularly allow to clarify and set the objectives we are pursuing.

However, whatever will be the Health System and situation of each country, some principles on which to base any Health System shall, in our opinion, remain the same.

Countries face often one common problem: the scarcity of financial resources. This is a main concern for rich and less rich countries. These days, we share all this same problem.

What are the principles on which a health system shall be based upon and how can we find a compromise between them and the financial challenges?

In the Italian National Health Plan for 1998 – 2000, we have adopted the following principles:

a. The respect of the human dignity, which means that all peoples are equal in dignity and rights.

b. The strengthening of prevention, that is preventing peoples' diseases and acting before they get sick.

c. The satisfaction of people's needs, that is setting as expenditure priority the satisfaction of basic and first level health care needs.

d. The respect of solidarity: expenditures will cover people most in need of assistance. This principle implies the transfer of resources to those who are more needy from the social, clinical and disease point of view.

e. Efficiency and benefit principles, whereby resources are addressed to those services that prove efficient and to those people who can benefit most from them .

f. Efficiency and cost principle: which implies to develop first those services and activities which prove to be more efficient and less expensive. As we have to choose between two different operations, giving the same results, we adopt as priority the less expensive one.

g. Fairness principle: all peoples have the right to equal amount of health care.

On adopting the above principles, any economical system for health care will provide fairness and solidarity to all.

According to that system human being has not to pay for his own health but every one will be contributing in improving the health of the others.

In the health sector we should proceed by putting priorities in the budget commitments and adopting a positive expenditure behavior that must not deny the goal of protecting peoples health.

Based on above, it should be agreed that the health system must meet fairness, quality and efficiency principles in sharing its resources.

Our Italian experience taught us that mastering the health sector expenditures should be a result of decisions which do not put additional charges on peoples and that expenditures will be more reasonable if adopts priority investments that lead to higher health results .

In the frame of the moral commitment towards equality principles, the health funding should tend to provide an equal allocation of all its resources to the geographical regions, while at same time taking into account specific needs of each region.

This is what we call the wise and civilized behavior regarding the health expenditures. In other word, the health budget must be a mean and not the end.

Likewise, all public and private hospitals and health sector managers were learned that adopting new payment system called DRGs does not mean the shift from the bureaucracy of regulations to the bureaucracy of the numbers. Indeed, that is why we are continuing, within the health sector, the process of splitting the technical administration and the political decisions.

Finally , His Excellency, I hope that this Congress will represent an important step towards the improvement of the Lebanese Health Sector and towards an active and intensified cooperation with Italy.

I would mention also that the agreement chart we will sign today will provide an objective frame for more tight links between both countries, while respecting the specificities of each of us .

Speech of HE the Italian Deputy Minister of Foreign Affaires HE the Senator

Mr. Rino Serri

Excellencies
Dear Audience
Ladies and Gentlemen,

It is our great pleasure to be here with you today, for the inauguration of this Conference, held in this commanding place , in the presence of distinguished personalities and covering the vital health issue of health care financing .

We are equally proud for having secured the attendance, for this convention, of Italian professionals, of international expertise and reputation.

Ladies and Gentlemen,

The great progress achieved by Lebanon after years of destruction and divisions could not pass unnoticed. This is for us a reason of great happiness, as we recognize owing to Lebanon and this Region a debt of civilization difficult to clear.

The Italian Government has followed-up closely the recent dramatic history of Lebanon and the Middle East. We are sincerely concerned that the all Region enjoys long-lasting peace and stability, two basic requirements for sustained development and well-being.

During the period of war and crisis, the Italian Government has provided through the Co-operation for Development Office and the Embassy urgent humanitarian aid for the population. This is an important mission of the Ministry of Foreign Affairs towards any country affected by wars and conflicts.

After the end of the unrests in 1992, the Italian Co-operation for Development started immediately to assist Lebanon in its reconstruction efforts, by setting up the first rehabilitation program in health sector, worth about 7 millions USD.

The start of the economic recovery and the improvement of the leaving conditions coincided with the growing awareness that the health care sector in Lebanon needed to meet peoples' demand for

qualified health care. This would require the availability of appropriate skills and sufficient finances.

Like many other countries, Lebanon has found difficult to satisfy the increasing demand for services. Indeed, such concern is shared also by Italy , as the Italian Minister of Health has been underlining in her speech. Choices need to be made.

On basis of these new general perspectives, the Italian and Lebanese health experts have being identifying new priorities for cooperation, which would stress development assistance in strategic areas.

Protocols were signed and new ones are under negotiation, covering important issues such as up-grading nursing profession and other health manpower. Close coordination was sought after with other donors and international agencies, especially the European Commission .

With the same spirit and objective in mind, we are providing direct technical assistance to the Lebanese Ministry of Public Health, we are supporting the development program of the Public Health Central Laboratory and we are promoting training, research and basic health care projects.

The Italian Government and the Italian Co-operation are willing to continue the fruitful partnership with the Lebanese Ministry of Public Health and the Lebanese Government, in order to ensure an efficient and effective public health sector development.

The inauguration of this Conference in the presence of Their Excellencies the Lebanese and Italian Ministers of Health is the proof of such a commitment.

We hope that this Conference will produce valid recommendations, that once approved and adopted, could give substantial practical results.

We hope also that this convention as well as the visit of HE Mrs. Bindi, the Italian Minister of Health, will strengthen the scientific and cultural ties between our countries.

The role of the Istituto Superiore di Sanità within the Italian National Health Service

Prof. G. Benagiano

There are several reasons why I am especially happy to be here today: the first is to have the possibility to greet my old friend Professor Karam Karam as the new Minister of Health of Lebanon; when I was here on my last visit (which coincided with the visit, in May 1997, by Pope John Paul the Second) I got the distinct feeling that something was "cooking" and that this appointment was forthcoming. Now I am extremely glad to be here ,so that I could wish him in person every success in this important, but difficult task.

The second - equally important reason - is to give testimony of the strong bonds (liens, I would say in French) between our two countries. The presence of our Minister of Health the Hon. Rosy Bindi bears witness to this renewed friendship and of our willingness to provide whatever support to the reconstruction of your country.

The third reason is to, so to speak, "check" the progress in the reconstruction: this is my fifth visit to your unique country and my memories go back almost 43 years to the Lebanon that was. I could tell you stories about those days, like my experience with your famous Casino du Liban -which has now reopened: it was a unique experience, in the sense that I spent most of a time in the toilet, as an aftermath of a visit to Sa'ada and a luncheon that did not really agree with my guts!

What I see now is a Lebanon on its way to be again what it was: striving, modernising, working hard to erase the wounds of the civil war, intent in the process of reconciliation.

I can only pray that this continues and that developments in 2 of your neighbouring countries, Jordan and Israel, will be positive and such to foster the cause of peace.

I am here today to talk to you about our Institute, the Istituto Superiore di Sanità, which is our National Institute of Health.

SL IDE 1

The Institute was founded in 1934 and is, since 1978, the official technical and scientific body of the Italian National Health System. The Institute is placed under the direct supervision of the Minister of Health and has the mission of promoting public health through scientific research, surveys, regulatory, supervisory control and testing activities in all the major fields of health sciences such as: infectious diseases; non-

SLIDE 7

Similarly, a number of major research activities carried out at the Institute are today funded through extra-budgetary resources. Some of our largest projects, like the effectiveness trial of a cellular pertussis vaccines, and the clinical phase H testing of the unconventional cancer treatment known as the "Di Bella multitherapy", were supported by extra-budgetary sources.

SLIDE 8

Utilising ad hoc funding, we have - over the last ten years - activated a number of special projects, some through specific legislation. I will mention only the three most important ones: the HIVIAIDS research programme that is in these days culminating with the publication in NATURE of an article reporting the non-human primate testing of an innovative vaccine aimend at preventing and blocking the HIV-1 infection; a programme for research on Cancer, in collaboration with leading US Centres; and a joint collaboration between the US-NIH and our Institute on ageing, cancer, HIV/AIDS and malaria.

SLIDE 9

In 1992, the Government took a step which we believe has had very positive effects on public health and biomedical research in our country: it decided that the National Health System should allocate 1% of its total resources to support research projects and action plans that address issues that are of high priority for the National Health Service.

SLIDE 10

Thanks to such funding, the Institute-together with a network of National Clinical Centres-has been carrying out a vast array of critically relevant basic and applied research projects in the public health sector.
Here is a list of some of the most relevant among them:

- Risk factors and prevention in maternal and child health;
- Quality of services;
- Viral epathitis;
- Tuberculosis control;

SLIDE 11

- Epidemiology of the Creutzfeld-Jacob and related syndromes;
- Mental health;
- Infectious diseases information and surveillance systems;

SLIDE 12

Referring now to the regulatory functions of the Institute, our role has been defined through ad hoc legislation and the issuing of regulations that request us to perform a vast number of analyses and tests, very often of confirmatory nature. This is due to the "devolution model" adopted by Italy in the field of Health. When, for instance, an analysis on a food product performed at a peripheral control laboratory proves to be positive, the producer may appeal for a second test that will be performed at the national referral laboratory, which is our Institute: we perform thousands of these tests every year.

SLIDE 13

The implementation of European Union regulations has had a very positive effect on our overall regulatory system, with the aim of establishing a System for Quality Improvement for each of the main sectors concerned (food, drugs, pesticides etc.); to comply with the new regulations, the European Union has activated a network of regional referral laboratories to verify, on a continuous basis the reliability and competency of laboratories licensed - within each nation - to perform controls and similar tests.

SLIDE 14

As a told you at earlier in my presentation, Italy has opted for the creation of only one Institution for most of the technical and scientific activities required in the field of public health.

Because of this decision, the Institute serves also as a sort of "Italian FDA", being charged with the technical and scientific evaluation of the pre-clinical tests conducted to establish the safety of products and technologies for medical use (drugs, vaccines, biotechnological products), or for those affecting in one way or another, the health of the population, as in the case of pesticides.

SLIDE 16

The list of our international activities is, I am afraid, too long to be itemised here. ISS experts are participating in many ad-hoc working groups active of the organisations I mentioned above, dealing with specific research topics like infectious disease control, drugs, food, environment and training and continuing education for health professionals.

SLIDE 17

It is thanks to such working-groups, that the EU has developed a multi-annual protocol of research in the fields of medicine and health, environment and bio-technologies. Our scientists act as project leaders or co-ordinators in a number of these research projects, within the Union Fourth Framework Programme and we plan to be full participants in the new Fifth Framework Programme. The in progress implementation of the Maastricht Treaty is expected to further develop collaboration within the EU.

SLIDE 18

One of the "natural international partners" of ISS is certainly the World Health Organisation and this strong relationship is certified by the presence, within the Institute, of eight WHO Collaborating Centres:

- Communicable diseases surveillance,
- poliomyelitis,
- Arboviruses and viral haemorragic fevers,
- Streptococcal infections,

SLIDE 19

- Influenza viruses, with a National Influenza Centre,
- Veterinary public health,
- Control of tropical diseases and
- Innovative educational methods for public health professions.

SLIDE 20

Let me conclude with a look into the future: we are fully aware of the ever increasing challenges that health services are facing in an ever changing world. For this reason the Government has set in motion, a process of major reform of the role and functions of ISS, within a decentralised health system.

I am convinced that wherever health services have been devolved to the periphery, a major need exists for strong central institutions for two important reasons:

- in each country, irrespective of size or expertise existing, there are functions, such as research and regulatory action, that must remain centralised, if we want to avoid wastage and inequality, or - worse - danger for some.
- local health authorities need a strong referral central entity for those functions that they cannot (economically or technically) carry out efficiently.

SLIDE 21

I am confident that the tradition of knowledge, culture and expertise accumulated at the Institute in so many years of activity and inherited by those who preceded us, will continue to provide the Italian health sector with knowledge, guidance and actions capable of not only maintaining, but further promoting the health, not only of our citizens, but on a wider spectrum, capable of contributing to the global progress in scientific research with benefits that are going well beyond national borders.

SLIDE 22

This is proven by the recognition of the work carried out at our Institute, which has taken many forms, including the award of the Nobel Nobel prize to three scientists who worked at the ISS, Professor Boris Chain,

SLIDE 23

Professor Daniel Bovet,

SLIDE 24

Professor Rita Levi-Montalcini.

I am confident that also in our case, as Shakespeare said in "the Tempest", the past will be our prologue and that new major success with important advancements in biomedical knowledge await our Institute at the opening of the new millennium.

Health Care Expenditures in Lebanon

Mr Osmat Azzam

Health Care Expenditures Process -Lebanon

- Developing a database process to support hospital funding and management reform.
- Break this process into areas for collection
- Gathering all data & developing funding formula for Hospitals.

Health Care Expenditures Process -Lebanon

Public Health Care Expenditures:

- At the MoH level
- At the other public Financing agents level.

(ONGOING PROCESS)

Private Health Care Expenditures

- Household (Out of Pocket)
- NGO's
- Private Insurance

(SURVEYS NEEDED)

Control Public Health Care Expenditures.

The following studies have been prepared aimed at obtaining accurate information for Public Health Care services delivered in hospitals and other health providers.

•A study of the MoH expenditures from 1992 to 1997 has been prepared
•A comprehensive study for 1996 public providers expenditures has been prepared.
•A comprehensive study for 1997 public providers expenditures has been prepared.

Cost Information System at the MoH level

Private Hospitals information system has been developed as follows:

1. Hospital classification and rates

2. Hospital financial data

Ongoing update of Hospital rates and Classification data

- **Private Hospital comprehensive list and classification granted**

- **Private Hospital data regarding award granted by service and department.**

- **Minister decrees and memos regarding classification and rates.**

Public Health Care Expenditures data

- National Health Care Expenditures study has been prepared for 1996 and 1997 and it will be an ongoing process.
- Forms have been designed and it is filled progressively by the appropriate **focal person** of each Financing agents (NSSF, CSF, Armed forces..) for compiling of NHA:

1. Form 1: Hospital reimb by National Financing agents
2. Form 2: National Financing agents yearly budget.

Public Health Care Expenditures data (Continue)

3. Form 3: National Financing agents beneficiaries & total cost of HC. By Financing agent.
4. Form 4: National providers Inpatients & outpatients expenditures, number of cases, number of days, ALOS, and cost /patients & /day.
5. Form 5: National Health Care Expenditure coverage scheme.

National Health Accounts

- NHA activity is being undertaking under the supervision of the MoH
- NHA is a framework to analyze

1. National Health resources
2. Review the allocation of resources.
3. Assess the efficiency of these resources.
4. Study and evaluate the health financing options.

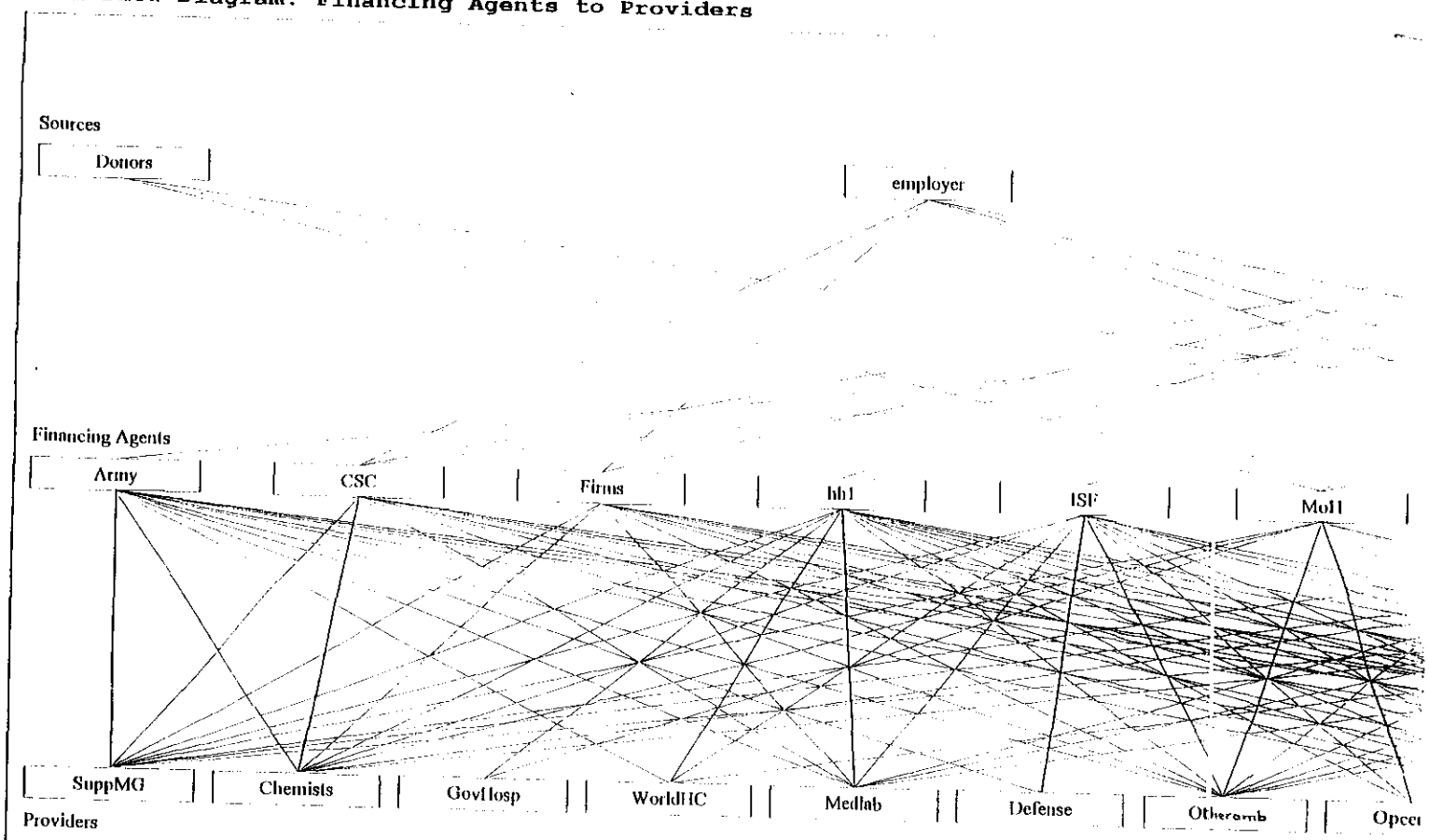
Why NHA for Lebanon

- Lack of information on Health care expenditures
- Not using existing information to improve the planning and management of health sector resources.

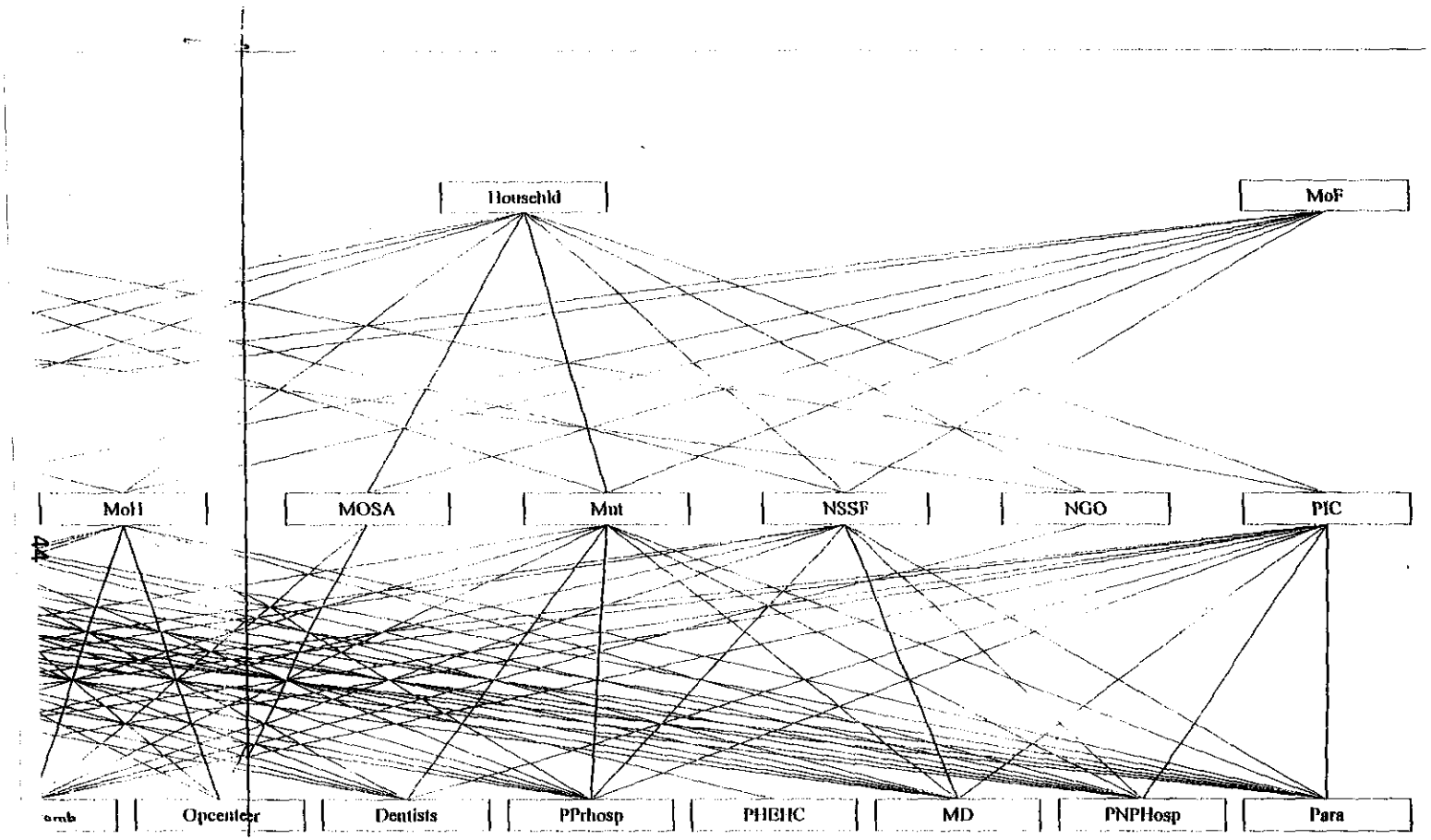
NHA view

- Source of Finance
  - Government NGO's HH
- Financing Agents
  - MoH CSF NSSF
  - Armed Forces
  - Private Insurers NGO's
- Providers
- Services Provided

Full Flow Diagram: Financing Agents to Providers



Feb 3 '99 OSMAT AZZAM


Household
MoF
MoH
MOSA
Mut
NSSF
NGO
PIC
Dentists
PPrhosp
PHEHC
MD
PNPHosp
Para

Hospitalisation dans le secteur privé à la charge du secteur public :

	# d'assurés	# de bénéficiaires	Coût total en 1997 en milliers de L.L.
Ministère de la santé			196 119 689
Sécurité sociale	341 330	1 194 000	177 410 000
Coopérative des employés	65 000	325 000	40 063 000
Armée	85 000	325 000	57 128 000
Sécurité intérieure	23 100	78 100	57 843 000
Sécurité générale	3 800	13 000	5 600 000
Sécurité d'Etat	1 463	3 877	2 288 246
TOTAL	519 693	1 938 977	536 451 935

Dépenses d'hospitalisation et soins externes comme apparues en date du 4 juillet 1998.

Type de soins	1992	1993	1994	1995	1996	1997
Hospitalisation-Chirurgie	32 624 000 000	51 937 000 000	64 967 000 000	89 127 000 000	112 909 000 000	139 276 162 000
Maladies chroniques mentales	5 016 000 000	10 884 000 000	11 626 000 000	11 809 000 000	15 584 000 000	18 764 434 000
Chirurgie cœur ouvert	8 728 000 000	11 325 000 000	15 755 000 000	16 234 000 000	16 258 000 000	19 058 777 000
Prothèse du rein	5 393 000 000	8 455 000 000	9 534 000 000	10 086 000 000	12 691 000 000	13 687 883 000
Chimiothérapie	732 000 000	723 000 000	576 000 000	588 000 000	400 000 000	1 081 982 000
Transplantation du rein		525 000 000	954 000 000	600 000 000	955 000 000	810 808 000
Brulés			1 388 000 000	1 184 000 000	1 047 000 000	435 390 000
Lab-Radiologie-MRI- CTS	1 223 000 000	1 446 000 000	1 333 000 000	2 139 000 000	2 516 000 000	3 004 253 000
TOTAL	53 716 000 000	85 295 000 000	106 133 000 000	131 767 000 000	162 360 000 000	196 119 689 000

NB : -Nombre d'admissions couvertes à 100% pour l'année 1997 : 27000.
-Subventions médicales offertes par le bureau du ministre ne sont pas signalées.

Distribution of population by area by hospitals:

Area	Population	Area in km²	# of cities & villages	7% of the population	# of beds needed	MOH beds needed 45%	Public Hospital beds	Private Hospital beds needed	
1&2 Beirut	700 000	18.00	1	49 000	817	368	14	354	354
3 Metn Nth	381 722	270.20	115	26 721	445	200	90	110	110
4 Metn Sth	455 826	186.70	66	31 908	532	239		239	239
5 Kesrw. & Jbeil	154 673	794.98	242	10 827	180	81		81	81
6 Akkar	107 869	713.10	203	7 551	126	57		57	57
7 Tripoli	337 638	807.98	156	23 635	394	177	154	23	23
8 Batroun & Koura	67 646	460.07	130	4 735	79	36	*	36	36
9 Saida	148 197	527.60	165	10 374	173	78	115	(37)	
10 Tyr	104 567	415.10	97	7 320	122	55	75	(20)	
11 Nabatieh	142 695	525.48	92	9 989	166	75	*	75	75
12 Aley	101 274	234.90	84	7 089	118	53	25	28	28
13 & 14 Shouf & Iklim	134 496	462.62	129	9 415	157	71		71	71
15 Zahle	113 118	413.68	56	7 918	132	59	62	(3)	
16 Baalbek	115 091	2 858.29	201	8 056	134	60	60	0	0
17 Bekaa West	55 898	1 008.31	76	3 913	65	29	* 40	(11)	
LEB Occupied Territories		755	61						
	3 120 710	10 452	1 874	218 450	3 641	1 638	595	1 003	1 074

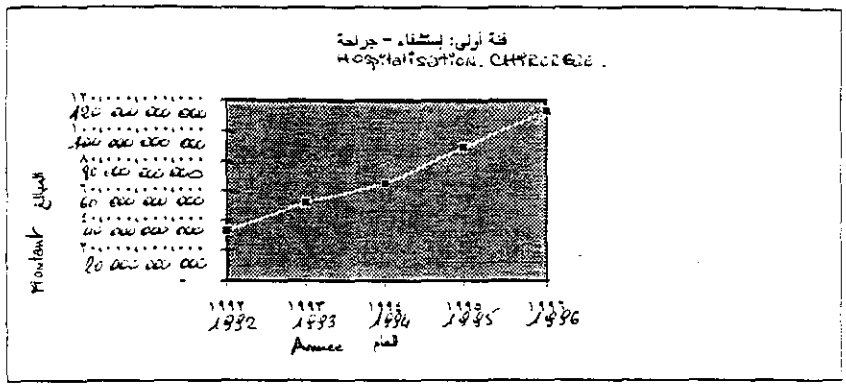
Hypothesis:
1. Makassed survey & Beirut 94 survey shown 7% of the population are hospitalized.
2. 45% of the population does not have hospital coverage (MOH patients).
3. LOS = 5 and occupancy rate of beds is 80%.

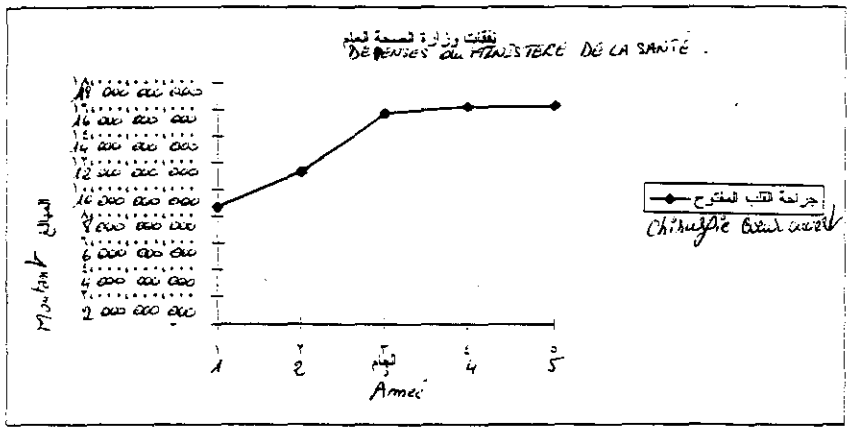
Coût des soins médicaux en milliers de L.L.
Statistiques 1997

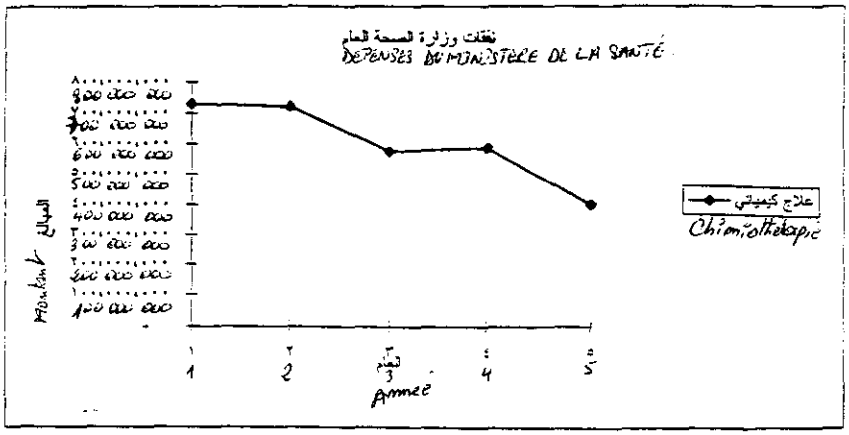
	Ministère de la santé	Sécurité sociale	Coop	armée	sécurité intérieure	sécurité générale	securite d'Etat	TOTAL
Coût total des aides médicaux pour l'année 1997	196119689	177410000	40063000	57128000	57843000	5600000	2288246	536.451.935
Coût des tests, analyses, consultations, traitements	3004253	77605000	18563000	9600000	10843000	2920000	878500	123.413.753
Coût d'hospitalisation(soins dans l'hôpital)	193115436 *(1)	99805000	21500000	47528000	47000000	2680000	1409746	413.038.182
# d'hospitalisations	122014	105000	16651	44100	34000	1650	1187	324.602
# jours d'hospitalisation	571001	420000	55949	120600		4970	3560	1.176.080
moyenne de séjour	4.68	4	3.36	3		3.01	3	3.51
moyenne de coût d'hospitalisation	1141)	950	1391	1075	1.382	1624	1188	1.250
moyenne de coût d'hospitalisation par jour	244	238	384	394		539	396	366

NB: *(1) Coût inclus coeur ouvert,, transplantation de rein, brûlés, chimiothérapie dans l'hôpital.
*(2) Moyenne de coût calculée par rapport au coût total d'hospitalisation estimé 39276millions qui concerne 122014 cas.

MoH payments 1992 - 1996
Hospitalization - Open Heart - Chemotherapy







The role of the National Social Security Fund In Funding Lebanese Health Sector

Mr Khalil Majed

Introduction

The guarantee offered by each society, to its citizens against all expected life risks they may face, has entailed the issuing of the basis for a promising system aiming at encountering above risks, mainly after a substantial improvement in understanding both, the conception and performance way of that guarantee.

The above indicated improvement, has experienced several changes coupled with an even better understanding of risks that human being may face, and on basis of which, we have moved into new era, in an ascending way.

At first, the conception of human being aid was based on individual act as a result of emotional background. Later on that help or aid was dictated by moralistic and religious behavior. At last, during the second half of the twenty-century, that help conception had developed into more complete and organized idea. Each society has to grant to its citizens all their rights by taking them in charge in case of risks that may occur to them.

Among above risks, the most relevant one is the one that may affect seriously the human being health, thus, of even importance are the measures to be taken in order to firstly prevent and then cure such hazardous risks.

To better understand this issue in Lebanon and how NSSF is dealing with, we should priory approach the following:

- The essence of Social Security and issues it covers.
- Actual Lebanese situation with respect with Social Security Coverage and services it provides.
- Role of the NSSF and extent of his contribution:
  - As per individuals and categories that get benefit of the office care.
  - As per his services coverage.
  - As per funding of above aids.
- The future of the NSSF in Lebanon regarding individuals they may benefit of its care as well as services it will provide .

1. **Disease and Maternity coverage by the Social Security**

The adopted system by the Social Security covers the following:

- Preventive and curative medical care, **in cases of health problem and** maternity, including medical exams, x-rays, laboratory tests and analysis, general medical care, drugs and pharmaceutical products and orthopedic devices and prostheses.
- It does also include hospitalization for both cases together with related surgical interventions.
- Funeral related expenses.

The following is not implemented yet:

- Reimbursement for temporary Health problem and Maternity job interruption.
- Dental care.

2. **The beneficiaries of the Social Security services in both cases: Disease and Maternity (medical insurance) according to NSSF law:**

2.1 Services of above insurance system are applied according to the related legal laws, year to date, on following people categories:

- Trained and permanent employees, dependent peoples of industrial, commercial, services and public sectors...and permanent employees of agricultural sector.
- Private school teachers.
- Universities students
- Taxis drivers and news papers sellers

2.2 The total beneficiaries number (1998 statistics) of above Disease and Maternity services as they include: husband and wife, father and mother and dependent children is:

- Public and Private sector employees and teachers of private schools	328,843
- Universities students	21,077
- taxis drivers	34,635
- News-papers sellers	100
Total	384,655

Whereas the beneficiaries total number of the above services system is variable, since it is directly related to job demanding market and its new yearly labor comers. There are roughly, according to family composition (usually composed of main beneficiary and dependent family members), 1,200,000 beneficiaries which is equivalent to one third of Lebanon population (about 3,600,000 inhabitants).

3. Comparative total number of beneficiaries of medical services secured by different public and semi-public structures in Lebanon [1] :

Sector	Number	percentage
Governmental Employees Cooperative	120,000	3,33%
Medical Brigade of the Army	400,000	11,11%
SSF (Social Security Fund)	1,200,000	33,33%
Cooperative of Interior Security Forces and the General Security	75,000	2,08%
		49,85%

In case of those who does not get benefit of above medical services according to the rules of Governmental Employees Cooperative, Medical Brigade of the Army, Social Security Fund and Cooperative of Interior Security Forces and the General Security, the Ministry of Health provide them the medical care in case of hospitalization. This is done upon political authority decision.

Above means that 50 % of Lebanese people does benefit of medical services of above indicated structures and the left 50 % are on the charge of the Ministry of Health .

[1] The listed values are approximate and not final. They are based on 1995 statistics and may be subject to some modifications whereas percentages are more indicative and may be used as general guidelines for left years.

4. Comparative financing study of all above involved structures [1] :

4.1 1995 statistics of different involved structures in funding the Health services are presented in the table below as follows:

Involved Sector	Share billion of Lebanese lira	Percentage of expense
Governmental Employees Cooperative [2]	60,000	21,99%
Medical Brigade of the Army	34,500	12,64%
Cooperative of Interior Security Forces and the General Security	20,000	7,33%
SSF	32,254	11,82%
Ministry of Health	126,000	46,19%
	272,754	100,00%

4.2 Above comparison shows the following:

- The NSSF, by securing health care for about one third of the population, does only spend 11,82 % of total parties share in public and semi public structure.

- The medical care coverage secured by the NSSF, as mentioned before, is almost complete. It is more or less similar to the other ones of this study, excluding that of the Ministry of Health. It may differ with that of others structures (Governmental employees cooperative, Medical Brigade of the Army and Cooperative of Interior Security Forces and the General Security) in the dental care services only.

Involved Sector in services providing	% of services Beneficiaries	% of financing share of total expenses
Governmental employees cooperative	3,33 %	21,99%
Medical Brigade of the Army	11,11 %	12,64%
SSF	33,33 %	7,33%
Cooperative of Interior Security Forces	2,08 %	11,82%
Ministry of Public Health	50,00 %	46,19%

- As the SSF (Social Security Fund) does, the Ministry of health provides only general hospitalization services.

[2] 90,000 billion Lebanese lira are added (as per 1995 government Budget) covering medical care of which two third (i/e 60,000 billion Lebanese lira) are dedicated for dental care and the left on third (i/e 30,000 billion LL) is for scholar ship, marriage, birth and death expenses.

- 50 % of SSF Disease and Maternity protection is for hospitalization services. With its share of 3,66 % of the total contribution of all above involved structures, the SSF provides services for one third of Lebanon population. Among all involved sectors, the 3,66 % of SSF share seems the more acceptable even when considering the qualitative difference of some of the other sectors services, such as, dental care, hospitalization classes differentiation (for ex. Governmental Employees Cooperative...). Along with providing these services (Disease and Maternity protection), the SSF was able to maintain its financial equilibrium, secured above services on regular basis and paid its overheads without any debts. This healthy status of the SSF will enable him to go forward in extending his domain of activity and prepare the necessary studies to cover care services that have not been implemented yet starting 1999 and to conceive the frame of its cooperation with left public and semi public structures involved in the funding of the Lebanese Health Sector (funding all medical care services of all kinds).

5. Recommendations :

- Unify the health care Budget in Lebanon under more commonly used topic : unification of Disease and Maternity Protection Budget, in order to avoid unnecessary overhead expenses due to the multiplicity of Health Care references.

- Define the strategic goals for Health Politic in Lebanon through the Ministry of Health that must supervise the implementation of above Health Politic and define its task in the Public Aid.

- Study the issuing of a common hospitalization system... that will provide the least hospitalization services of all kinds. This system must take into account also the most dangerous diseases and the kind of care to be offered with its cost and the beneficiary contribution in it.

- Find a common general frame of cooperation between all implemented health care systems in the public sector in order to avoid, simultaneously, the unnecessary expenses and authority misuse, until an unified hospitalization system will be implemented.

- Make an efficient use of the NSSF experience over the past 30 years in the implementation of Disease and Maternity protection system, mainly in the field of medical and administrative supervision.

Health Care Reform
Exploring some ethical issues

Dr. Angelo Stefanini

The ethical implications of health care reforms is perhaps the most difficult, and in certain ways the most uncomfortable, challenge that currently confronts health policy makers throughout the world. This is underpinned by two main sets of values: on the one side, the neo-liberal principles of free market, competition, and a shrinking role for the state; on the other side, the utilitarian approach to set priorities and allocate health care resources.

The ethics of markets and resource allocation

Much of the concern about various proposals for change has focused on the possible effects of increased competition and market forces on the distribution of resources and quality of services. While it may be argued that a free market will work more efficiently than a state-planned system, certain people will necessarily be excluded from this health care system, as from any other. The defence on the market rests upon the moral acceptability of that exclusion. Clearly some see more dangers than others, but both the pessimistic and the optimistic would agree that careful monitoring of the situation is necessary because there are potentially major pitfalls. Competition by its very nature results in winners and losers, and in a health care market, not just the weakest services but also the chronically sick and economically weaker members of society could be the main losers.

The health maximisation goal of the utilitarian approach based on economic techniques like cost-effectiveness and cost-utility analysis, is also ethically controversial. Allocating scarce resources in the attempt to respond to an ever increasing demand of health care is a daunting task. Even more so it is under conditions of extreme poverty and greatest health needs. Priority setting or, as some would call it, rationing health care, thus becomes a highly sensitive exercise that transcends its mere technicalities to involve broader societal issues and personal values, including the principles of equity and justice. Utilitarian believe that justice is, using the jargon of economists, "maximising utility" that is achieving maximum benefit for the highest number of people. In the health sector is therefore necessary to reach a compromise between limited resources and virtually infinite demand so that benefits are maximised and costs minimised for the majority of the population (however, not necessarily for those most in need)[1]. Benefits are measured by econometric studies (cost/benefit, cost/effectiveness, cost/utility) and economic indices like QALYs (Quality Adjusted Life Years)[2] and DALYs (Disability Adjusted Life Years) [3] that represent a seemingly objective measure of clinical effectiveness in terms of *health gain* (i.e. number. of QALYs or DALYS saved).

The World Bank has incorporated this approach into its policy presciption as spelt out in the 1993 World Development Report[4]: governments of low and middle-income countries should buy for their population minimum clinical and public health 'essential packages' which are calculated to be of maximum cost effectiveness as measured by DALYs saved. The basic premise then is that money should be spent 'efficiently'. Treating one child might save X years of impairment, while treating another may only improve a condition without sparing him/her the impairment, which according to the model is less cost effective. If a treatment is cost effective in these terms, it should be provided; otherwise it should not. This means that in a poor country, interventions like, say, measles immunisation, which is effective and reasonably cheap, would be provided, but treatment for a disabled child whose conditions were not wholly remediable would not. Nor it would be for a child with HIV which led to secondary infections. because lie or she would be bound to die anyway.

A North/South double standard?

Detailed criticisms oil the calculation and use of DALYs and its methodology can be found elsewhere [5 6 7 8]. The question addressed here concerns the ethical underpinning of a rationing approach as proposed to poor countries. How does it compare with rationing strategies followed by other countries, particularly in the North?

1) a first issue relates to the use of DALYS:

- The introduction of DALYs as a unit of health for statistical analysis is supposed to provide an aid to reduce public funding of health services by including only low-cost services in the developing countries. In fact, the criteria advocated are fundamentally different for Third World and industrialised countries. Whereas for the former only the cheapest services are defined as essential, for the latter also those expensive and sophisticated are *essential interventions.* The very meaning of 'essential' as referred to certain clinical services, and the criteria used to define it, is evidently open to a wide discussion[9].

- Although to compute the DALYs estimates different parameters are used in relation to different countries, 'pre-packaged' results are applied as if they were universally valid. Little consideration is given to the fact that the concepts of disease and disability are profoundly affected by ethical values and social preferences which of course greatly differ between one type of society and another.

- DALYs' evident elegance and sophistication, however, conceal all even bigger problem when it is suggested that they should be used to prioritise health interventions for financing. As argued by Green and Barkel., [10] excessive reliance on economic techniques for priority setting is likely to reinforce a medical technocratic approach and leave an unjustified power in allocating health resources in the hands of the medical profession. With the use of these techniques young patients and acute disease will be ranked respectively higher than old people and chronic, debilitating conditions. Minorities affected by diseases expensive to treat

and with poor chances of long term survival will inexorably be excluded in favour of the more fortunate.

2) Second, the rationing approach:

- As shown above, the rationing approach for health care proposed is founded upon the classical utilitarian theory of justice, i.e. "the greatest happiness for the greatest number" is pursued by providing only cost-effective interventions that will lead to the maximum number of DALYs saved. Such an approach is also called "rationing by exclusion" or "rationing by refusal", as it defines what services should not be provided as well as those that should[11]. Although resource distribution by means of explicit exclusion could help remove some inequalities and, in theory, everyone would know were they stood, the approach has been widely criticised as crude and inevitably reductionist.

- Furthermore, in a welfare democracy, defining the package should be a matter of political choice, an explicit process in the public domain. Rationing by exclusion is the strategy followed, after years of hot debate, several revisions and embarrassing policy U-turns, in the state of Oregon in the USA[12]. Though criticised as basically flawed, Oregon's methodology included the commendable effort to involve the public in allocative decisions. Meetings were held and people questioned on what to include in the publicly financed essential package of health services. The same methodology as applied to poor countries, however, does not include similar political subtleties like the use of a participative approach; politics are better kept at bay. Decisions are exclusively technical and left to highly skilled epidemiologists and health economists based in Washington. One other country, The Netherlands, attempted to follow the Oregon path, only to reject it eventually on ethical grounds after years of public discussions, commissions of enquiry and political debate[13]. Countries like Sweden, Finland, New Zealand, UK (to mention only those most actively engaged in ,he international priority setting debate) have either *a priori* excluded the "essential package methodology" as a viable option or managed to by-pass it as too politically embarrassing. The unavoidable question is why a social experiment like a rationing approach that, apart from the Oregon's experience, has not been willingly and independently adopted by any other country in the North is now so enthusiastically promoted as the answer to poor countries' resource problem.

3) A third problem with this approach to priority setting and allocative decisions is the political environment in which such decisions are made. Poor countries heavily rely for their sheer survival upon external economic assistance, with the World Bank and the International Monetary Funds at the top in terms of volume of aid. Subjected to donors' powerful economic leverage, countries from the South may be induced into experiments of social and economic engineering which may trigger irreversible processes that will affect the poor. For example, regarding the choice between the essential package methodology and other rationing strategies, one might question whose power is the decision over such far-reaching political judgements. These

profound ethical and value questions in most modem societies are resolved through democratic means. On the contrary, some donors' approach appears to disregard democratic procedures on the assumption that governments and parliaments cannot make fair decisions about health care. Government decisions on the essential package for the poor are then made 'objective' through the application of cost-effectiveness calculations. In this way a political decision has been transformed into a technical one.

The main problem with utilitarian theories, as those embodied in the essential package rationing strategy, is therefore that *maximisation of utility* does not necessarily mean *justice*. On the contrary, at times utilitarian thinking may lead to rather disconcerting conclusions when, for instance, the welfare of the greater number ends up legitimising injustice against minorities. As demonstrated by human history, minorities' interest is not always safe in the hands of the majority. It is apparent that utility as measured by cost-benefit techniques cannot bring to the denial of the principle of equity up to the point of leaving a person without health care.

Critical issues

Current experience with health care reform throughout the world derive from relying perhaps too naively on the following assumptions [14]:

- **The realistic trasferibility of policies, tools and techniques between different social and political environmenents.**

Complex priority setting tools, such as the DALY, for example, have been criticized for not being intenationalily comparable[15]. Moreover, by concentrating on maximizing the benefits gained with no proper consideration to their equitable distribution, they are likely to neglect those who are in greatest need. Innovative strategies, including new financing schemes, should be adapted to the unique conditions in each of the respective countries. On a more global scale, concerns have been raised about the risks of the wholesale import of models conceived (and so far not yet proven successful) in the North of the planet.[16]

- **The willingness of governments to adopt, and the institutional capacity to implement recommended policies.**

Governments in the North are under constant pressures by the electorate, community groups, powerful professional, industrial and sectoral lobbies. In the South we may add donors and international organizations. Decisions are therefore rarely made on rational and informed choices and with the aid of the best available information. On the other side, it is not enough to strengthen financing mechanisms and increase aid flow to compensate for the shortage of human resources and local institutional capacity.

- **The ready availability of financial, human and management information resources.**

For any region of the world useful policy decisions and sophisticated health outcomes calculations are difficult to make on the basis of what are often not more than simple

guestimates[17]. Beside, standard essential care packages so prescribed tend to concentrate on clinical and public health interventions without specifying organizational and management concerns. Moreover, the sheer, absolute present lack of resources, very unlikely to be significantly increased in the near future, makes the cost of recommended packages of essential services to be provided by government unaffordable.

- **The likely achievement of the reform objectives.**

What is puzzling in this regard is the lack of appreciation of the importance of evidence-based policy making both at macro and micro level. The experience of rich countries is, to say the least, equivocal and unconclusive. Even less evidence of success comes from the South where, on the contrary, especially in Asia, undesirable and unintended consequences of reforms have been documented[18]. Equity is possibly lagging behind other goals in its attainment.

Conclusion

On June 1996.WHO European member states signed the *Ljubljana Charter on Reforming Health Care*[19]. The event was prompted by the rising inequities the quality and distribution of health care as perceived by the experience of the countries implementing health care reforms. The Charter articulates a set of fundamental principles which should orient health care systems and should be keys to managing change effectively. In summary, the Charter reaffirms the importance for health care systems to be driven by values, to be targeted on health, centred on people, focused on quality, based on sound financing and oriented towards primary health care as a coherent pail of an overall policy for health to which citizens should make a significant contribution. The fact that countries experiencing current reforms should feel the need to produce such a document it says a lot about their perceived uneasiness ill dealing with changes ill the health sector which involve much more than mere technicalities and impinge upon a wider. field of deeply felt values.

Interestingly enough no Ljubljana-like Charter has been drawn up fol. non-European countries. Dr. Tarimo, from WHO Geneva, has proposed a Code of Ethics to monitor government achievement in what he calls the *Health for All social contract.* There is therefore an urgent need to develop alternative ethical frameworks for health resource allocation and health policy.

References

[1] Beauchamps TL and Faden RR. (1979), The Right to Health and the Right to Health Care. *The Journal of Medicine and Philosophy* 4: 118-13 1.

[2] Gudex C (*1986), QALYs and their use by the health service.* Discussion Paper n. 20.York, Centre for Health Economics, University of York.

[3] The World Bank (*1993), World Development Report. Investing in Health.* Oxford University Press, Oxford.

[4] Ibid.

[5] Barker C. and Green A. (1996),Opening the debate on DALYS. *Health Policy and Planning* 11(2): 179-183.

[6] Cooper R.S., Osotimehin B., Kaufman J.S., Forrester T. (1998), Disease burden in sub-Saharan Africa: what should we conclude in the absence of data? The Lancet 351: 208-210.

[7] Wiseman V., Mooney G. (1998), Burden of illness estimates for priority setting: a debate revisited. *Health Policy* 43: 243-25 1.

[8] Paalman M., Bekedam H., Hawken L., Nyheim D. (1998), A critical review of priority setting in the health sector: the methodology of the 1993 World Development Report. *Health Policy, and Planning* 13(1): 13-3 1.

[9] Ugalde A and Jackson JT (1995), The World Bank and international Health Policy: a critical review. *Journal of International Development* 7(3): 525-541.

[10] Green A and Barker C (1988), Priority setting and economic appraisal: whose priorities, the community or the economist? *Social Science and Medicine* 26(9): 919-929.

[11] Hunter D (*1993), Rationing dilemmas in health care.* National Association of Health Authorities and Trusts, Research Paper No.8.

[12] Dixon J, Welch HG (1991), Priority setting: lessons from Oregon. *The Lancet* 337: 891-894.

[13] *Choices in Health Care.: A Report by the Government Committee on Choices in Health care (1992),* Rijswijk, The Netherlands: Ministry of Health Welfare. and Cultural Affairs (AJ Dunning, chairman).

[14] Thomason JA, Health sector reform in developing countries: a reality check. Http://www.acithn.uq.edu.au/conf/papers97/thomason.htm

[15] Barker C, Green A (1 996), Opening the debate on DALYS. *Health Policy and Planning* 11(2): 179-183.

[16] Collins CD, Green AT, Hunter DJ (1994), International transfer of National Health serive reforms: problems and issues. *The Lancet* 344: 248-250.

[17] Cooper RC, Osotimehin B, kaufman JS, Forrester T (1998), Disease burden in subSahai-an Africa: what should we conclude in the absence of data? *The Lancet* 351: 208210.

[18] Herrin A., Thomason J. (1997), Health sector reform in Asia: policy and research issues. Proceeding of regional conference on health sector reform in Asia, May 22-25, 1995. Asia Development Bank.

[19] The Ljubljana Charter on Reforming Health Care. *British Medical. Journal* 312: 16641665.

SOCIAL INEQUALITIES AND MORTALITY IN ITALY

Dr. Giuseppe Costa

A question of relevance

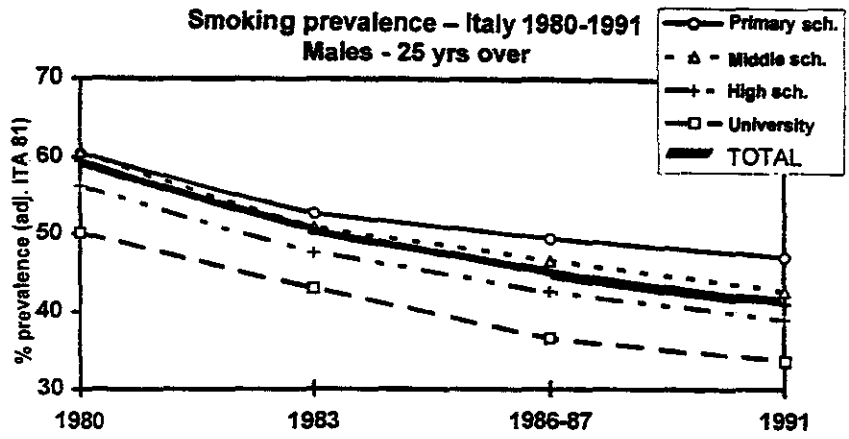
In a debate on health care reform and financing it is necessary to submit some simple questions of relevance, in order not to forget which is the mission of health policies. Is health care able by itself to improve health in the population? Are different ways of financing it so relevant to modify the epidemiologic profile of the population? Health in the population being defined as the occurrence of diseases and the ability to survive to them with a good quality of life.

Geographic studies did not demonstrate any correlation between health care supply and life expectancy in western countries. United States spend 50% more than other OCSE countries in health care and show one of the worst life expectancy and perinatal mortality profile. In Italy cross-regional differences in aggregate health indicators (favouring the south) are weekly related to per-capita health expenditure and health service supply (favouring the north).

It has been estimated that no more than 15% of the 30 years of life expectancy gained in this century by western populations has to be attributed to health care. Of course this does not mean that medicine and health care are irrelevant: the improvement of survival and quality of life correlated to surgery of, for instance, varicose veins, cataract, coronary disease, hip joint replacement, are fundamental.

While medical services have had in the past a significant effect on health, the current marginal contribution of health care on health appears to be slight. Other determinants are to be considered, biology, lifestyles, and stressful environments. A re-allocation of resources towards health promoting and prevention programs and a reinforcement of intersectoral policies are required.

However the results of these programs rise very interesting questions. For instance, health promotion campaigns for smoking, the single more influencing cause of diseases, have been followed by a decrease in smoking prevalence among males since the early 80s; but this decline was deepest among the more educated, widening inequalities.



Similarly, advances in health care have improved the survival of several cancers responsive to effective treatment, for instance lymphoaemopoietic cancers or large intestine cancers. But at the end of the 80s this improvement was concerned only among the upper classes. Having a colon cancer during the 80s in Turin, a one million people industrialized city of the north-west of Italy, with a modem-egalitarian-free-of-charge health care system, was implying an Sexcess risk of dying for the less educated of more than 50% compared to the more educated.

RR* INCIDENCE (INC), LETALITY (LET)
AND MORTALITY (MOR)
TURIN 1980' S
MALES

EDUCATION	COLON-RECTUM			LYMPHOMA AND LEUKEMIA		
	INC	LETş	MOR	INC	LETş	MOR
UNIVERSITY	1	1	1	1	1	1
HOGH SCH.	0.54*	1.24	0.99	0.81	1.46	1.02
MIDDLE SCH.	0.59*	1.33	1.08	0.85	1.85	1.44
PRIMARY SCH.	0.48*	1.48	0.92	0.81	2.08	1.37

$P < 0.05$
§ = M+F

Most of the variables influencing quality of care or effectiveness of prevention (timeliness of intervention, appropriateness of protocols, etc.) have a different distribution across social classes, producing a relative advantage in favour of groups that are able to use health care and health promotion opportunities in a more effective way. Thus even if free access to interventions is assured to all citizens, it may be expected that the weakest use less adequate services than the
richest, because of non income factors influencing health.

The new question is: are health care policies concerned with such social differences? The answer is: yes, because they represent the easier and the more effective way to define health objectives. If somebody performs better than other, than it means that it is possible to improve the health of the population by reducing such differences between the two. How? Tackling the determinants of such inequalities in health.

For this reason a reduction of inequalities in health is now a priority for several European governments. Also the Italian Government has expressed its concern about inequalities in health and has translated this concern into a central premise of its National Health Strategy (Ministero della Sanita', 1998).

In my communication I will address this issue, reviewing and summarising the epidemiologic evidence of existing inequalities in health, and discussing how much remediable they are, providing an appropriate agenda of policies that can be defined and given priority.

Inequalities in health: a European perspective

An editorial in The lancet in 1997 described social variations in health as the "United Kingdom's biggest issue" (Editorial, 1997). A recent European cross-national comparative analysis uncovered similar inequalities in all European countries, showing a stepwise increase of the risks of ill-health and premature death with decreasing socio-economic standing (Mackenbach et al, 1997). Relative risks of the lowest socio-economic group compared to the upper one were ranged for morbidity between 1.5 and 2.5 and for mortality between 1.3 and 1.7, with significant variations between countries. The figure plots the average rank of relative inequality in morbidity and in mortality of each country.

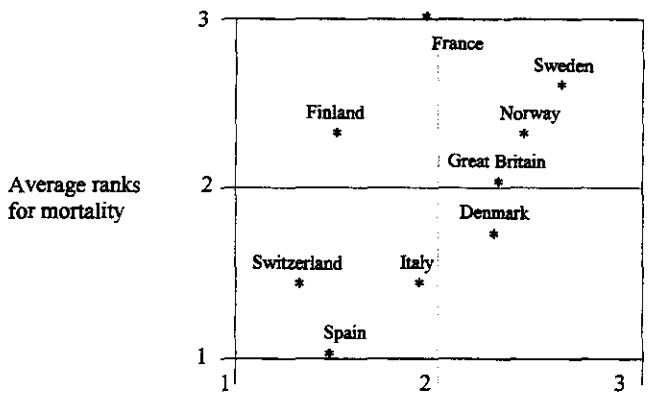


Figure 2: **Average ranks for morbidity and mortality**

Latin countries show an average rank lower than Nordic ones, challenging the conventional view on the relation between societal characteristics and the size of inequalities. These data do not support the hypothesis that relative inequalities in health are smaller in countries with social, economic and health care policies more influenced by egalitarian principles, such as Sweden and Norway. Indeed the size of absolute inequalities in these countries is smaller, because both high and low groups benefit of egalitarian policies; but relative inequalities do not seem to have been affected. Lack of data comparability may have biased such inter-countries differences. Moreover inequalities observed in the 80s are determined by socio-economic differences in lifetime exposures, that have different time patterns in different countries.

In addition to this general pattern of inequalities in health, there is a growing concern that inequalities are widening in some countries (Sweden, Finland, United Kingdom, Denmark and Spain) (Drever, 1996).

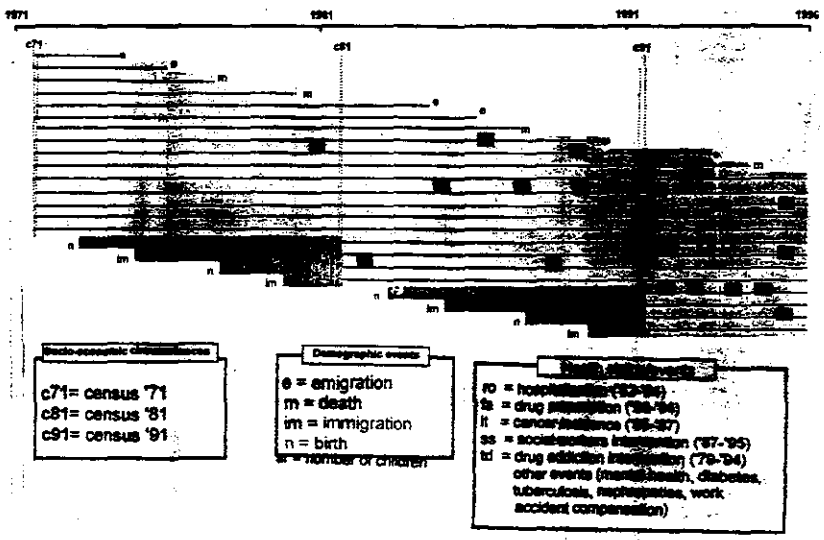
What about Italy during the 90s? I will review the latest available information on inequalities in health in Italy, using the best available data set, the Turin Longitudinal Study, a local study.

The Turin Longitudinal Study (TLS)

The TLS is the most comprehensive study on inequalities in Italy: it is based on individual data on socio-economic status, it is concerned both with mortality and morbidity; it has a long longitudinal view dating back from 1971, being able to demonstrate the dynamic intersection of several factors in a life course perspective; and it

may provide estimates with sufficient statistical power; finally its socio-economic context is well studied. The more fragmentary evidence at the national or local level is substantially consistent with the one coming out from the Turin Longitudinal Study. Moreover it may be interesting to look at the TLS as a model of an information system specifically designed to monitor variations in health.

The TLS is an integrated information system implemented in Turin in order to support a communication network among administrators, professionals and non professionals; its objectives are to identify and monitor the social processes that cause variations in the health of the population of the City and to support objective-based planning (Costa et al, 1998).



The TLS was established to monitor inequalities in health in the Turin population by combining census data, vital registration records and medical records. The study is based on all subjects who were resident in the City at least in one population census (1971, 1981, 1991). More than half a million people were present in all of the three censuses; more than seven hundred thousand at two; about one and a half million people joined the TLS at least in one census. Less than 3% of people enumerated were not traced in 1981 and 1991 population registers; in 1971 the proportion was higher (15%) because of the poor quality of both sources at the very beginning of the computerisation; however the social distribution of the unlinked was not significantly different from the linked ones, implying a loss of observation but not a bias in the measure of the differentials.

Several indicators are derived from individual variables, such as economic position and occupation, education, social class, status inconsistency, family status, housing quality, migration history, at individual and household level. The local health information systems provide data on health related issues, such as causes of death and morbidity data. Main limitations of TLS are the poor quality of data collected for administrative or statistical purposes; and the losses of people emigrating out of the City, the vital status of which cannot be followed up (a follow up of a 5% sample of these emigrants demonstrated that a health migrant effect is working, but that it is randomly distributed).

The data presented in this paper are concerned with mortality in 1971-95. Specific causes of death have been selected in order to indirectly evaluate the contribution of specific explanations of inequalities in health, for instance: lung cancer for smoking, opiate overdose for damage reduction policies, work accidents for safety risks, causes amenable to effective treatments for inequalities in access to health care, etc.

Inequalities in mortality in Italy

I will try to point out the main characteristics of inequalities in health that are listed in the next figure, by showing some example from the TLS.

SOCIAL INEQUALITIES IN HEALTH

REGULAR

WIDENING

CONSISTENT

INTERACTING

RELATIVE DEPRIVATION

ABSOLUTE DEPRIVATION

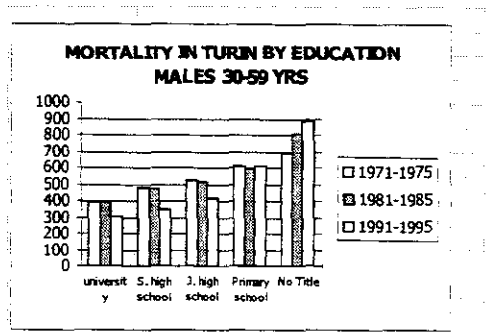
AVOIDABLE

NEW ENTRIES

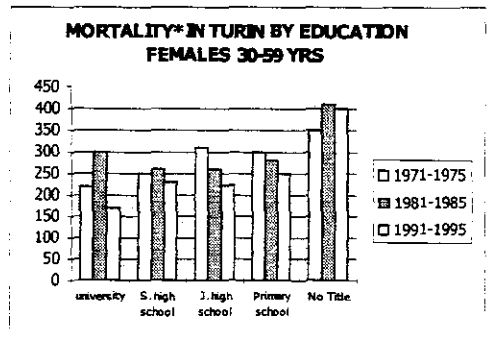
EXPLANATIONS

In the next figures temporal trends of mortality rates according to education are described. Male adults mortality increases regularly from more educated to less educated and, what is more worrying, inequalities seem to widen from 70s to 90s: a fall in mortality rates over the 70s to the 90s is observed for people with at least a compulsory level of education; while the mortality rates of people with a primary

school degree or lower were unchanged or even higher in the 90s than twenty years earlier. Not only the differential between the top and the bottom increases, but the increase happens also across the whole spectrum of educational levels.



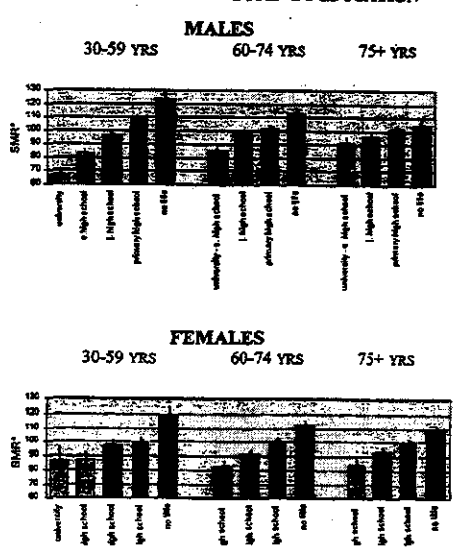
* rates, age and area of birth adjusted



* rates, age and area of birth adjusted

The relation of mortality to education in all ages and genders may be seen in the next figure, showing the SMR'S; SNM equals 100 for the mortality of the general Turin population with the same age distribution. The educational gradient is steeper in the age-group 30-59 and is more pronounced in men as compared to women. It is then weeker among elderly of both genders, because of selection of survivors and of cohort effects.

1981-95 MORTALITY IN TURIN BY EDUCATION



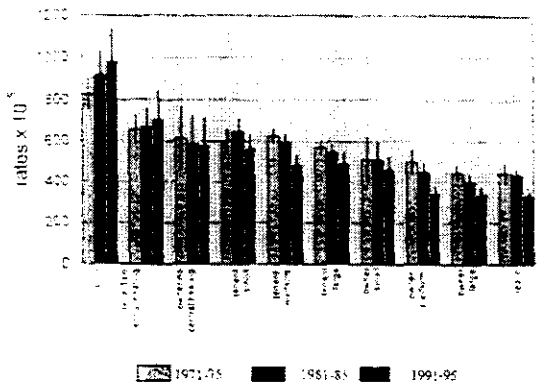
As a first character, inequalities seem regular and linear along the social scale and persisting or even widening with time.

Education is an indicator of cultural resources of an individual. A number of different measures can be used to indicate socioeconomic position. Inequalities in health exist whether categorised by different socioeconomic measures.

The next figure analyses mortality rates among male adults according to a composite index of housing quality (an indicator of material resources), ranging from people living in houses lacking basic amenities, to tenants, from small to large flats, to owners, from small to large houses, to houses in ownerships, large and with several amenities. Mortality increases linearly along the scale of this index, and differentials widen from 70s to 90s.

MORTALITY' IN TURIN BY HOUSING QUALITY

MALES 30-59 YRS



rates* , age and area of birth adjusted

Social class is an another socio-economic measure, indicating the availability of resources in power. Next figure describes the mortality among males in working age according to household social class: during the 90s the working class had a 55% mortality excess compared to upper class. Unskilled manual workers of the services showed the worst mortality profile among males, with about three years of difference in partial life experience compared to managers. Even in this case the mortality rates of working class have fallen from the 80s to the 90s slighter than the upper and middle class ones.

MORTALITY (RR*)' IN TURIN 1991-94 ACCORDING TO HOUSEHOLD SOCIAL CLASSIFICATION MALES 18-59 yrs

SOCIAL CLASS	RR
BOURGEOIS CLASSES	0.89
WHITE COLLAR WORKERS	1
SMALL OWNERS, CRAFTSMAN , TRADERS	1.23*
MANUAL WORKERS	1.23*

(1) RR age and area of birth adjusted

* $p < 0.05$

MORTALITY (RR*)' IN TURIN 1991-94 ACCORDING TO HOUSEHOLD SOCIAL CLASSIFICATION FEMALES 18-59 yrs

SOCIAL CLASS	RR
BOURGEOIS CLASSES	0.99
WHITE COLLAR WORKERS	1
SMALL OWNERS, CRAFTSMAN , TRADERS	1.27*
MANUAL WORKERS	1.21*

(1) RR age and area of birth adjusted

*$p<0.05$

As a third comment we can say that these analyses reveale a consistent pattern of stepwise increased risk according to lower cultural, material and occupational standing. In the next table an alternative description of the absolute impact of such inequalities is summarised.

DEATHS (%) IN TURIN ATTRIBUTABLE TO DIFFERENCES IN...

		EDUCATION	HOUSING QUALITY	SOCIAL CLASS	FAMILY STATUE
MALES 30-59 YRS	1971-75	39	26	-	9
	1981-85	30	21	(19)	12
	1991-95	39	26	30	20

DEATHS(%) IN TURIN ATTRIBUTABLE TO DIFFERENCES IN...

		EDUCATION	HOUSING QUALITY	SOCIAL CLASS	FAMILY STATUE
FEMALES 30-59 YRS	1971-75	25	21	-	11
	1981-85	-1	17	(4)	15
	1991-95	17	19	16	15

If all individuals had the same death rates as those with university degree, it is estimated that each year from 1991 to 1995 there would have been 39% and 17 % fewer deaths among male and female adults respectively. If all individuals had the same death rates as those living in better houses, it is estimated that each year from 1991 to 1995 there would have been 26% and 19 % fewer deaths among male and female adults respectively. And if all individuals had the same death rates as those of upper bourgeoise classes, it is estimated that each year from 1991 to 1995 there would have been 30% and 16 % fewer deaths among male and female adults respectively.

The size of such inequalities for the Beirut population could be described as one of a big plane crush occurring each week. Moreover such percentage of deaths attributable to social inequalities should be added to the one attributable to differences in family resources: 20% and 15% of deaths among males and females adults would have been saved if all individuals lived in married couples with children.

A new conclusion must be listed in our summary table: inequalities interact each other, with the effect of increasing the disadvantage in health.

Let's move to the discussion about relative and absolute deprivation. Are such inequalities caused by poverty or by relative disadvantages? The answer is both. In the

next table differences in partial life expectancy within white collars are described according to class inconsistency. Individuals with education or housing quality not adequate to their social position show a shorter life expectancy than individuals with status consistency.

**PARTIAL LIFE EXPECTANCY (30-80 YRS)
IN TURIN 1981-95
AMONG WHITE COLLAR WORKERS**

STATUS CONSISTENCY*	PARTIAL LIFE EXPECTANCY
CONSISTENCY	**45.9**
MILD INCONSISTENCY	**45.6**
HEAVY INCOSTENCY	**45.1**

It is quite evident that relative deprivation is active: for any social indicator measured on an ordinal scale it is possible to observe differences in favour of the more advantaged compares to the group immediately less-advantaged, whichever level is considered Nevertheless, absolute deprivation is active too. The underprivileged groups, suffering material deprivation, show dramatic effects on mortality. Next figure describe the relation between mortality and unemployment. Being one the general mortality of males in working ages during the 90s, each new spell of unemployment during the last twenty years increases significantly the risk: four spells give rise to a more than threefold risk.

**1991-95 MORTALITY* IN TURIN
BY EMPLOYMENT STATUS**

NUMBER OF SPELLS OF UNEMPLOYMENT ('76 - '91)	MALES 18 - 59	
	SMR	IC 95%
None	**92**	89 - 96
One	**121**	109 - 134
Two	**182**	154 - 213
Three	**228**	178 - 288
Four	**322**	244 - 416
219.735 SUBJECTS IN WORKING AGE SCRIPT	**100**	

* SMR age and area of birth adjusted

1991-95 MORTALITY IN TURIN BY PATTERNS OF EMPLOYMENT IN THE LAST 20 YRS MALES 18-59 YRS

Patterns of employment 1976 - 1991	RR*	IC 95%
from school to employment	0.83	0.70-0.98
always employed	1	-
from unemployment to employment	1.22	0.95-1.58
instability between empl. - unempl.	1.29	1.09-1.52
From employment to retirement	1.93	1.76-2.12
from employment to unemployment	2.30	1.96-2.72
always out of the work-force	2.86	2.36-3.46
always unemployed	3.46	2.55-4.96
discouraged in looking for a job	4.31	3.58-5.20

* age and area of birth adjusted

The same dramatic impact may be observed for people standed by the social workers of the municipality (handicapped, disabled, unemployed, drug dependents, financially constrained). In the next table life expectancy of these groups show huge disadvantages when compared to the one of people not assisted by social services.

LIFE EXPECTANCY IN HOUSEHOLDS STANDED BY SOCIAL WORKERS TURIN 1991-96

YEARS OF LIFE LOST COMPARED TO PEOPLE NOT STANDED	MALES (6223)	FEMALES (7016)
AT 0 YEARS	-13	-7
AT 20 YEARS	-13	-7
AT 35 YEARS	-9	-6
AT 65 YEARS	-2	-2

The penalties of inequalities in health affect the whole social hierarchy and usually increase from the top to the bottom. Thus, although the least well off may properly be given priority, if policies only address those at the bottom of the social hierarchy, inequalities will still exist.

Are there any evidence that these differences could be avoided? Yes, in our data mortality among children and adolescents 1-14 years old was unequally distributed during the 70s, and is now uniformly distributed, according to mother's education. In this age group injuries are the prominent cause of death, and less privileged children should have benefit from improvement of safety in the City more than their richer counterpart.

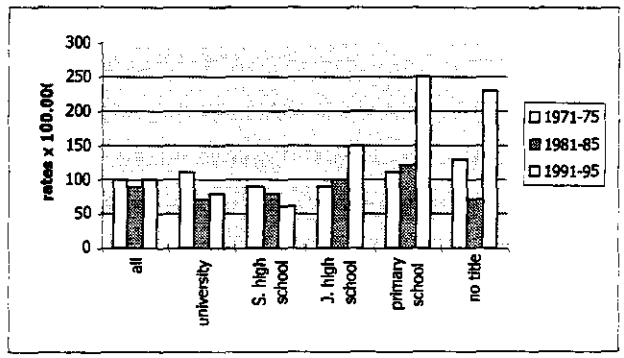
1991-95 MORTALITY IN TURIN AMONG MALES CHILDREN AND ADOLESCENTS (1-14yrs)

MOTHER'S EDUCATION	SMR 71 - 75	IC 95%	SMR 81 - 85	IC 95%	SMR 91 - 95	IC 95%
University	**47**	15-109	**94**	40-187	**92**	25-236
S. high school	**66**	54-130	**74**	43-117	**110**	55-198
J. high school	**77**	55-106	**100**	72-135	**95**	52-159
Primary school	**121**	99-147	**103**	72-144	**111**	12-402
No title	**119**	69-190	**291**	116-601	-	-

On the contrary inequalities in the 90s show a new entry. In the next figure mortality rates among young people (15-29 years old) are related to mother's education: in this age group the general mortality has not improved with time and social inequalities have deeply widened, mostly due to opiate overdose and Aids epidemic among less educated families.

MORTALITY* IN TURIN BY HOUSEHOLD EDUCATION, CALENDAR PERIOD AND GENDER.

MALES 15-29 YRS

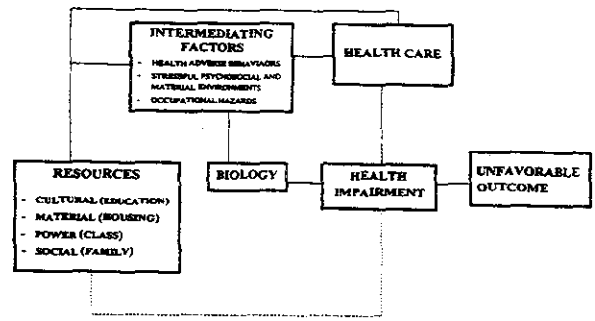


* rates, age and area of birth adjusted

EXPLANATIONS

All these attributes of inequalities in health make them a good. candidate for the agenda of priorities. But are these inequalities explainable and can be opposed by specific policies?

The next figure gives an explanatory framework. Lack of resources (cultural, material, relational, familial and social) must determine differential exposure to intermediate factors that interact with biology in order to damage health. At the same time lack of resources may reduce the ability of health care (timely access to appropriate and safe care) to face health impairment? The occurrence of an unfavourable outcome is the result of such process that may be stopped. It is the. challenge of research to sort through the complexity of causes of inequalities in health in order to determine where the chain of causation could potentially be broken. But some key intervention points to reduce inequalities may be suggested by the available evidence.



Mortality from specific causes of death may help us to outright these intervention points. A few important causes of death show the higher correlation to social indicators. In liver cirrhosis about 70% of cases among adults of both genders is attributable to differences in education: it means that excessive alcohol intake is a strong inter-mediator of the effect of inequalities in mortality, a potential objective of selective health promotion intervention.

1981-95 DEATHS (%) IN TURIN ATTRIBUTABLF, TO DIFFERENCES IN EDUCATION

	MALES			FEMALES		
	30-59	60-74	75+	30-59	60-74	75+
STOMACH	54	46	29	67	64	40
LUNG CANCER	46	31	10	-1.6	-6	-8
CANCER OF COLON- RECTUM	9	-11	8	-11	13	20
BREAST CANCER				-7	-19	-15
DIABETES	45	25	-11	100	46	34
ISCHAEMIC HEART DIS.	24	0	-12	47	26	21
CEREBROVASCULAR DIS.	34	13	10	36	23	16
RESPIRATION DIS.	53	34	11	47	26	13
LIVER CIRROSHIS	69	40	26	71	53	21
OVERDOSE	(33)	-	-	(100)		
SUICIDE	7	26	31	-8	57	44
HOMICIDE	20	-25	-	20	100	100
TRANSPORTION ACCIDENTS	3	19	13	-24	7	-8
WORK ACCIDENTS	55	22	17	-88	25	33
AVODAIBLE CAUSES	33			41		
OTHER CAUSES	32	13	13	8	13	12

Work accidents among males in working age demonstrate the second higher percentage of deaths attributable to social differences: 55%. Occupational risks for safety and health represent a strong mediator of the effect of inequalities, and are a potential objective of selective occupational control and prevention intervention.

About 50% of deaths from stomach cancers and respiratory diseases and 20-40% from cardiovascular diseases and 50-100% from diabetes are related to socio-economic differences. These causes are related to the cumulative differential exposure to health damaging or health promoting environments, starting with deprivation in childhood or even in intrauterine and perinatal age and proceeding to adult exposures to environmental and behavioural risk factors. These causes point to the responsibility of policies of health promotion, of material and social support for mothers and families, and of selective health promotion targeted to underprivileged adults.

Lung cancer with more than 40% of attributable cases among males and less than 0% among females is an indicator of the role of smoking, the social distribution of which is in favour of more educated among males and of less educated among females. Also ischaemic heart disease among males shows inequalities of different size and direction according to age, due to different social distribution of patterns of eating, smoking, drinking and physical activity. Among the older cohorts smoking, sedentarily lifestyles and high-fat-low-vegetables-low-fiber diet used to be more common among upper classes; on the contrary younger cohorts of upper classes began earlier to stop smoking, to make exercise, and to change diet as a result of health promotion. This is again the paradox of health promotion, that benefits more the upper classes: more selective reinforcement must be devoted to lower classes with specific policies.

An increase in illicit drug use or in susceptibility of poor drug users may account for the findings of high mortality from Aids and overdose among lower educated families. Policies of damage reduction must be strongly socially oriented.

About 30% of a variety of diseases for which a substantial proportion of deaths are potentially avoidable by medical intervention are socially related. Interventions to promote equal availability and improve effectiveness of medical care will be necessary to reduce inequalities and to enhance health.

The possibility of artefacts due to selection should be considered. Ill health may be more common in people of lower socio-economic class, because it acts as a barrier to upward mobility or it leads to downward mobility. The question is relevant in order to explain inequalities in health and to identify potential discrimination in social opportunity. The social mobility between 1981 and 1991 in the TLS has been related to the previous health status of an individual, as measured by hospitalisation between 1983 and 1989. Upward and downward age-adjusted occupational mobility were respectively reduced and enhanced among ill individuals compared to the not ill ones. The size of differences was about 10-15% and varied according to the occupational position in 1981.The same differences were observed for the attainment of an educational title among young people between 1981 and 1991. A discrimination in social mobility based

on health selection may be demonstrated with these data. However it is of a too small size to be able to influence the direction and the size of inequalities in mortality we observed before.

OCCUPATIONAL MOBILITY IN TURIN AMONG HOSPITALIZED COMPARED TO NOT HOSPITALIZED MALES 30-59 yrs

OCCUPATIONAL POSITION IN 1981	OCCUPATIONAL MOBILITY 1981-91[1]	
	DOWNWARD	UPWARD
CONTRACTORS	1.19	0.91[2]
PROFESSIONALS	0.71	1.07[2]
MANAGERS	1.26*	0.95[2]
MIDDLE CLASS	1.21*	0.87*
PETITE BOURGEOISE	1.09	0.88
WORKING CLASS	1.04*[2]	0.82*
WORKING CLASS	1.15*[3]	
UNEMPLOYED	1.05[2]	0.97

EDUCATIONAL QUALIFICATION AMONG YOUNG PEOPLE (15-29YRS) HOSPITALIZED COMPARATED TO NOT HOSPITALIZED

EDUCATION QUALIFICATION			RR[1]
1981		1991	
JUNIOR HIGH SCHOOL	-	SENIOR HIGH SCHOOL	0.84
SENIOR HIGH SCHOOL	-	UNIVERSITY	0.66
JUNIOR HIGH SCHOOL	-	UNIVERSITY	0.60

* $p < 0.05$

(1) RR of other hospitalization vs never hospitalized, standardized by age

(2) Stable

(3) Unemployed

Recommendations

Inequalities by socio-economic groups can be demonstrated across a wide range of measures of health and of determinants of health. Across the last two decades Italy has got richer and healthier but inequalities in income and in health have widened markedly. Variations in health could be a serious barrier to the achievement of health targets launched by the National Health Strategy of the Government. Tackling inequalities in health appears an essential prerequisite for wider gains in health. Provided that inequalities in specific causes of death suggest that many of these inequalities are explainable and remediable, which conclusions may we recommend?

ASK FOR ...

*** POLICES**
INTERSECTORAL
LOCAL

*** HEALTH SERVICE**
EQUITY IN ACCESS TO HEALTH CARE
ADVOCACY"ROLE

*** RESEARCH**
COMMON LANGUAGE
FOR EPIDF-MIOLOGIC,
AND SOCIAL RESEARCH
LIFE COURSES, STRESSFUL ENVIRONMENTS,
MACROSOCIAL DETERMINANTS

*** INFORMATION SYSTEM**
DEPRIVATION INDEX

*** COMUNICATION**
"ALWAYS EXISTED"
"PARTISAN ISSUE?"

*** SOCIETY**
AUTORITY FOR EQUITY"

It has become clear that the range of factors influencing inequalities in health extends far beyond the remit of the National and Local Health Service, and that a response by the National and Local Government levels as a whole will be needed to deal with them. Multiple causes points to the need for wide-ranging intersectoral policy solutions. In the light of the evidence of inequalities in health, a UK Independent Inquiry chaired by Sir Donald Acheson has conducted a review to identify priority areas for future policy development (Acheson et al, 1998). Some of them offer evidence-based-opportunities for National and Local Governments to develop beneficial and affordable interventions to reduce health inequalities. Some policies will deal with wider influences on health inequalities such as income distribution, education, public safety, housing, work safety and hygiene, employment, social networks, transport and pollution. Some other policies will have narrower range of benefits, such as on health behaviours. The underlying message of this Inquiry is for "a broad front approach": a package of policies that target these levels of influence in a concerted and co-ordinated way. The local level is the one that provides more concrete and specific form to the formulation of objectives and to the development of institutional, professional and social networks able to pursue them.

Figure 3: Three examples of recommendations of the Independent Inquiry

- uprating of benefits and pensions according to principles which protect and. where possible. improve the standard of living of those who depend on them and which narrow tie cap between their standards of living and average living, standards
- further measures to improve the nutrition provided at school. including the promotion of school food policies. the development of budgeting and cooking, skills. the preservation of free school meal entitlement. the provision of free school fruit and the restriction of less healthy food
- the further development of the role and capacity of health visitors to provide social and emotional support to expectant parents. and parents with young children

What can the health care system do? Of course it must ensure equity in access to health care. Equity should be a requirement of quality to be taken in account in each application for financing health care programs.: no resources without an assessment of equality of access and utilization of appropriate health care and without the identification of procedures able to tackle inequalities during the program.

But the health care system should also play the role of advocacy in the society, providing evidence of inequalities and of their causes: local communities must be informed and urged to initiate programs for cities healthier and less unequal.

The society at a general extent should ask for an independent agency able to monitor inequalities and the impact of policies.

Usually the information system is inadequate to monitor inequalities. In most countries only geographical variation may be surveyed. But geographical variations may be uninformative because of the influence of other determinants of health distribution. Information systems should be revised in order to be able to report on inequalities both at the individual level (like the TLS model), a quite expensive solution, or at an aggregate level, using the model of the deprivation index. A small-area-based-social-class indicator represents a valid and useful approach to overcoming the absence of individual data on socio-economic status and it allows neighbouring markers of social class to be taken into account. In the TLS we compared inequalities measured at individual or aggregate level. The direction of the two estimates is the same and the size of differentials is only slightly underestimated in the case of aggregated data, due to ecological bias.

1981-85 MORTALITY* IN TURIN AMONG MALES ACCORDING TO THE LEVEL OF SOCIO-ECONOMIC DEFINITION

INDIVIDUAL LEVEL: EDUCATION (30-59 YRS)	SMR	SMR	GEOGRAPHICAL LEVEL: DEPRIVATION INDEX (15-64 YRS)
UNIVERSITY	71	80	VERY LOW
S. HIGH SCHOOL	83	96	LOW
J. HIGH SCHOOL	97	102	MEAN
PRIMARY SCHOOL	107	102	HIGH
NO TITLE	128	122	VERY HIGH

(*) age and area of birth adjusted

What about research? The agenda of research on inequalities ask for both political and scientific initiatives. Good research is available in countries where a common language has been created between epidemiology, social sciences and economy. A common language means methods, data bases, procedure of financing. Three main selected explanatory frameworks offer most promise for scientific advances: life courses influences on health, health effects of stressful environments in adult life, and macrosocial determinants of morbidity and mortality (Graham et al, 1998).

Finally the media should avoid two insidious traps. "Inequalities always existed!": it is a not-news, probably an anti-news, nobody would matter. "Inequalities are a partisan issue" and not an issue of the whole community: it is a weapon for the politics, but it is impossible to be performed into concrete bipartisan policies.

These are the reasons why and the instruments with which we must give priority to improve the health of those in poorest circumstances and with the greatest health needs. The National Health Strategy of the Italian Government ask each actor of the scene, public health above all, to do their job in developing concrete interventions to tackle inequalities in health.

References

- Editorial. health inequality: the UK's biggest issue. The Lancet 1997; 349:1185.
- Mackenbach JP, Kunst AE, Cavelaars AEJM, Groenhof F, Geurts JJM. EU Working Group on socio-economic inequalities in health. Socio-economic inequalities in morbidity and mortality in western Europe. The lancet 1997; 349:1655-1659.
- Drever F, Whitehead M, Roden M. Current patterns and trends in male mortality by social class (based on occupation). Population Trends 1996; 86: 15-20.

- Ministero della Sanità. Piano Sanitario Nazionale 1998-2000. Un patto di solidarieta per la salute. Roma, Ministero della SanitA, 1998.

- Costa G, Cardano M, Demaria M. Torino. Storie di salute in una grande citts. Torino, CittA di Torino, Ufficio di Statistica. 1998.

- Graham H, Mackenbach J, Marmot M, Siegrist J, Theorell T. European Science Foundation (ESF). Social variations in health expectancy in Europe. A proposal for a ESF scientific program in SCSS and in EMRC. September 1998.

- Acheson D et al. Independent Inquiry into Inequalities in Health. London. The Stationery Office, 1998.

Public Hospital Autonomy in Lebanon: Legislation.

Dr Issam Nadim Moubarak [1]

Introduction

The actual civil and urban development dictates on each nation to update itself, through the issuing of new laws and modernizing its old ones to fill the gap that might cause the passing unchanging years. This could be done by creating non-public establishments that can help the public sector and make use of private sector experience without being private [2].

By changing and modernizing its laws, Lebanon has tried to meet this development trend alike other countries. In fact not only political issues had been reviewed in TAEF agreement, but interior administrative matter had been examined too, in addition, to evenly important matter such as organization. This was done by setting a number of general guidelines concerning those matters without going deeply in details and leaving this task to the ruling system of the country.

Our main concern of above reforms is the issues related to decentralization, which may induce the modernization of the internal organization. Because the decentralization is a mean that helps in improving services performance and it focuses on distinguished features of life priorities [3].

In this frame more care was given to one feature of the decentralization which is the decentralized Service Sector that implies the creation of Public Establishments (PE) to manage vital public sectors [4].

Above was becoming imperative especially that the centralized administration had experienced many gaps in administration efficiency, whether in job performance, while serving the citizens, or in the mutual contact between those citizens and public administrations [5].

---

[1] Ph.D. degree in laws. University Professor and lawyer

[2] In the same frame:"these changes meet the same fundamental need of adaptation; handling differently what had became very complicated, create an authority level enabling to be more responsible." Michel Crozier: A society cannot be changed by a decree, Crasset edition 1979, p.65.

[3] "If decentralize does not entail management improvement, decentralized management remains as similar as its domain of activity." Jacques Baguenard, La decentralisation, P.U.F. Que sais-je 1980., p.78.
See also, "Comissariat General du Plan: Pour un Etat garant de l'Interet General, French documentation, the commission report" Etat, administration et service publique de l'an 2000, janvier 1993.

[4] See, in the same issue, L.Roche, J. Sabatini et R. Serangue Fontenne, L'economie de la santé, P.U.F. Que sais-je 1982, pp. 57 et s.

[5] See Issam Moubarak, Lebanon; L'Etat et la Dcentralisation, these Paris, 1996. Within the same argument, Y. Prats consider that there is an effort waste caused by a centralized system". Development and decentralization, Bulletin l'I.I.A.P, edition Cujas 1973, p.11.

What is the Decentralized Sector? Purposes of the creation of Public Establishments (PE): the Decentralized Service Sector is one of the systems by meaning of which vital public sectors are managed. This could be done by the foundation of Public Establishments (PE) whose moral entity as well financial and administrative independent status is granted by the law [2].

The foundation of the Public Establishments (PE) for the management of Governmental Hospitals is dictated by the following:

1. Involve the executive organism of the Public Heath Sector in the managerial activity in such a way to motivate him doing his best for the welfare of the mentioned sector [7].

2. Encourage peoples to give financial helps to a health public sector that enjoys of a moral entity. Thus, the donor will contribute generously, being confident that his money will be invested to achieve the goals he is looking for.

3. The management of this public health sector will be held by qualified peoples, moreover it will enjoy of moral entity as well as financial and administrative independent status [8]. Doing so, it will be kept away of political interference's. Section one: Foundation of Public Establishments (PE) for the management of Governmental Hospitals:

[2] It could be considered as a daughter establishment of bigger public structures. Its active peoples as well potential resources enables it to carry out some of heavy public structure tasks, without being completely independent.
Administrative ruling system –Chafic Hatem- Al ahliya edition and publishing 1985, p. 36.Lebanese Legislation states the Public Establishments (PE):
Legislative decree Nr. 9 of 23/12/1954 concerning Accounting Department
Legislative decree Nr. 10 of 19/12/1954 concerning Public Accounting .
Legislative decree Nr. 150 of 12/6/1959 concerning Independent Business .
Legislative decree Nr. 6474 of 26/1/1972 concerning General System of Public Establishments .
Legislative decree Nr. 4517 of 13/1/1972 concerning foundation of Public Establishments for the management of the Ministry of Health hospitals (subject of this study) .

[7] See, X. Frege, la decentralisation, la decouverte edtion, C, Reperes, 1986, p. 34.
[8] "Being a moral person it has access to Jurassic world. Enjoying of rights and duties it can accomplish all acts resulting of this real existence, coming of an inheritance and getting more responsible. Being moral person of public right, it can make use of prerogatives of public power". Jacques Baguenard, La decentralisation, op.cit. p. 46.

1. Definition of Public Establishments (PE) for the management of Governmental Hospitals:

In Lebanese legislation above definition was not mentioned at all. even in the modified act # 544 of 24/7/1996 [9] that legitimates the foundation of Public Establishments (PE) for the management of Governmental Hospitals enjoying of moral entity as well as financial and administrative independence but under tutelage of the Ministry of Public Health (MPH).

We shall list the elements [10] which make of this establishment at least theoretically independent.

By defining the PE, the following elements shall be considered:

First element: the moral entity is the basic requirement for the foundation of administratively as well as financially independent Public Establishment[11] which will allow the experienced peoples to act freely of central administration interference. In that way, the Establishment own funds will be used only to achieve the Establishment goals. But, independent financial status alone does not involve its moral entity thus, its administration will not be treated as Public Establishment.

Second element: the goal for Public Establishment foundation is the management of Public Health Hospitals which is a public specialized service sector [12].

Third element: dependence of this Public Establishment of another moral entity structure (Ministry of Health or Finance) will imply the tutelage and financial control of the last structure as we shall see later.

---

[9] Lebanese legislation gradually has defined how to start a PE. The second article of legislative decree nr. 150 of 12/6/1959 concerning the PE, states that foundation these PE should be legitimated by law. Same as per decree nr. 6474 of 5/8/1997 violation of these decrees to facilitate the foundation procedure was done in decree nr. 4517 of 13/12/19972 according to which all PE are founded, merged and dissolved by decree issued by the cabinet.

[10] Rene connois, La Notion d'Etablissement Public en droit administratf francais, These Paris, L. G. D. J. 1958, pp.13 et s.

[11] "We recognize two basic aspects of the PE: A personalized public service and a clear inheritance dedicated for the expenditures of that service". Jeze, Principes generaux de droit administratif, 1930, T.II, pp. 24 et s. Same argument, see, Bonnard traite de droit administratif ,1943, 4 edition, pp. 55, 686.

[12] See, Jacques Chevallier, Le service Public, P.U.F. Que sais-je 1987, p. 79. The results of privatization principle are:

- no other activity is allowed out of Public Establishment foundation charter.
- no illicit funds and contribution are allowed that may commit the Establishment to duties out of its domain of activity and goal.
- The establishment has the right to appeal the judiciary to defe4nd its interests as indicated in the foundation charter.

2. Public Establishment's organization chart and submission to nomination principles[13]

The Public Establishment personality results splitting the Establishment of the Government administration and will follow a centralized system. Special organism will be responsible of the management working on the behalf of the Establishment and under the central power tutelage . the above status is meant to be administrative independence.

The fourth article, of the decree # 11214 of 29/10/1997, has limited the making-decision authority into a nominated administrative authority without mentioning anything about executive authority. Whereas the fourth article [14] of the decree # 4517 of 13/12/1972 concerning the general ruling system of Public Establishments reveals that the last authority is related to a director or general director.

Moreover and under the minister of Heath suggestion, the cabinet nominates a government Commissioner in the Establishment organization. Thus, the making-decision authority, of Public Establishments managing the Governmental Hospitals, is the liability of an administrative council which number of members ranges between three and nine. Whereas the head of this council as well the members are nominated by the mean of cabinet decree, upon Minister of Health suggestion, for a total mandate period of three years [15].

The fourth article of decree # 11214 has listed the administrative council duties and authorities. It is to be noticed that four of above twenty authorities do not require the Ministry of Heath or the Ministry of Finance approval.

They are:

clause 2: "the supervision of medical, administrative financial and hospitalization activities within the hospital".

clause 12: "close the material supply, laboring and services deals that do not exceed the fifty million Lebanese lira. If above total lira amount exceeds the 100 million Lebanese pounds,

[13] Due to the dependence relation-ship between the Establishment and the central power, the representative of the Establishment must comply to the above power injunctions .J.J Servan Schreiber, "le pouvoir regional",Grasset edition, p. 1971, pp. 57-58.

[14] Clause 2 of the first article of the law nb 602 of 28/2/1997 (implying the modification of some rules of law nb 544) states the following: the Public Establishments should comply to the judgments of the decree nb 4517 of 13/12/1972 that deals with the general ruling system of Public Establishment as long as it fulfills above decree judgments.

[15] See for example the decree nb 12962 of 3/9/1998 (nomination of Beirut hospital administrative council) official bulletin nb 40.

then, it should undergo the government control system" (article 10, clause 7).

clause 17: "appealing the court"

clause 18: "sign contracts with Doctors upon the general director suggestion".

The administrative council financial authorities are:

- the suggestion to the Ministry of Health an increase in both financial charges and contribution of patients

- to decide an increase of the charge of services offered to Insurance Companies.

- to decide also an increase of first class hospitalization charges on wealthy patients.

As per the Establishment charter, it should be firstly studied by the Ministry of Health then to be discussed with the Establishment for the final approval by the Ministry.

Concerning the executive authority, as mentioned before, it is held by the Director or a General Director, nominated by the cabinet upon the minister of Health suggestion and after civil service board advise.

However the decree # 11214 of 29/10/1997 has mentioned (in the following articles: 2-5-6-14) the director or the general director position, without specifying neither his nomination procedure nor his authorities. But if we consider that the administration council head is assuming the executive authority, the eighth article does only mention his supervision role.

To be noticed with this regard, that the central authority through the Ministry of Health puts some times pressure on council establishment members even indirectly. As the nominated member will remain subordinate of the authority it have nominated him, he will not act freely neither in starting his job nor in supervising how things are going in the Establishment. Consequently, This will give no meaning for the establishment self-dependent existence [16].

[16] see I. Moubarak, Liban: l'Etat et la Decentralisation. Op. Cit. Pp.291 et s.

3. The restrictions of the Public Establishments self-dependent status

The increasing number of the Public Establishments, the differing procedures on how to start those Establishments, diversity of their duties and charters texts and multiplicity of terminology owing all to same meaning (authority, approval, endorsement and control), has driven the state to set a general organization system for those Establishments defining the prerequisites of their foundation, the role of each of their executive and legislative authorities and the extent of their dependency of the centralized authority (Ministry) through tutelage as well administrative and financial control.

3.1 Administrative tutelage [17]

The Lebanese law, allowing the foundation of Public Establishments does not clearly define the administrative tutelage but it does only mention it and how it is applied. The above tutelage is applied through two complementary procedures:

- The administrative council decisions should be endorsed by the Ministry of Tutelage as per the tenth article of the decree # 11214.
- The nomination of the Commissioner by he Cabinet in the above council and upon the Minister of Health suggestion.

The features of administrative tutelage (by the Ministry of Health) are quite enough presented within two above procedures which will enable consequently the Minister to supervise and control efficiently the Establishments activities.

3.1.1 Administrative tutelage through endorsement of the council decisions.

The need of the administrative council decisions to be endorsed by the Ministry of Public Health (according to the tenth article of the decree # 11214 of 29/11/1997) is considered one of the most relevant aspect of above tutelage. This tenth article lists the twenty decisions needing prior endorsement and of which only four were left with any endorsement need.

The above tenth article has adopted the same endorsement deadline as stated in the general organization system of those Establishments. It states that the Tutelage Authority (Ministry of Health) has to examine and finalize the endorsement matter within one month period starting the day when the decisions had reached the Ministry.

[17] As we noticed, the Lebanese Legislation still use the terminology of Administrative "tutelage" instead of administrative control. It is more advisable to use the last terminology since it gives the real meaning.

It is also stated that the above deadline can be reduced to 15 days i/o 30 days in case of deals. Finally it mentions that the decision will be automatically endorsed once the deadline is expired.

In addition the same article consent to the Tutelage Authority to ask for needed additional written clarifications. For this purpose it allows the renew for a once, of above legal deadline of 10 more days in case of deals and 15 more days for the remaining decisions, starting the day when those needed documentation reach the Ministry.

Whatever the above indicated deadline seem so long, which may harm to the Establishment performance and delay the decisions implementation [18].

To be noticed that the act # 544 which legalizes the foundation of Public Establishments for the management of Governmental Hospitals does not mention neither the case of disapproval of the Ministry nor how this disapproval is practiced. The omission of such above important statement by the law is unjustified especially that the Ministry according to its tutelage right can reject the decisions.

Consequently adequate judicial laws are needed in order to show out clearly where the Ministry has the right to disagree and where the Establishment has the right to justify itself and to indicate the most appropriate third party is supposed to mediate between both parties during the endorsement phase and in case of disagreement.

It would be advisable also to appeal the former ruling systems had been applied and /or appealing the Cabinet to settle the matter.

3.1.2 Applied tutelage through the nominated commissioner

The Government Commissioner is the representative of the Ministry within the administration council of The Public Establishment. The procedure of his nomination as well as his prerequisites and authorities are stated in the articles 12 and 13 of the decree # 11214 of 29/10/1997.

According to same decree, the commissioner must be of the second or third rank of the Ministry's employees.

The necessary belonging of the commissioner to the Ministry's staff, reveals how much is relevant the role of above Ministry within the Public Establishment.

[18] The modern management of the state predicts a shortcut way of any decision..." See decentralization; L'age de la raison, rapport du groupe" decentralisation: bilan et perspectives." Comissariatgeneral du plan, la documentation francaise, 1993, p.46.

As per the commissioner's authorities within the council, they vary from his attendance right to council's meetings to the decisions communication to both Ministers of Health and that of Finance, the Accounting Department and the Central Inspection. Passing through his right to vote, reporting his opinions in the council's meeting record.

To be noticed also that the above same decree # 11214 does not mention any role of the Civil Service Board.

The active attendance as well as participation of the commissioner to the council's meetings (as per his authorities), through the recording of his interventions, will fulfill exactly the scope of his presence in the council: control closely the council activity.

Whereas granting him the decision-making authority, through voting, may on one hand compromise the independent status of the Establishment and on the other hand it may create conflict situation within the administrative council. This is because the tutelage Ministry may approve a decision in which the commissioner has participated actively to issue it.

As the Lebanese legislation states: the council dissolution has to be done in the same way it has been formed, i/e by the law system (see decree # 544 of 24/7/1996), thus, it is of the Tutelage Ministry right to suggest to the Cabinet to dissolute the above council by a decree.

3.2 Ministry of Finance control[19]

The financial independence of Public Establishments does not mean that their fund incomes are treated differently as per states revenues.

Consequently, an unavoidable government control on Establishment's revenues is carried-out (that government has created by a decree) [20]. But this should not also mean that the Ministry of Finance overuses its control authority to restrict seriously the independent status approved by law of the Establishment.

As to prevent above misuse of authority (power), the article six and following in decree # 12399 of 23/6/1998 (concerning financial system of Public Establishments managing the Governmental Hospitals) sets an objective frame of work for an efficient control that does not compromise the decentralization principle.

[19] Nevertheless, the hospital nowadays is a firm enjoying of theoretically total management autonomy". Health Economy, op, cit. P. 66.

[20] The first article of the decree nb 2868 of 12/6/1959 clearly states the fundamental control role played by the Ministry of Finance in handling state,s cash money.

However implementation of written rules may not be as accurate as planned, just due to the desire of some one to overuse and even abuse the authority he has. This situation will lead to a misunderstanding that may result in the deterioration of the situation. The commitment as well as the autonomy of some Public Establishments will change into a straight subordination system that may seriously harm to the Establishment itself and the goals set for it.

The Ministry of Finance control is divided into three aspects:

3.2.1 Through its authority to endorse administrative council decisions:

Within one month (legal deadline), the endorsement, or not, should be done by the Ministry of Finance, other wise the above indicated decisions will be automatically endorsed as the deadline expires.

Just mentioning the above proves us how heavy is the Ministry control on the financial activity of Public establishments.

The bipartite of the control of both Ministries (Health and Finance) may lead to a conflict's situation in phase of council decisions endorsement, considering possible disagreement of both Ministries concerning some issue.

To prevent such harmful situation, the decree # 12399 of 23/6/1998 (financial system) has predicted that in case of conflict's situation between the two ministries, the Ministry of Health, upon administrative council Public Establishment request, can appeal the Cabinet to settle above conflict situation. Useless to remind in this case, how damaging will be to compel the council to comply to both ministries decision once they overcome their disagreement. Noting that the council is not authorized to appeal any third its disagreement cases, neither with both ministries nor with each one separately. Certainly, above council obligation will harm to the Establishment activity and to its self-dependent status.

As the legislation has prevented that conflict's situation between both ministries due to possible disagreement (decree # 12399), it should have done it for the Public Establishment by authorizing it to appeal the Cabinet when above conflicts occur.

3.2.2 Through its authority to endorse the Public Establishment Budget

The most impartial law is the article 24 of the decree # 12399 of 23/6/1998, concerning the financial system of Public Establishments managing Governmental Hospitals. It gives to the minister of Finance or Health the authorization to suggest to the Cabinet blocking part of the Establishment Budget

it had been approved before. It also authorizes the cabinet to approve above minister suggestion as there is enough justification for it.

In that case the Establishment is supposed to comply to the Cabinet decision without any protestation right . As said previously, such impartial measures may restrain the free action of the Establishment, thus, lower its efficiency, since all set plans was done on basis of already approved Budget.

3.2.3 Through the control of Finance Ministry: inspector

Within one week, starting the day the inspector receives the administrative council (board) decisions, he should be finalizing the following:

- checking the fulfillment of above decisions with the applied rules and laws.
- checking also their fulfillment with set Establishment goals.
- Coming out with a report mentioning his justified opinions if any and suggestions.
- Finally the complete report, within one week deadline, must reach the Minister of finance following the administrative hierarchy.

The above deadline may be reduced to four days in case that decisions concern supply material and labor.

We shall comment here below two issues:

1. The fact that financial inspector is exceptionally authorized to sign the document proving the fulfillment of council (board) decisions with set Establishment goals does certainly contradict the independent status principle of the Establishment.

2. The one week deadline period given to the financial inspector to submit his report to the Ministry of Finance, is an additional period to the previous one month given to the Ministry of Health.

   Obviously , the above will delay the Public Establishment activity as well as its decisions endorsement procedure. It would be better that, the legislation should have included the inspector deadline period within the Ministry deadline one. The above detailed control of the ministry of Finance puts more light, from a financial point of view, on how the Public establishment are ill willingly tied not only by mean of missing laws, but by the misinterpretation of these law .

3.3 Other control system

In addition to previously mentioned control of the Tutelage Ministry (Health) and that of Finance, we will be examining the other control system to which the Public establishment must comply, such as the Accounting Department and Central Inspection.

3.3.1 Accounting Department control [21]:

The control of above department is shown in its annual report that represents the outcome of his control and all laws reforms does suggest, implementation of which leads to financial results. Above control is also shown in the department annually report showing the fulfillment of submitted accountings with proof documentation as indicated in the law of general accounting.

There are two kinds of Accounting Department controls:

3.3.1.1 Control on accounting:

The scope of above control is stated in the article # 8 of the decree # 15604 of 19/2/1964. It allows the calculations checking of the establishment accounting responsible or any one who is in charge of the collection or payment of the Establishment cash money, without enjoying of legal status [22]. Whereas article 9 of same decree states the following:

- concerning Establishment incomes: check the delegation and collection formalities and their fulfillment with applied laws as well as flow of collected money to peoples in charge
- concerning outcomes dues: check the proving documents according to which the payment has occurred and their fulfillment with applied laws
- concerning imported materials: check the exactness of receipt, storing and delivering of above materials as well as accuracy of inventory reports

[21] For more details, see financial Sciences and Budget- Khattar Chibli, Sader printing, 1979, p. 184 and following.

[22] Whereas article 9 of same decree states the following:

- concerning Establishment incomes: check the delegation and collection formalities and their fulfillment with applied laws as well as flow of collected money to peoples in charge
- concerning outcomes dues: check the proving documents according to which the payment dues have occurred and their fulfillment with applied laws
- concerning imported materials: check the exactness of receipt, storing and delivering of above materials as well as accuracy of inventory reports
- concerning accounting: exactness of accounting and their fulfillment with applied laws as well as their fulfillment with declared proving documents.

- concerning accounting: exactness of accounting and their fulfillment with applied laws as well as their fulfillment with declared proving documents.

3.3.1.2 Employees Control:

The article eleven of the decree # 15604 has defined above control extent, on people handling the Establishment funds or any one else who is doing the same without enjoying of legal status [23].

3.3.2 Central Inspection control :

The first article of the decree #. 602 21/2/1997 has delegated to the Central Inspection the control authorities of Public Establishments that manage the governmental hospitals.

Being under Central Inspection control does not mean at all putting restrictions on independent status of those Establishments. Consequently, previous status has been automatically approved considering that the Establishment is a an essential part of the administration.

[23] It attributed the employee status to every one who is in charge of handling the Establishment funds even if he does make part of decision-making board. Additionally the article 12 of the same decree has predicted the punishment of employee according to article nb 57 and following of the decree nb 118 of 12/6/1959.

4. Impact of the Control on Public Establishments that mange the Governmental Hospitals

The principle of the tight control and tutelage of Public Establishments hence, of those that manage the Governmental Hospitals, is stressed in the general rule system of these Establishments.

Almost all of the administration council decisions have to be approved by the Ministry of Health whereas most of them have to undergo a double control check: from both Ministries (Health and Finance). In some other cases some decisions require the endorsement of the Cabinet.

Respecting above time consuming control procedures, useless to remind how delay and thus, damage will cause this for both activity and efficiency of above Establishments.

Also, some frustration cases should be ceased, when some Public Establishments suffer of central power carelessness which will be expressed by stopping to supply above Establishments by necessary material and needed human resources.

For better Establishment efficiency and productivity, we should approach the full-time job principle (full-dedication) of the council head and members [24].

With this respect, it is useful to remind the failure of semi-dedicated councils (boards). In this case, it may be more workable to adopt small fully-dedicated councils or councils including some fully-dedicated members [25].

* The heavier and most efficient control is the Ministry of Finance control, through:

- the Establishment cash money and credits control .
- modification of the rules

[24] "Anyway the remuneration system of private sector is more advantageous of that in public sector. The renumeration of the public sector is uncomparable with that of pruivate..." J. Zaarour:" La situation actuelle de la fonction publique au Liban." Lectures done at International Institut of Public Administrtion in Paris, the 10 th of february 1981. I.I.AP. p. 13.
See for the same argument: William Haddad, assay of administrtive reform in a developping country. L.G.D.J. 1970, p. 91.

[25] "Looking to be everywhere, the elected member will be no where, thus, will be unable to examine accurately files submitted to him. In this case, and due to the elected member frequent moves, the above files proceed in the administrtion in a chaotic way. This situation will compel the elected to submit to its subordinate the files to ensure the management continuity. This delegation of tasks is a non responsibility signal especially when this tasks delegation will become uncontrolled and systematic." Jacues BaGUENARD, La decentralisation, oop. Cit. P. 65.

- decisions endorsement

- the Ministry financial inspector role within the Establishment.

The above Ministry control has two aspects:

- positive aspect represented in the help secured by the Ministry to the Establishment in setting and later on implementing the Establishment Budget especially in the frame of Establishment's revenues and dues distribution, in listing Establishment's basic requirements, in avoiding extra charges and in reducing administrative expenditures at reasonable level. Moreover, all above mentioned positive points would not be possible, if much often, the central administration (Ministry) had not a qualified personal.

- negative aspect [27] represented mainly in compromising the Establishment efficiency or at least drawing back its activity.

It is generally agreed-on that all Public Establishments, as a part of decentralized public service, must comply to the central financial control authority (Ministry of Finance), in order to keep the establishment activity within the political frame work of the Ministry, as well to respect the rule system standards applied politically, economically and socially and finally to not jump beyond a level dictated by financial and economical pressures of near surrounding as well international circumstances.

However, all above must not imply that the Public Establishment becomes a department or office of the Ministry of Finance as some researchers suggest.

The reason that compels us to encounter the negative aspect of the Ministry of Finance control is that the Public Establishments were founded to meet two main scopes:

1. find a decentralized public service liable to manage such vital public sector i/e the Governmental Hospitals.

2. secure to that Establishment the necessary versatility lacking in above Hospitals.

If the first scope was achieved, the second one obviously is not achieved yet.

[27] It is to remind that:"the moral entity involves the judicial self-dependent character of concerned entity. This self-dependence character will imply a financial autonomy to the entity necessary for the implementation of its decisions." Michel durupty, "transposition et mutations du modele administratif francais" (Lebanese and Tunisian case). Middle east judicial studies, 1973,. N33, p. 89.

In the Governmental Hospitals the decision-maker is the Minister himself, whose decisions should be implemented on all levels , whereas, in the Public Establishment the decision-maker is the gathered administrative council or board (composed of 3 to 9 members and not fully-dedicated) whose decisions should much often be approved by both ministers the Health and Finance besides the close control of the Commissioner (Minister of Health representative) and the financial inspector (Minister of Finance representative).

* The Central Inspection control is necessary whatever will be the impact on the Establishment efficiency. Because the Central Inspection has never overuses its given authority or cause any draw back in the efficiency of Public Establishment. This statement is approved by our review of the Central Inspection activity as well as its report consolidated by the Prosecutor-general proceeding at the Accounting Department.

* As per the Accounting Department control role; it is represented in the special reports that prepares, listing of necessary remarks in its annual report or advisory role in financial issues. Generally, the Central Inspection Control causes no big troubles except when administrative accounting reports of some Establishments are not submitted to above control system.

* The judicial control on Public Establishment accounting and employees is necessary. Above control is not of the kind that may delay or harm to the Establishment activity, because is a post-job accomplishment control. It concerns the job control of those who are handling the public money which is considered as a normal procedure in Lebanon.

The different control systems (the Ministry of Health, Ministry of Finance and other central organisms...) on the Public Establishment activity, although some times seem heavy, it should not cause conflicts between Public Structures, because what above structures have in common is deeper than these small details: is to secure, after all, the public welfare through the essential services offered.

Moreover the above mentioned control system may legitimize the activity of Public Establishment that should finally comply to the outcomes of this control. At condition that these results help the Establishment to move a head in citizen service.

At last, it is useful to remind that principles of independent status and freedom of the Public Establishments that mange the Governmental Hospitals have many positive results that should be shown out in Establishment activity:

1. the work initiative is always up to the Establishment and the endorsement authority given to tutelage power which can not replace the Establishment.

2. Although that tutelage power has endorsement authority, but, it can not modify any sentence of Establishment decisions under its control.

3. The tutelage power, basically enjoys of some authority approved by law. But same law strictly determines when and how this authority should be used.

4. The misuse of the tutelage power authority right and implementation is considered a violation of the judicial system .

PUBLIC PROVIDERS AND HEALTH AUTHORITIES IN ITALY: LEGISLATION, FINANCING AND EXPERIENCE

Dr. Eleonora Verdini

National Legislative Framework

At the beginning of the 1990's, as was the case in many other countries, the Italian National Health Service also began its process of profound transformation and reform. It had become impossible to ignore the growing costs and lack of available resources, the health care system was in need of some form of rationalisation if costs were to be contained.

Bill n' 502 passed in 1992 and revised in 1993 by legislative decree n' 5 17 proposed the following strategic objectives:

- to guarantee uniform access to health care services throughout the country
- to rationalize resources
- to improve the quality of health care services

In order to assure the meeting of the above goals, the law also provided for the regionalization of the NHS making the regions financially liable, incorporating the local health authorities enterprises or ""trusts", introducing an internal market through the purchaser/provider split, granting legal autonomy to the university teaching hospitals and to the local health authorities, and giving citizens the freedom to choose their providers.

The reorganisation on of the NHS began in 1994 and regions were given the possibility of setting their own timetables. However, by January 1995, every region had seen to the reorganisation of the territorial jurisdiction of its local health authorities.

I will now give an overview of the funding of public hospitals with a brief description of the different models adopted by the regions and will conclude with a case in point, the Region of Emilia-Romagna.

The Hospital Financing System

Starting in January 1995, the purchaser/provider split provided for by the aforementioned law, introduced a prospective hospitalization payment system based on DRGs (Diagnosis related groups).

Before shifting to a prospective system Italy funded services based on a retrospective system that aimed at covering total costs but gave no incentive to the providers to op health care delivery. Under the prospective payment system, financing is tariff-based with payment being given per service rendered. This type of system leads to the creation of measures to contain costs and to improve efficiency.

Working under a fee-for-service payment "em does create the risk of raising the volume of services, however, we chose hospitalizations as our unit of reference because it is less inflationary than single services, and certainly because admissions are easier to mange both through information systems and from an administrative standpoint.

It is up to the Regions to monitor, control and maintain the level of quality of services. In order to help regions do this, it was mandated in 1995, that all providers would have to publish a Patient Charter and Guide to Services, and in February 1997, a decree was passed setting standards and deadlines to be met by the Regions in defining the requirements for accreditation.

The ministerial decree mandated in 1994 and revised in July 1997, introduced a national tariff system based on DR0s but gave the regions the responsibility of defining their own tariff system based on the national standards, which allow for maximum compensation, proposed by said decree. Having been given the possibility of allocating the maximum compensation, a greater bargaining margin was created between providers and purchasers. Obviously, the system will have to be constantly revised according to cost variation and the advent of new technologies.

The introduction of a fee-for-service payment system has made necessary the monitoring and control of the effects of this system; in order to do this guidelines produced in January 1995 listed those indicators subject to external monitoring: an increase in repeated admissions, a notable reduction in the average length of stay, patient transfer to other facilities/institutions, appropriateness of the services delivered. It is therefore essential that the control function be constantly active in order to ensure that opportunities remain greater than the risks generated by the introduction of a fee-for-service payment system.

The general framework given above has been used as reference for the development of the several options chosen by the different Regions. It is important to state that, in order to satisfy the health needs of their populations, the Local Health Authority "Trusts" provide services within their own facilities, purchase services from the hospital trusts and from the private sector licensed to provide services for the public sector. This means that the Local Health Authorities have become both providers and purchasers. Two theoretical models form the basis of the systems adopted by each Region:

Third Payer Model: under this system, users are at total liberty to choose their providers which in whether public or private, compete among themselves for clients.

This is the model that has been adopted by the region of Lombardy. The population has total freedom of choice and the health care institutions and services compete for clients. All health care facilities are licensed (accredited), therefore relegating the role of the Local Health Authorities to that of third payer.

Planner Model: The Local Health Authority "Trust" defines annual activity plans with its own facilities, with the public hospital trusts, and with the private sector. The tariffs agreed upon serve to define financial volumes, thereby investing the regions with a strong role in planning. The Regions of Emilia Romagna and Tuscany have opted for this model.

The "third payer model" does seem to allow the objectives of efficiency and quality to be pursued, however, the experience of Lombardy relates that this model, in not offering ways of controlling demand, also offers little with respect to cost containment.

The "planner model" allows for control over expenditures but does not always encourage drives to improve the quality and the efficiency of the services offered.

Over the last few years, the general evolution of the system nationally has been more or less heterogeneous: The National Health Care Plan - 1998-2000 and law decree 419/98 have confirmed the overall "aziendalizzazione" or incorporation of the health care system with regards to organisation on and management; the central position held by citizens in terms of freedom to choose their health care providers leading to improvement in a more efficient utilisation of resources and in the quality of care delivered. The role of the region in this context is as a guide, planner, and controller of the entire system. The system (from hospital trusts to community services) is regulated according to agreements on long-term strategy of supply. The system went from following a model based on competition to a model based on co-operation. It is essential to underline the fact that regions are financially liable and responsible for the organisation of the supply of services.

I will now turn to the story of Emilia-Romagna since 1996, emphasising its system of health care financing.

A Case in Point: the Region of Emilia-Romagna

According to the reorganisation and reform of Italy's NHS (Law Decree 502/92), the regions were given die responsibility not only of redefining the health care system from an organisational standpoint but, through the introduction of financial liability, also for planning and resource allocation. Financial liability has meant greater decisional and executive authority for the regions. We must not forget that Italy was recovering from a period in which the total centralisation of financial liability had created a situation in which accumulated deficit spending was consistently covered by central government.

It is within this context that our region began, in 1994, the process of so-called "aziendalizzazione", the introduction of financial liability and of a business-like organisation into the running of public health care institutions. We also began our search for an equal and transparent allocation of monies from our regional health care fund. There was no doubt that allocation would have to be based on distributive equity vis a vis the real health needs of the population, and on the total transparency of criteria on which distribution would be based.

The pivotal principals of our financing system are distributive equity meaning the just distribution of resources vis-a-vis the needs of the population. An important goal of a health care system based on principals of solidarity as is Italy's, is to guarantee basic levels of health care for equal needs. This means that the system of financing is not responsible for assessing absolute need, but rather of evaluating the upper and lower limits of each LHA's population's demand for resources. A financing model that is sensitive to the relative need of health care of a given population, and not based in any way on the supply of services, should guarantee equal access to and a uniform utilisation of services.

Another important aspect of the model developed and adopted by the Region of Emila-Romagna is transparency. Before the LHA's were made financially liable, resource allocation was based on historical need and the various HA's received funding was largely based on the bargaining capabilities of their managing directors.

Finally, it had become necessary, given the exorbitant sums of money spent for health care, to establish a health care policy aimed at a greater rationalisation of resources and at a better control of expenditure.

The model chosen respects the principals set down by the health care reform laws 502/92 and 517/1993, that establish the separation between "pure providers" - the Public Hospital "Trusts" - and the "purchasers or payers" - the Local Health Authority "Trusts". The latter are responsible for answering the needs of the resident populations under their jurisdiction, using the funds to which they have title. The Region also provides separate funding, based on specific criteria, for special programs of interest on a regional level.

Based on the levels of health care defined by the National Health Care Plan 1994-1996, revised in the 1998-2000 Plan, the percentage of resources allocated to each level was established : Level 1 5% :community services; Level 2 - 18.9%: primary health care services; Level 3 - 10.5%: specially, semi-residential (care for the elderly and disabled), and community services; Level 4 - 46%: hospital services; Level 5 - 6%: residential and semi-residential care for the elderly and disabled; Other levels - 13.6%.

Under a model of this sort the transference of resources among levels is easily monitored and so it can become an extremely crucial element in the strategic planning and regional control of health care.

Epidemiological indicators were selected for each level necessary to the estimation of resource need matched to the demand for health care services m each level.

Our reference population is the resident population of Emilia-Romagna. The percentage of resources allocated to each level is fundamentally based on our health care policy platforms.

The tariff systen.4 differentiated according to type of hospital, was redefined so that it could adjust the yearly resource allocation to hospitals according to changing costs and health care policy and also used to "reward" appropriate (i.e.; increase in day surgery and day hospital activities) and "discourage" inappropriate behaviour. So, tariff policies have become instruments used to control the impact of the payment or allocation system. A three-year contract was agreed with private sector providers ; global budget being fixed for the entire three years. The "trusts" were also granted the possibility, within the fixed budget of negotiating activity typology and volume.

The Region has worked hard in the planning and reorganising of services, renegotiating activity planning and strategies for increasing financial returns with the various health care facilities (LHA and Hospital "Trusts") every year. The Region has also encouraged the "Trusts" to contract supply agreements with the "pure providers", private sector, and among the Local Health Authority Trusts in order to strengthen their role as agents and for managing demand. (This has been reinforced by the recently approved Regional Health Care Plan - 1999-200 1).

The result of all our efforts may be summarised by a single fact that may not be exhaustive but does give a good idea: admissions have gone down since 1996, with a hospitalisation rate for 1998 of approximately 175 per 1000 including the deficit incurred by patient flow outside the region, in 1996 the rate was 189 per 1000. It is quite clear that one statistical fact does not a perfect system make, but it may be interpreted as a tangible indicator that some sort of control over the system has been achieved.

I would like to conclude my brief presentation by stating that the semi-market or conditions of managed market under which Emilia-Romagna's health care system operates, and thanks to a careful articulation of activity planning that involves not only hospitals but community services as well, have enabled us to gain control over and positive management of our health care system.

References

AA.VV., A Formula for Distributing NHS Revenues Based on Small Area Use of Hospital Beds,The University of York, settembre 1994.

Arcangeli L., France G., La concorrenza strata nel nuovo sistema sanitario nazionale, in "L'Assistenza Sociale" 1,1996

Baraldi, Sistemi di finanziamento: tariltazione, finanziainento per prestazioni, i DRG/ROD, atti del XVH Seminario dei Laghi "Stato, Regione, Mercato per una Saniti migliore", Moltrasio, 5-7 ottobre 1995

France G., Modelli relazionali tra i servizi sanitari nazionali e i fomitori di prestazioni, in France G.(a cura di), "Concorrenza c Servizi Sanitad', Istituto di Studi sulle Regioni, CNR, Quademi per la Ricerca, 33, Roma, 1994

Health Committee, Priority setting in the NHS: Purchasing - First Report, Vol. 1 e H, London: HN4SO, gennaio 1995.

Langiano T. (a cura di), DRG: strategic, valutazione, monitoraggio , Il Pensiero Scientifico Editore, 1997

Mapelli V., Concorrenza e regolazione nel servizio sanitario nazionale, in Petretto A. (a cura di), "Econoniia della Sanità', Il Mulino, Bologna, 1997,

Peacock S., Smith P., The Resource Allocation Consequences of the New NHS Needs Formula - Discussion Paper 134, The University of York, maggio 1995.

Rebba V., Tariffe, R.O.D. e regolazione delta qualiti delle prestazioni ospedaliere, Atti del HI Workshop di economia sanitaria: "Potenzialitk condizioni e limiti del mercato", Universiti Cattofica del Sacro Cuore, Mlano 30-31 maggio 1996.

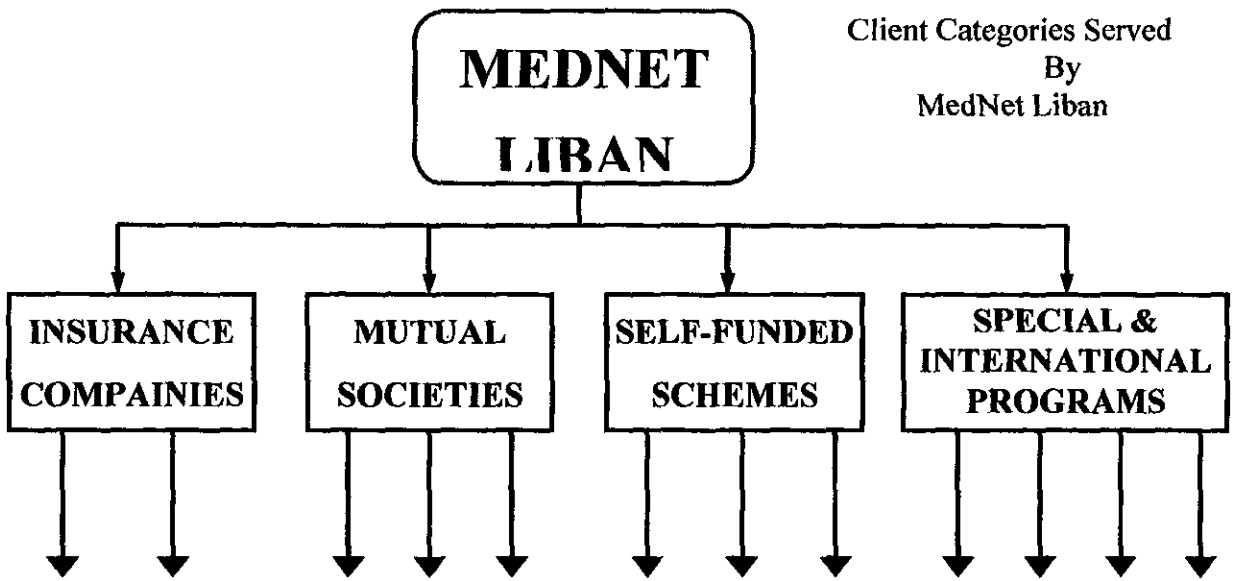
Taroni F. DRG/ROD e nuovo sistema di finanziamento degli ospedali, 11 Pensiero Scientifico Editore, 1996

THIRD PARTY ADMINISTRATION IN LEBANON EXPERIENCE & RESULTS

Mr. M. Kharma

POTENTIAL CLIENT GROUPS

- Insurance Companies
- Professional Associations and Orders
- Self Funded Employer-Employee Groups
- Mutual Societies,
- NG0s
- Cooperatives
- Groups Covered by Public or Private Plans



220 PLAN COMBINATIONS SERVED

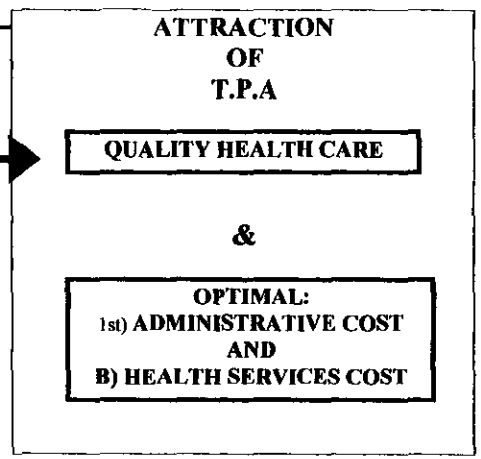
ATTRACTION
OF
T.P.A.

QUALITY HEALTH CARE

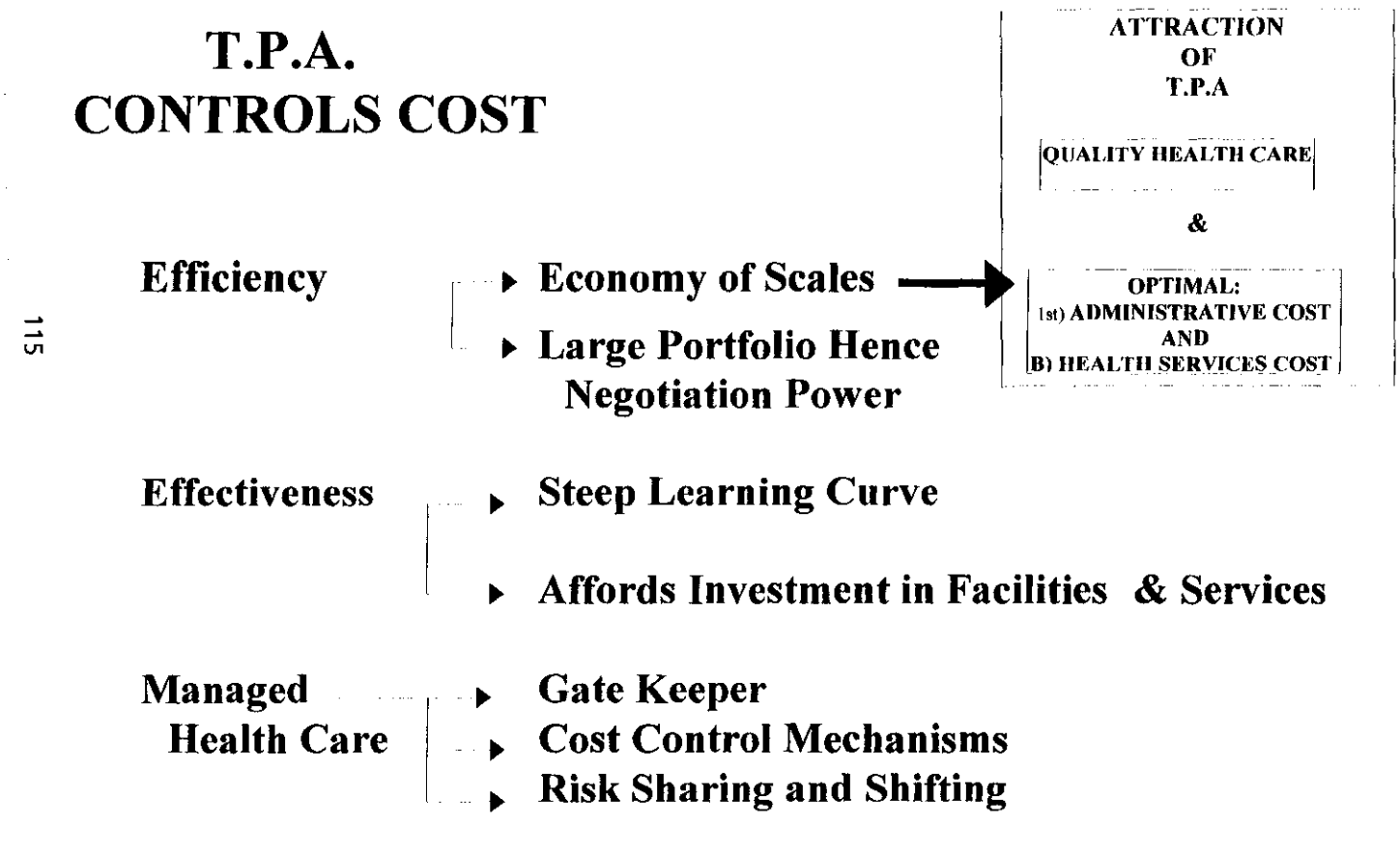
OPTIMAL:
1st) ADMINISTRATIVE COST
AND
B) HEALTH SERVICES COST

T.P.A.
PROMOTE QUALITY HEALTH CARE

- Quality Care Through Managed Care Programs
- Introduces peer review
- Promotes Quality Standards & Practice Guidelines
- Outcome Management



T.P.A.
CONTROLS COST



TYPES OF OWNERSHIP

- Insurer-Owned TPAs
- HMO-Owned TPAs
- Hospital-Owned TPAs
- Commercially Owned TPAs
- Quasi-Public Owned TPAs

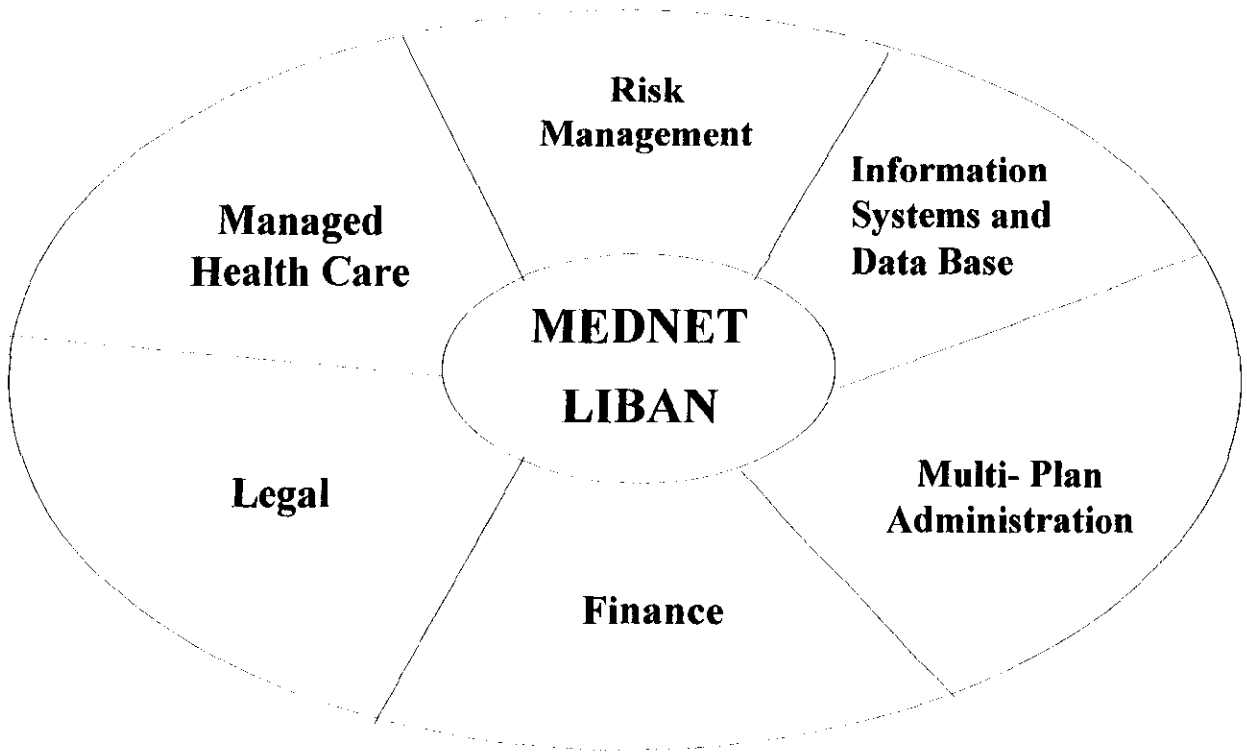
T.P.A.
SERVICES
BASIC

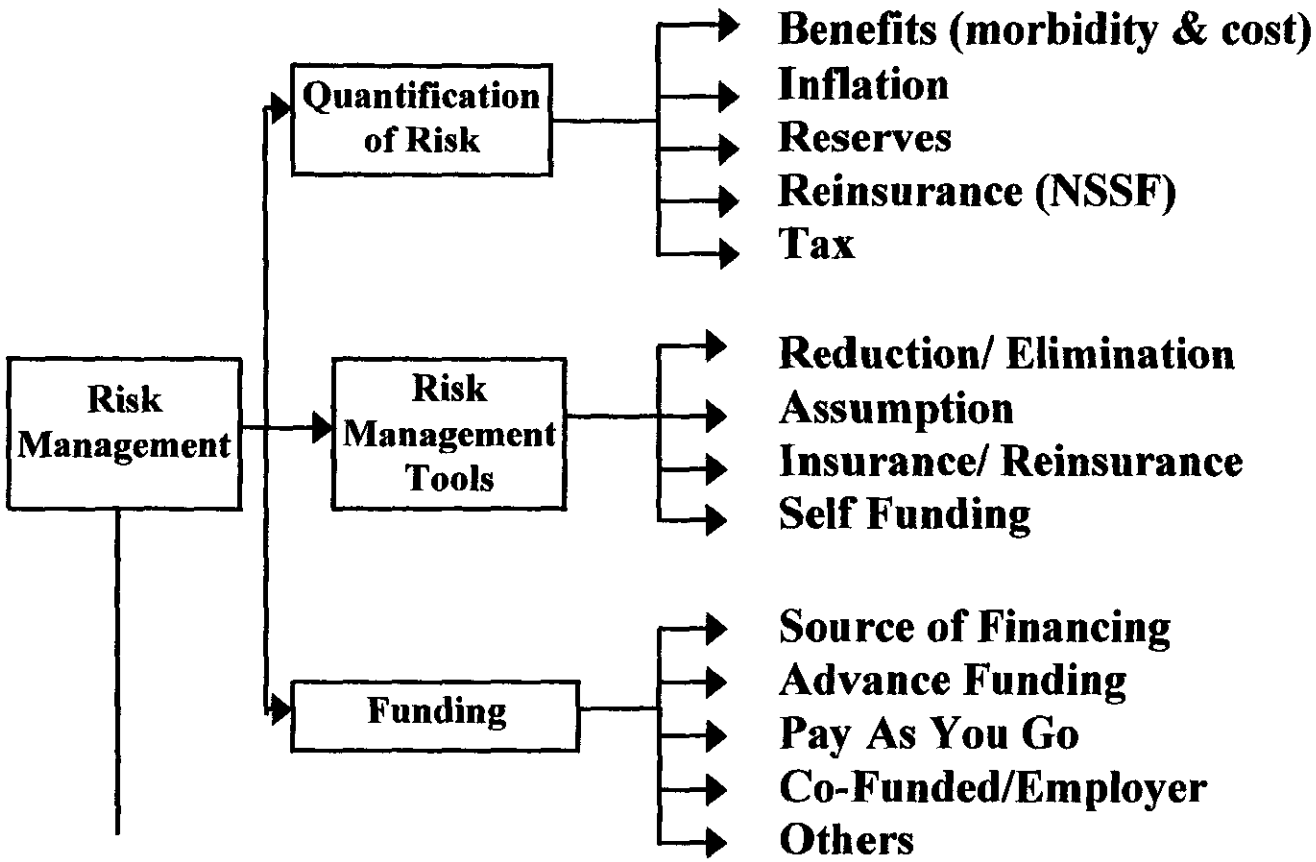
- Providers Organization * Hospitals
  * Others
- Pre-Certification of Cover for the Insured
- Concurrent Review & Utilization Management
- Discharge Planning
- Adjustment and Audit of Hospital Bills

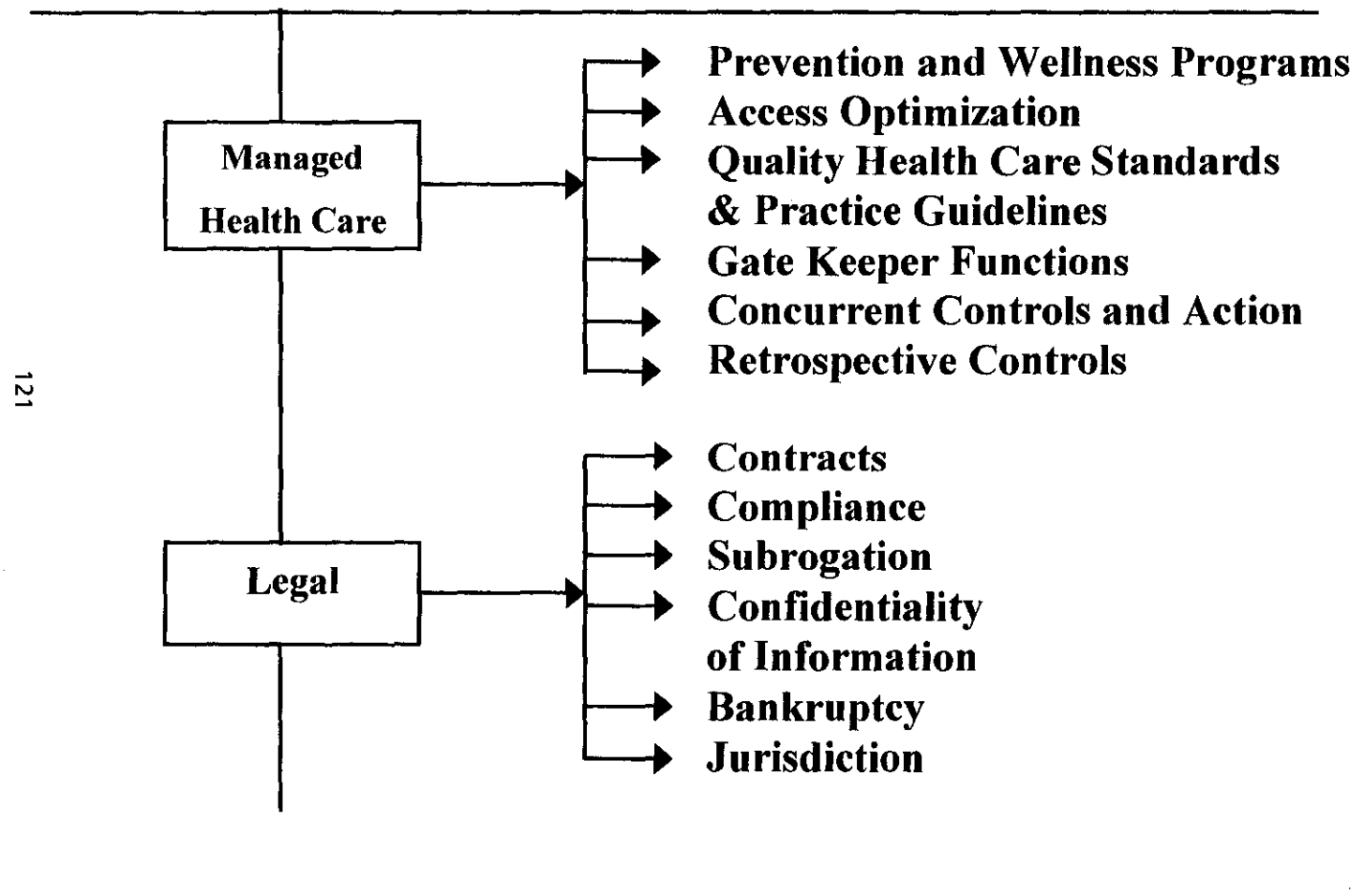
T.P.A
SERVICES
SUPPLIMENTARY

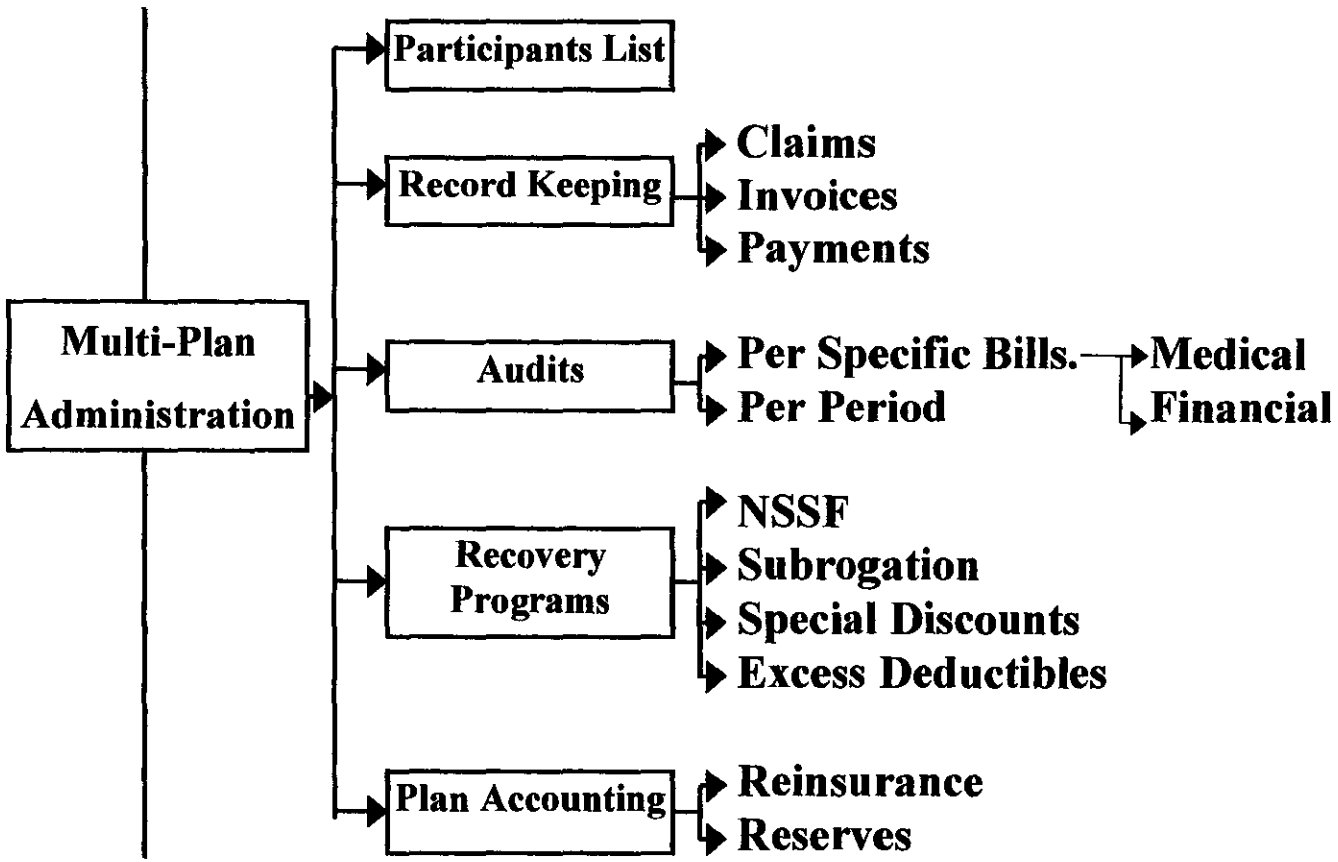
- Physicians Network (PCP and Specialists)
- Prescription Drugs Benefits
- Risk Carriers & Providers Accounts
- Utilization Review & Benchmarking Services
- Multiple Plan Administration
- Patient Awareness Communications
- Actuarial Services
- Compliance Reporting
- Legal Services

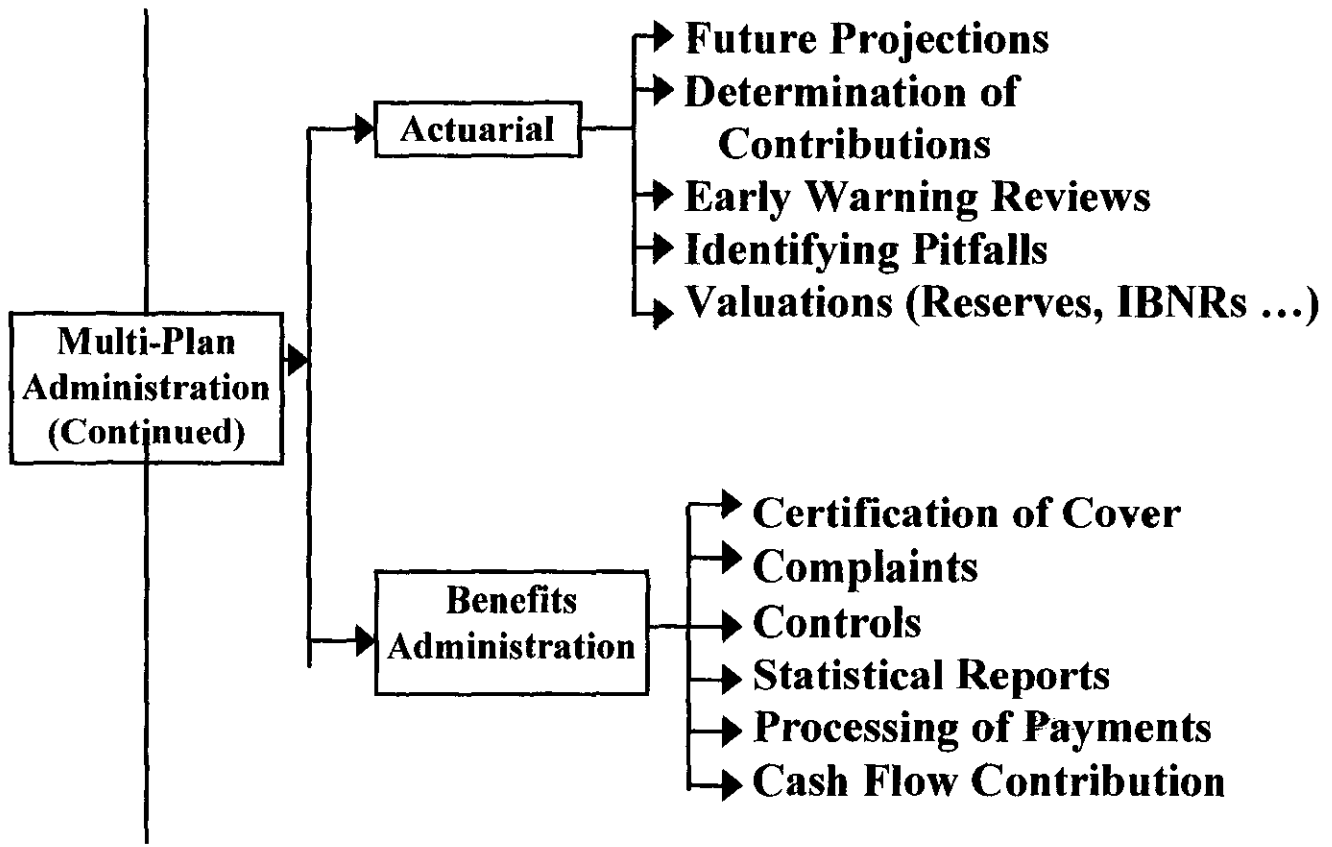
CORE KNOW-HOW

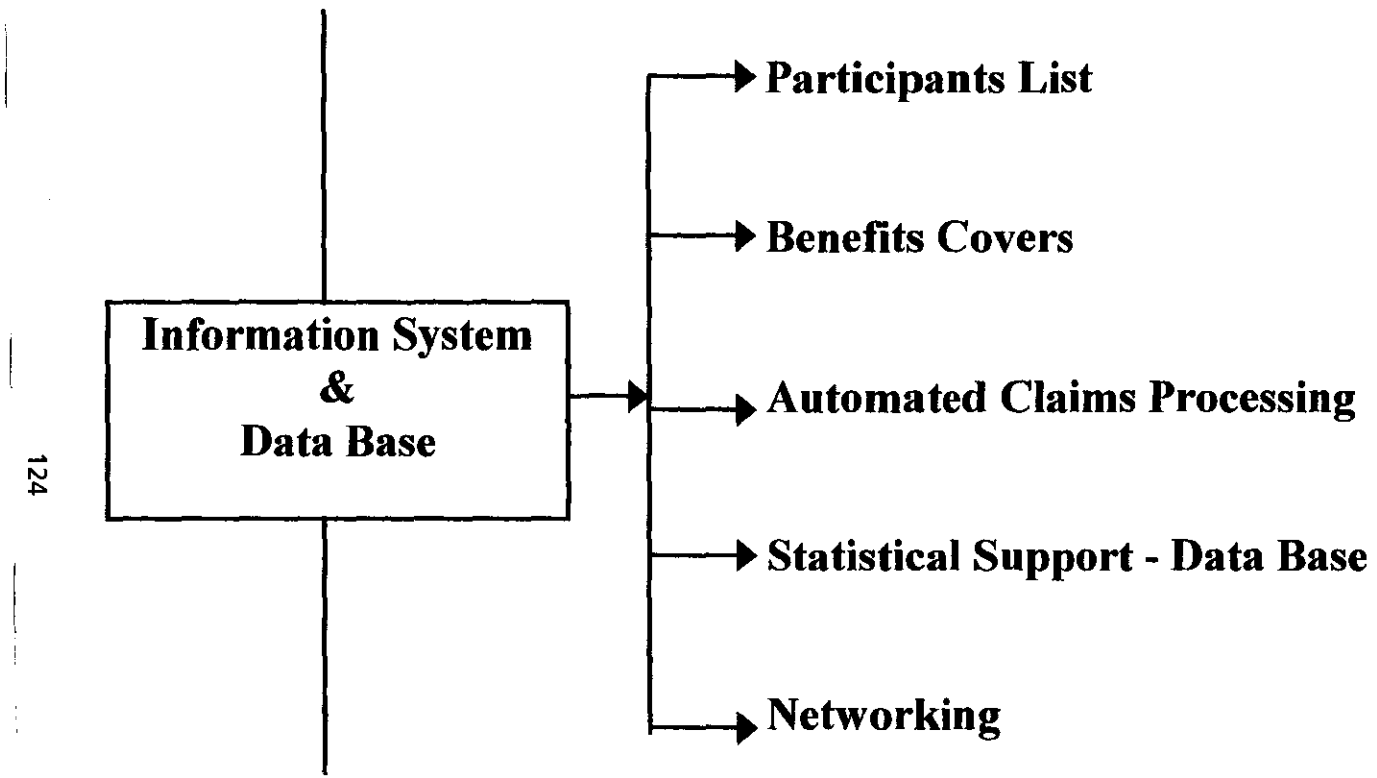



Risk Management
Quantification of Risk
Risk Management Tools
Funding
Benefits (morbidity & cost)
Inflation
Reserves
Reinsurance (NSSF)
Tax
Reduction/ Elimination
Assumption
Insurance/ Reinsurance
Self Funding
Source of Financing
Advance Funding
Pay As You Go
Co-Funded/Employer
Others


Managed
Health Care
Prevention and Wellness Programs
Access Optimization
Quality Health Care Standards
& Practice Guidelines
Gate Keeper Functions
Concurrent Controls and Action
Retrospective Controls
Legal
Contracts
Compliance
Subrogation
Confidentiality
of Information
Bankruptcy
Jurisdiction


Multi-Plan Administration
Participants List
Record Keeping
Claims
Invoices
Payments
Audits
Per Specific Bills.
Medical
Financial
Per Period
Recovery Programs
NSSF
Subrogation
Special Discounts
Excess Deductibles
Plan Accounting
Reinsurance
Reserves


Multi-Plan Administration (Continued)
Actuarial
Future Projections
Determination of Contributions
Early Warning Reviews
Identifying Pitfalls
Valuations (Reserves, IBNRs ...)
Benefits Administration
Certification of Cover
Complaints
Controls
Statistical Reports
Processing of Payments
Cash Flow Contribution


Information System
&
Data Base
Participants List
Benefits Covers
Automated Claims Processing
Statistical Support - Data Base
Networking

MedNet Achievements

Achievements

1) **Projections** are of high level of **accuracy.**

2) Very well **tested cost control systems** in place.

3) A well-structured and documented **Database** in place.
4) History of **positive technical results.**
5) A number of **quality care promotion** programs successfully instituted.
6) **Systems** are highly **articulated** and **documented.**
7) **Can** easily and efficiently **expand existing** processing **capacity** by several folds.
8) **System** easily **adaptable** and **transportable.**

9) Focused efforts towards **patient satisfaction.**

Results

1) Risk Carriers enjoy **confident business plans** with no nasty surprises.
2) Significant **reduction** in **misuse, abuse** and **wastage** of **resources.**
3) Analytical depth and confident product design and modifications
4) **Profits** or **savings** to clients.
5) **Healthier** and **more satisfied insured population** base.
6) Can offer **partial** or **full set of services.**
7) This will further improve on existing economies of scale.
8) Can swiftly **adjust** to **different working environment** and plan parameters.
9) A further **step towards a shared social vision.**

Flat rates development in Lebanon

Dr. F. Najjar

Ministry Of Public Health
Lebanon

World Bank Project

Cost Containment Task Force

Objective: Study means of controlling health expenditure

Faysal Najjar, M.D.

March 1999

COMPONENTS OF COST

SHORT AND LONG TERM CONTROL MEASURES

	Short Term		Long Term
	Yes	No	Yes
Nbr. of Admissions		√	√
Length of Stay		√	√
Utilization		√	√
Day Surgery	√		√
Professional Fees	√		√
Total Cost		√	√

MOH Expenditures 1993-1997

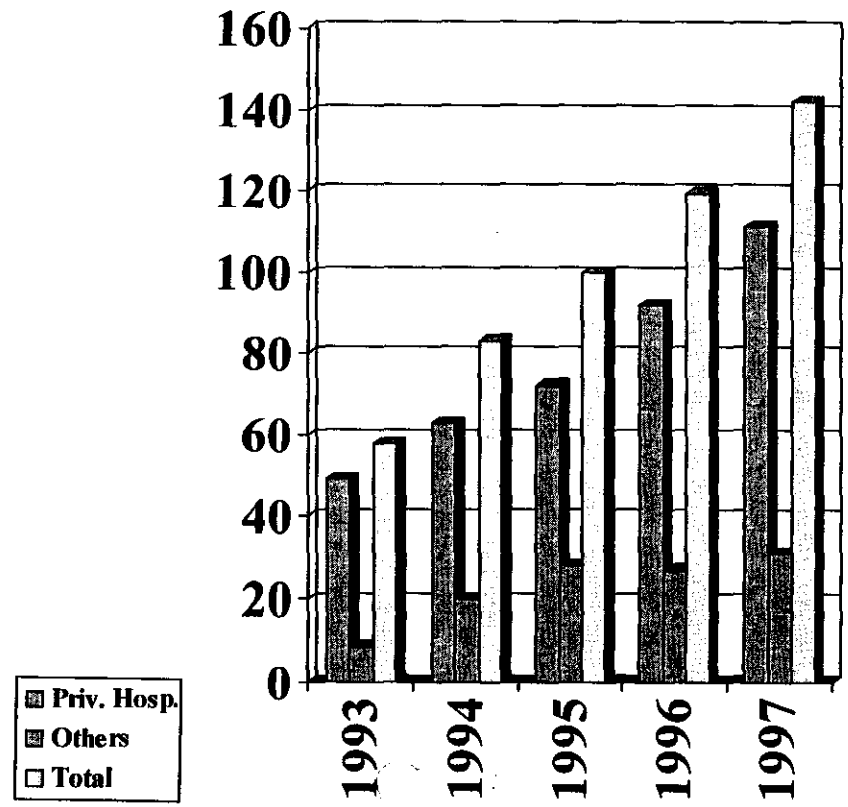
Millions of USD

	1993	1994	1995	1996	1997
Priv. Hosp.	49	63	72	92	111
Others	9	20	28	27	31
Total	58	83	100	119	142

MOH Expenditures 1993-1997

Millions of USD

- **A Steady Increase in the Expenditure to Private Hospitals is Noted**
- **This Expenditure is 78% of the Total**



Project Components

- **Hospital Services Cost Analysis**
- **Case Costing**

Hospital Services Cost Analysis

Objective: Determine cost of services provided in Hospitals

Cost Center	Unit	Cost (LL)
Laboratory	L	201
Radiology	R	447
O.R.	K (O.R.)	7,800
Delivery	Patient	142
Normal R & B	Day	83000
ICU	Day	385,000
Endoscopy	Procedure	51,000
Emergency	Visit	27,000
Cardiac Cath.	Procedure	328,000

Hospital Services Cost Analysis

Methodology

RVU Based Departments

- Frequency of each test and/or procedure
- Relative Value Unit (RVU)
- Cost of Equipment (annual depreciation and maintenance)
- Cost of Labor
- Cost of Supplies
- Indirect costs (allocation from support departments to the patient care departments)

Hospital Services Cost Analysis

Methodology

Non RVU Based Departments

These are services for which a system of relative value units is not applicable (Deliveries, Room & Board, etc.)

- **Number of activities (Deliveries, Patient Days, etc.)**
- **Equipment depreciation**
- **Labor cost**
- **Supply cost**
- **Food cost**
- **Allocation from other department**

Case Costing

Methodology

- A list of common surgical procedures was selected
- Encounters in each case were included by reviewing data from major hospitals and bills submitted to the MOH.
- Common encounters were included while sporadic ones were excluded.
- The figures from the costing study were used, multiplied by the frequency and the total case cost was obtained.
- The obtained cost was compared with those currently paid by the MOH

Case Costing

Common clinical practices for frequent surgical procedures were reviewed

Activity	Qty./Freq.	Unit Cost	Total Cost
Room & Board			
Drugs			
Medical Supplies			
Radiology			
Others			
Operating Room			
Professional Fees			
Surgeon			
Anesthesiologist			
Consultant			

DIAGNOSTIC RELATED GROUPS

- In 1983, U.S. Congress mandated a national hospital prospective payment system (PPS) for all medicare patients
- This PPS utilized DRGs to determine hospital reimbursement
- HCFA (Health Care Financing Administration) administers the PPS and issues all rules and changes with regard to DRGs

WHAT IS A DRG ?

A DRG (Diagnosis Related Groups) is one of 503 groups that classify patients into clinically cohesive groups that demonstrate similar consumption of hospital resources and length of stay patterns

SURGICAL AND MEDICAL DRGs

Out of the 503 groups that classify patients into clinically cohesive groups:

- **247 are Surgical**
- **256 are Medical**

DRG Program

Keys to a financially successful program:

- ↓ **Length of Stay**
- ↓ **Resource Utilization (test/procedure)**
- ↑ **Early discharges**
- ↑ **Pre-admission testing**

DRG Payment System

The DRG payment system is based on averages

- **Payment is determined by the resource needs of the average patient for a given set of diseases or disorders**
- **These needs include the length of stay and the number and intensity of services provided**
- **Therefore, the more efficiently a provider delivers care, the greater its operating margin will be**

Functions of the DRG Program

- Reimbursement of providers of services
- Evaluate the quality of care
  - Analysis of treatment protocols
  - Critical pathways are designed around DRGs
  - Benchmarking and outcome analysis can be launched using the DRGs clinical framework.
- Evaluate the utilization of services
  - Case mix and complexity can be analyzed and monitored in relation to cost and utilization of services
  - High volume conditions and services can be identified and monitored

COSTING OF SERVICES

Cost Center	Frequency	Unit/Freq.	Equipment Cost	Depr. (Years)	Depr/year($)	Maint.	Labor Cost Hosp. Staff
Laboratory	17,300,000	L	919,693	6	153,282	64,379	481,000

Cost Center	N.C. Supplies	Allocation Total	% Allocation	Allocation/year	Total Cost Hospital	Cost/Unit ($) Hospital
Laboratory	519,000	8,600,000	10.14%	872,040	2,089,701	0.12

Cost Center	Cost/Unit (LL) Hospital	Total Cost M.D.	Cost/Unit ($) Prof. Fee	Cost/Unit (LL) Prof. Fee	Cost/Unit ($) Total	Cost/Unit (LL) Total
Laboratory	181	228,000	0.01	20	0.134	201

SURGICAL PROCEDURES - PROPOSED FORMAT

Code				Description	K	ARE		Surgeon Fees	Anesth. Fee	Hosp. Charges	Total Charges
F	9515	M	G	Cesarean delivery only i	60	20		300,000	100,000	612,918	1,012,918
D	9520	S	G	Repair inguinal hernia, any age: recurrent, with or without prosthesis	70	24		350,000	120,000	487,533	957,533
D	4950	M	G	Appendectomy, any method	60	20		300,000	100,000	514,372	914,372

PROFESSIONAL FEE SCHEDULE
SURGICAL PROCEDURES

- **Total Number of Procedures 2,652**
- **Procedures are divided into:**
  - **Same Day Surgery (SDS) 667**
  - **Multiple Day Procedures 1,546**
  - **Other Diagnostic Procedures 439**

CODING SURGICAL PROCEDURES

A 5055 S L

A	**Organ system** **A: Auditory** **C: Cardiovascular**	◆ **The first digit of the C.P.T. Code was replaced by an alphabetical letter for easy reference to organs involved**
5055	**Last Four Digits of C.P.T. Code**	◆ **The last four digits of the C.P.T. Code were kept to enable link with the original C.P.T. list**
S	**S: Same Day** **M: Multiple Day** **P: Procedure**	◆ **The indication of S, M and P will help in categorizing the surgical procedures in groups for future studies.**
L	**L: Local Anesthesia** **G: General Anesthesia** **W: Without Anesthesia**	◆ **Stating the type of Anesthesia has an impact on cost , specially for lump sum calculations.**

SURGICAL PROCEDURES IN PROTOCOLS

- **Total Number of Procedures** **2,652**
- **Procedures included in Protocol:** **763**
  - **Same Day Surgery (SDS)** **648**
  - **Multiple Day Procedures** **115**

SETTING RATES OF SURGICAL PROCEDURES

- 7500 bills were reviewed
- Mapping of all services and encounters was done and recorded
- The total cost of each procedure was calculated by multiplying the frequency of encounters by unit costs
- Comparison was done with the present rates paid

LEBANESE DRG

- Applied in Phase I for surgical procedures
- Only frequent procedures are included
- Rates are assigned per procedure and not per group of procedures
- More accurate and specific
- Allows introduction of individual care maps
- Easily amended for any changes in current procedures or addition of new ones

DRG COMPARISON - USA vs LEBANON

DRG DESCRIPTION	MOH RATE ($)	USA	RATIO
Craniotomy, Age Greater than 17 Except for Trauma	2,500	12,672	5.07
Craniotomy for Trauma, Age Greater than 17	2,267	12,509	5.52
Craniotomy, Age 0-17	2,133	7,988	3.74
Lens Procedures with or without Vitrectomy	1,507	2,216	1.47
Cleft Lip and Palate Repair	1,374	5,324	3.88
Cardiac Valve Procedures without Cardiac Catheterization	5,473	23,414	4.28

LEBANESE DRG IMPLEMENTATION

- Intensify Control on Certificate of Admission
- Implement Outcome Measurement after Discharge
- Review Re-Hospitalization for the Same Pathology
- Consider Incentives for High Quality Care Delivery
- Assess Patient Satisfaction
- Review Periodically

Establishment and management of the DRG system in Italy: Principles and effect

Dr. Mario Braga

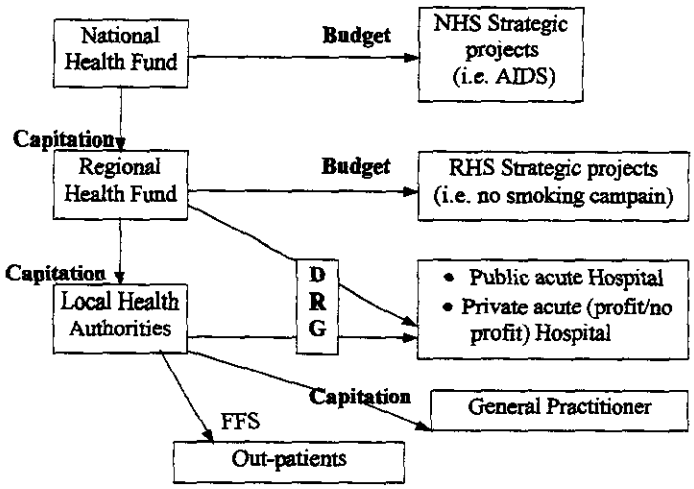
The 92193 Italian reform of the national health service follows the main stream of the majority of the developed countries: introduction of quasi market elements in the health sector context. The major concern which motivates these interventions is the control of expenditure. Increase efficiency and reduce waste are two faces of the same medal. Under those circumstances, the decision of adopting a prospective payment system to reimburse the hospital activity is coherent with the need to control (increase the operative efficiency) the mayor source (>55%) of health expenditure.

The main purposes of this presentation are to:

- Describe the Italian financial flows:
- Compare different hospital financial 1 schemes;
- Compare the USA and Italian PPS system;
- Describe the overall impact of DRGs on hospital care;
- Present an outlying case;
- Conclusion.

Italian financial flow

The flow chart describing the financial stream from the central government to the peripheral units clarifies the existence of different schemes. The main cash flow from the central government to the different regions and down to the local health authorities is allocated via a weighed capitation. The same allocation method. even if through a different model, is used to finance the primary care sector. A pre-defined budget is used to finance projects which are of strategic value both for the national and the regional point of view.



The focus of this contribution will concern the Prospective Payment System (PPS) adopted to reimburse the acute hospital care. This is based on the HCFA-DRG classification system 10th revision.

Hospital financial schemes

The decision to move from a dual reimbursement arrangement, compensation of the production factors for the public sector and day fixed payment for the accredited private hospitals, to a unique financial scheme based on predetermined tariffs is coherent with the willingness to promote same sort of "competition" between producers (public and private hospitals are treated similarly from a financial point of view), to encourage an efficient use of the available resources, to have a system for measuring the volume and the composition of hospital care (adoption of the HCFA-DRG classification system), to induce organisational changes (development of ambulatory care, day care, rehabilitation and long term care).

The key aspects of the Italian PPS system for the acute care sector are:

- Definition of national maximum tar s by DRG. Each region is allowed to define their own tariffs based on local costs or to adopt the national tariffs discounted up to a 20%;
- Identification of extra-tariff reimbursement for specific services (burn units, intensive care, organ transplantation,. teaching and research, ...);
- Use of contractual agreement between Local Health Authorities (or Regional Health Authorities) and Hospital trusts to negotiate the kind a d volume of services produced yearly;
- Activation of a regional control system (Peer Review Organisation) in order to prevent abuses;
- Update of the tariff system every three years;

***Dimensions of hospital* care**	**Risks**	**Opportunities**
activities	increase in improper admissions	waiting list reduction
accessibility	selection of patients	Activity specialisation
***length of* stay**	early discharges	timely discharges
profile of care	reduction of needed care	increase of the appropriateness in the use of resources
***hospital care* level**	improper transfer ; moving of the activities towards more rewarding levels	horizontal and vertical integration development of alternative level of care

USA and Italian PPS system

The Italian translation of the USA PPS system based on the DRG classification of the acute hospital output has meant some relevant modification of the original system. The following table represents the major differences existing between the two countries.

Italy		USA
regional tariffs	*versus*	national tariffs
Costs of the physicians included	*versus*	Costs not included
Costs for the investments (mostly) not (mostly)included	*versus*	Costs for the investments included
Single payer	*versus*	Multiple payers
Mostly public providers	*versus*	Mostly private providers

A further element of diversity is the way of calculating the DRG average reimbursements In the Italian case, the financial equilibrium is reached not at the DRG (or Operative Unit))level but at the hospital level. This means that the average production cost for some DRG has been overestimated while for others DRGs the average cost has been underestimated, This implies that is meaningless to put pressure on single clinical units within the hospital since their being or not financially in balance depends on decisions outside their control.

Impact of DRGs on hospital care

There are two major questions which have to be answered:

- Will the cost-cutting incentives go beyond eliminating unnecessary or marginally beneficial care and also affect needed care?

- Will reductions in length of stay or use of specific services lead to poorer patient outcomes? (increased severity of illness at discharge, increased re-admissions, higher morality rates).

With the available information it is not possible to provide an answer at the national level. Most of the regions started using a computerised discharge abstract at the start of the 95 reform or later (in 95' only half of the regions furnished the computerised archive to the Ministry of earth) making impossible to make a pre-post evaluation; the quality and availability of information show a strong spatial heterogeneity (all the regions initially lacking the discharge abstract information belong to the centre-South of Italy)., in the vast majority of the regions it is not possible to calculate the re-admission rate (lack of a unique personal code) and the mortality 30 days after discharge.

Nonetheless, it is evident that the hospital productivity has increased (both ordinary admission and Day Hospital) and there is scattered and sometime anecdotal evidence of inappropriate hospital use.

Hospital activity indicators (source: ISTAT)

Years	n. of beds/1000	n. of discharges	Hospital Admission rate	Utilisation rate	Length of stay
1991	6.2	8463864	149.1	70.1	10.6
1992	6.0	8696550	153.0	71.7	10.3
1993	5.8	8830136	154.8	74.0	10.2
1994	5.7	8895231	155.5	74.5	10.0
1995	5.5	9027057	157.6	73.4	9.3
1996*	5.5	9807867	170.9	73.2	8.6

It is not possible, at the moment, to affirm that this picture is synonymous of low quality of care.

An outlying case: the Friuli V. Giulia region

The situation of this region shows a pattern which differs from the national one.

The following table display the temporal trend in hospital discharges by level of care (ordinary and day hospital discharges). After the introduction of PPS the total number of discharges decreases, despite the notable growth of the day care activity.

Discharges by year

Friuli Venezia Giulia

	1992	1993	1994	1995	1996
Total discharges	239.978	249.074	263.229	256.664	237.330
Ordinary	239.186	244.581	245.729	232.393	204.054
Day hospital	792	4.493	17.500	24.271	33.276
Day hospital in-patient days	3.042	16.351	55.176	79.935	108.515

The reduction of the hospital volume of activity is predominantly attributable to the lowest DRG weight classes, This could be explained by an increase of the quality and completeness of the discharge abstract (artefact) or to a real increase in patient complexity admitted to the hospital.

Discharges by Class of DRG weight

FriuLi Venezia GiuLia

Class	1992		1993		1994		1995		1996	
	#	%	#	%	#	%	#	%	#	%
1	43.549	18%	44.927	18%	48.738	19%	44.163	17%	37.880	16%
2	60.263	25%	61.888	25%	64.096	24%	58.827	23%	52.462	22%
3	39.046	16%	38.872	16%	40.411	15%	39.132	15%	35.314	15%
4	27.489	11%	29.055	12%	28.975	11%	27.992	11%	25.567	11%
5	25.050	10%	26.887	11%	29.293	11%	32.519	13%	33.628	14%
6	30.076	13%	31.084	13%	32.613	12%	31.739	12%	29.087	12%
7	7.863	3%	9.046	4%	9.849	4%	11.912	5%	13.004	5%
8	6.136	3%	6.901	3%	8.377	3%	10.196	4%	10.307	4%
All	**239.472**	**100%**	**248.660**	**100%**	**262.352**	**100%**	**256.480**	**100%**	**237.249**	**100%**

The average length of stay has lowered after the PPS implementation. The LOS reduction has been particularly remarkable in the private sector.

Discharges and LOS by hospitals' categories

Friuli Venezia Giulia

	1994		1995		1996	
	Discharges	LOS	Discharges	LOS	Discharges	LOS
Directly Owned	99.850	7.9	99.475	8.5	82.150	8.1
Teaching hospitals	9.548	5.6	11.678	5.6	10.506	6.5
IRCCS	16.202	2.5	23.132	2.3	18.640	3.3
"Classificati"	1.497	29.9	1.488	29.9	1.413	28.2
Private Hospitals	17.316	13.8	17.091	13.5	16.333	10
Trusts (Aziende)	104.661	10.1	110.365	9.7	108.288	9.7
All	**249.047**	**8.9**	**263.229**	**8.7**	**237.330**	**8.7**

In order to evaluate more deeply the impact of the PPS o hospitals we measured several indicators for specific pathologies, The main results are a substantial reduction of ordinary admissions and LOS, a stable in-hospital morality (except for colorectal cancer - M) and re-admission rate which are indirect and rough measures of quality of care,

	Ordinary Admissions	Severity of illness	Transition to day hospital	ALOS (ord.adm.)	In-Hospital Mortality	Readmission
Appendicitis-S	-14%	8%	n/a	-20%	n/a	-2%[3]
Bacterial Pneumonia -	3%	3%	no	0%	n/a	*
Diabetes Mellitus - M	-41%	13%	yes	5%	0%	-2%[4]
Colorectal Cancer - M	-35%	31%	yes	36%	5%	*
Colorectal Cancer - S	16%	14%	n/a	-16%	0%	*
Cholecystitis - M	-32%	14%	yes	-3%	-1%	*
Cholecystitis - S	12%	11%	n/a	-23%	0%	*
Bronchitis/COPD - M	-13%	17%	yes	-17%	-1%	2%[4]
Cerebrovascular Disease / Stroke - M	-5%	11%	yes	-12%	-2%	*
Coronary Artery Disease / AMI - M	-6%	15%	yes	-8%	-4%	*
Hip Fracture - S	13%	0%	n/a	-11%	1%	-3%[3]

(1) Ordinary *hospital admissions*, percent variation at stages 2,3
(2) Difference between observed and expected mortality (1996)
(3) Rate of readmissions 30 days after discharge
(4) Annual rate or readmissions (2+Discharges)
n/a = Not applicable
* = Did not do readmission analysis for this condition

Conclusion

The choice of financing the hospital sector using a prospective payment system based on the DRG's was motivated mainly by the willingness to increase the hospital efficiency and to use financial incentives to shift patients between levels of care (i.e., from in-patient to out-patient). The risks linked with this choice were well known in advance and the countermeasures were already present in the health reform. T e failure in developing those countermeasures (institution of organisations responsible of the control function PRO like organisations, development of alternative to hospital care, ...) is partly responsibility of the local regional government (lack of human and financial resources, antagonism to the development of new institutions) and partly of the central government (lack of financial support,. limited capacity to influence the local decisions). As a consequence. each region has experienced different impacts of the PPS system on the hospital care with the prevalent situation of an explosion of hospital productivity (particularly in the private sector) and the growing hostility of the heart personnel to a reform which is mainly seen as financially motivated and possibly threatening the health of the citizens. To our knowledge, this fear in unmotivated and, even if we may not disagree on some undesired effect due to the implementation of the PPS for the hospitals, we consider as extremely positive the existence of an informative system for the hospital activity and the pressure on a more rational use of the health care resources induced by the DRG system.

Information management and DRG system implementation

Dr. M. Arca'

PPSs need information to:

- **determine and manage reimbursements**

- **monitor and control improper behaviors**

- **describe the supply of acute care and evaluate hospitals**

- **describe and analyze the population demand of hospital care**

- **plan reimbursements schemes aimed at promoting effectiveness and equity**

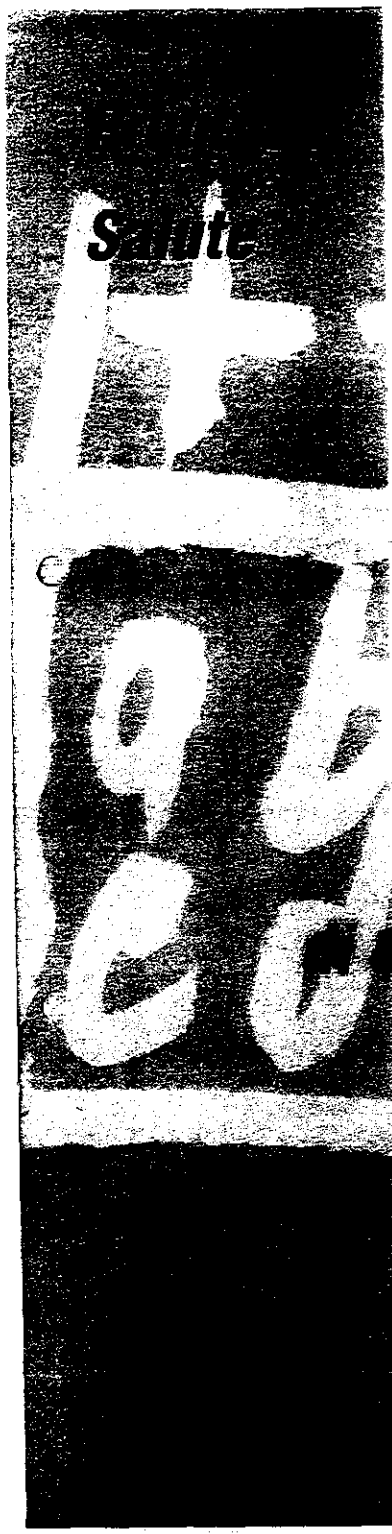
Prospective Payment systems (e.g. DRG) need :

- **timely**
- **analytic**
- **standardised**
- **complete**
- **accurate**

Information

LAZIO REGION: SELECTED INFORMATION

Total population	5,143,000
n° acute care hospitals (NHS)	125 (41% contracted)
n° beds	26,6% (23% contracted)
n° beds x 1000	5.2



RAD 1997

Rapporto sull'attività di assistenza ospedaliera nel Lazio

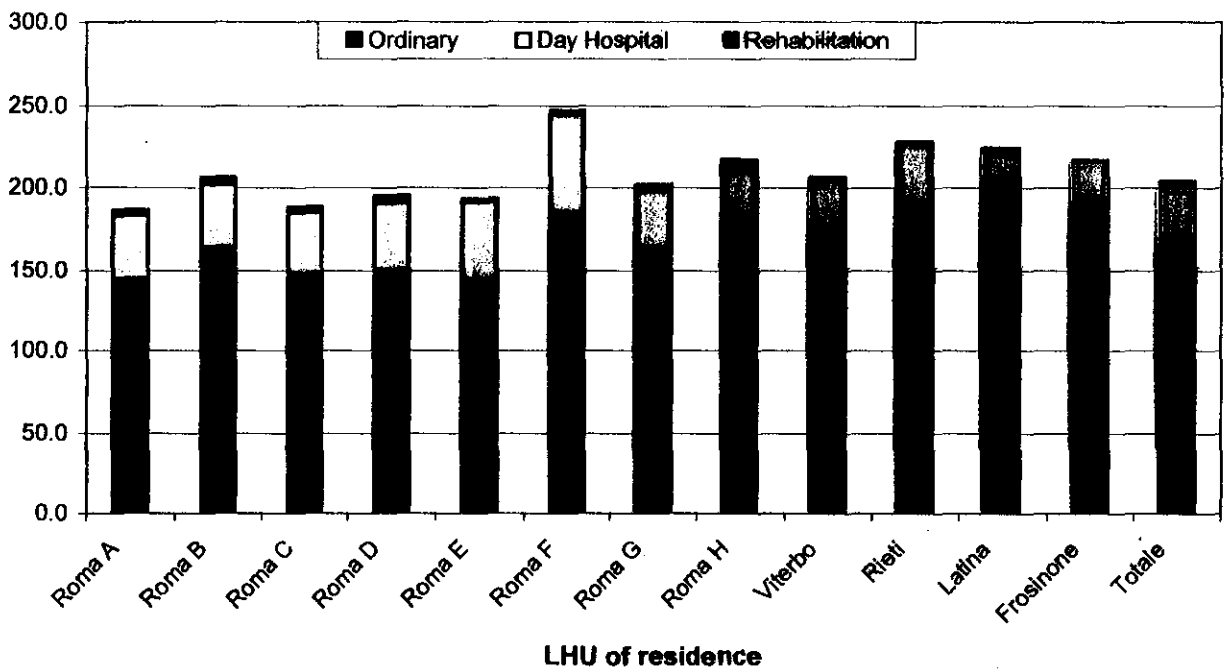
41

Anno XIV - giugno 1998
rivista trimestrale
spedizione in abbon. postale
70% filiale di Roma
ISSN 0392 - 9124

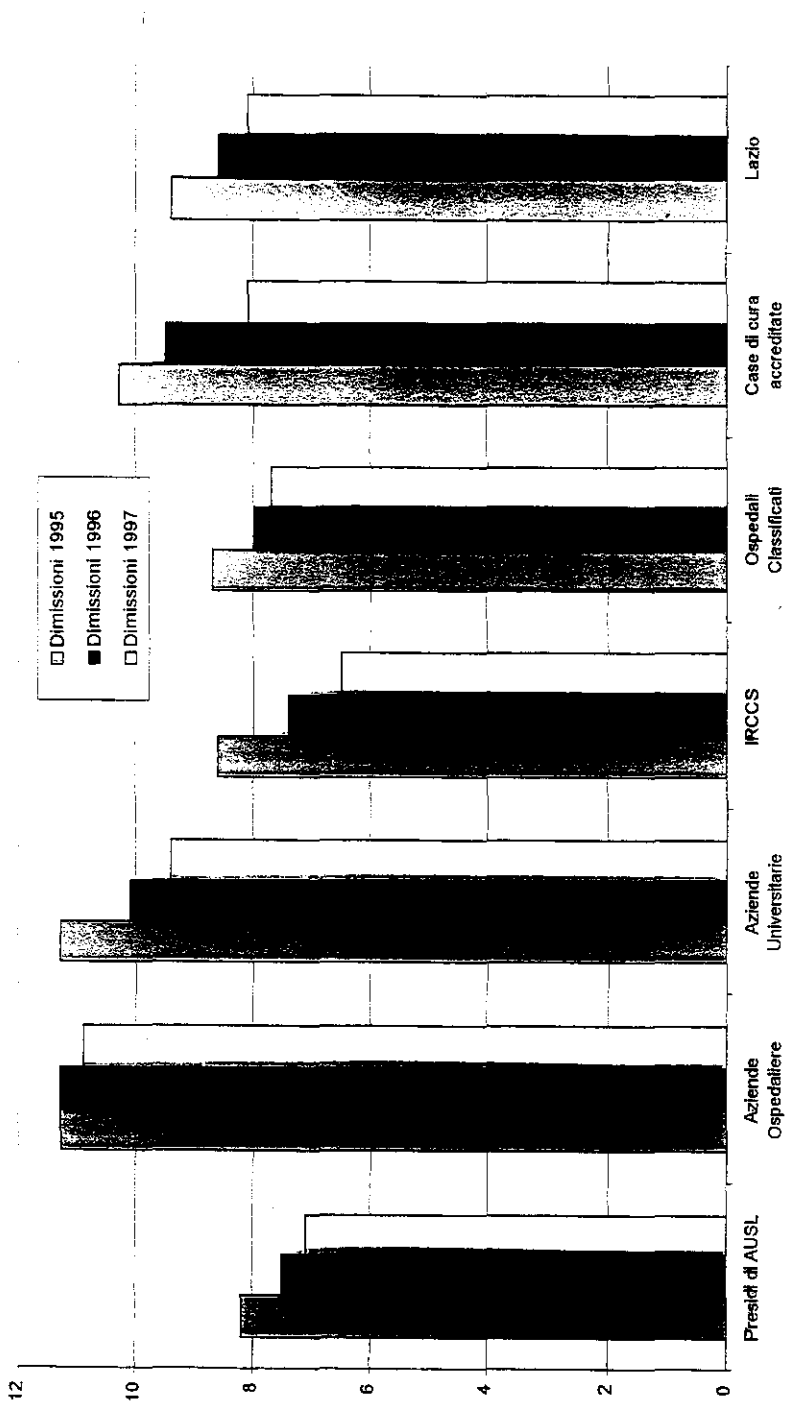
Discharges, average length of stay, total stay, DRG weight and expenditure by type of admission. 1997

	Year			Diff. 96-95	Diff. 97-96
	1995	1996	1997	%	%
Acute					
Discharges	799880	853591	875861	6.7	2.6
LOS	9.4	8.6	8.1	-8.5	-5.8
Total days	7437329	7357849	7054641	-1.1	-4.1
DRG average weight	1.000	1.053	1.069	5.3	1.5
Expenditure	3 621 934 228	4 002 541 195	4 159 894 321	10.5	3.9
Day-hospital					
Discharges	104786	151373	192210	44.5	27.0
DRG average weight	0.841	0.827	0.806	-1.7	-2.5
Spesa	178 686 953	283 943 707	369 070 609	58.9	30.0
Rehabilitation					
Discharges	12151	15328	19674	26.1	28.4
Total					
Discharges	958525	1063754	1132212	11.0	6.4
Total days	7736912	8822569	8696808	14.0	-1.4
Expenditure	4 123 126 810	4 691 221 235	4 972 897 495	13.8	6.0

Age standardized hospitalization rates (per 1000). Lazio 1997. Females



Average Length of Stay by type of hospital. Acute admissions. 1997.



CONTROLLI SISTEMATICI SUGLI ARCHIVI

- DRG incoerenti (468, 476, 477)
- DRG o procedure incompatibili con le caratteristiche dell'erogatore
- numero complessivo dei ricoveri
- degenze brevi ordinarie
- trasferimenti tra ospedali per acuti
- ricoveri ripetuti (per istituto, reparto, DRG)
- DRG ad alta frequenza di ricoveri inappropriati
- manipolazione della SDO
- spesa e degenza sui ricoveri ordinari per acuti
- numero di accessi per ciclo di day hospital
- uso del day-hospital per diagnosi e procedura effettuata
- durata della degenza e ricoveri ripetuti in riabilitazione

EVENTI DA SOTTOPORRE A CONTROLLO

- validità della documentazione trasmessa
- attività di assistenza non compatibili con i servizi dell'ospedale
- dimissioni precoci
- ricoveri anomali per durata
- appropriatezza del ricovero
- ricoveri ripetuti / frazionamento del ricovero
- selezione dei pazienti
- 'cessione' dei pazienti per trasferimento

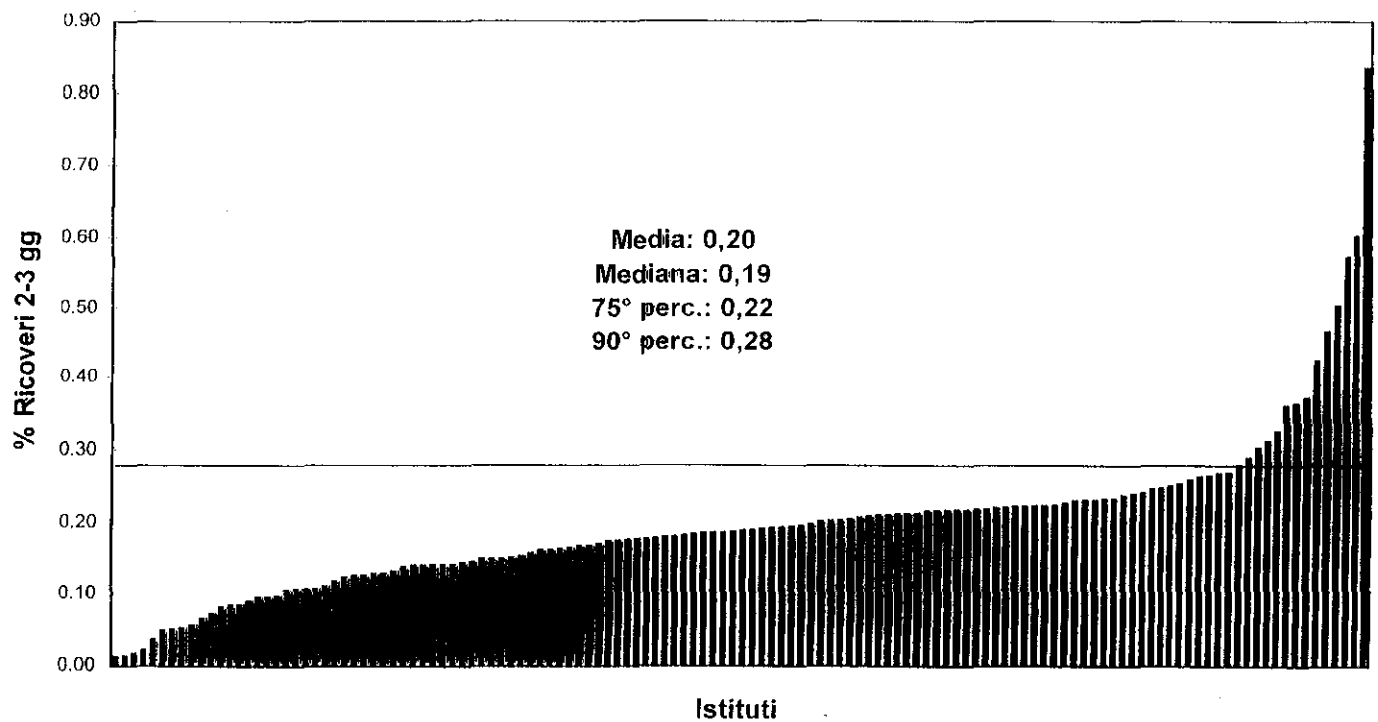
Tabella 2.4.1 - Medie regionali degli indicatori di controllo. Ricoveri ordinari. Onere SSN

	1995		1996		1997		Diff %	Diff %
	n°	%	n°	%	n°	%	95-96	96-97
DRG anomali	8897	1.1	4810	0.6	2699	0.3	-49.7	-44.9
DRG incoerenti	9984	1.3	9676	1.1	6339	0.7	-9.9	-36.5
1 giorno	112402	14.2	102800	12.0	96242	11.0	-14.9	-8.7
2-3 giorni	129346	16.3	166538	19.5	193827	22.1	19.8	13.4
Oltre soglia	30644	3.9	25247	3.0	20174	2.3	-23.4	-22.2
DRG complicati	69245	16.7	87694	20.0	97204	21.7	19.6	8.5
DRG chirurgici	82822	47.9	96951	52.5	101821	53.9	9.6	2.6
Deceduti	20587	2.6	22299	2.6	23095	2.6	0.8	1.1
Trasferiti tra 2 e 7 giorni	3811	0.5	5619	0.7	5678	0.6	37.4	-1.5
Trasferiti totali	14437	1.8	20906	2.4	23169	2.6	34.8	8.0
Ripetuti 30 gg	62771	7.9	69352	8.1	73351	8.4	2.6	3.1
Ripetuti 365 gg	117753	14.9	134135	15.7	142920	16.3	5.8	3.8

Tabella 2.4.2 - Medie regionali degli indicatori di controllo. Ricoveri in day-hospital. Onere SSN

	1995		1996		1997		Diff %	Diff %
	n°	%	n°	%	n°	%	95-96	96-97
Medici								
singoli accessi	60156	64.6	81574	61.3	96687	57.6	-5.0	-6.1
m.a.	6.7		6.5		6.1		-3.6	-6.2
>10 gg	5050	15.3	7795	15.1	9976	14.0	-1.0	-7.6
Chirurgici								
singoli accessi	9808	78.8	11850	64.6	12673	52.1	-18.0	-19.4
m.a.	3.7		3.4		3.2		-8.7	-5.9
Ripetuti								
DHm/Oc	4350	4.8	8735	6.6	9294	5.5	37.9	-15.7
DHm/DHc	160	0.2	287	0.2	597	0.4	22.9	65.1

Distribuzione per istituto della percentuale dei ricoveri di 2-3 giorni.
Lazio 1996 - Ricoveri Ordinari - Onere SSN



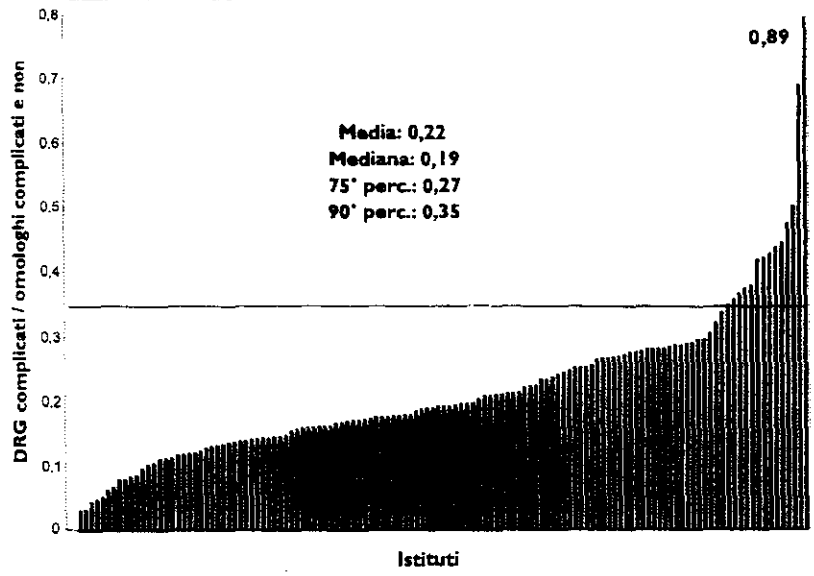
Esclusi Trasferiti e Deceduti

Sviluppo di indicatori per il controllo esterno dell'attività ospedaliera

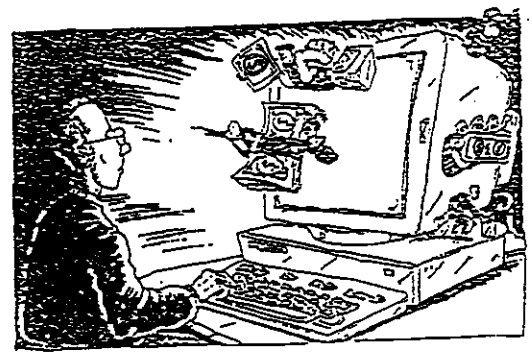
Legge Finanziaria 1998 - Capo I, art. 32:

"Le regioni, le aziende unità sanitarie locali e le aziende ospedaliere assicurano attività di vigilanza e controllo sull'uso corretto ed efficace delle risorse: raccolgono ed analizzano sistematicamente i dati concernenti le attività ospedaliere ... e i relativi costi e adottano tempestivamente azioni correttive nei casi di ingiustificato scostamento dai valori standard nazionali o locali."

Distribuzione per istituto del rapporto fra DRG complicati e DRG omologhi complicati e non.
Lazio 1996 - Ricoveri Ordinari - Onere SSN



Osservatorio Epidemiologico



SOUNDING BOARD

DRG CREEP

A New Hospital-Acquired Disease

"Diagnostic related groups" (DRGs) have become the watchwords of the health-services research, regulatory, and planning agencies. Introduced in 1975 by Thompson et al.,[1] they were intended as a means of grouping patients by discharge diagnosis to measure a hospital's output. These measurements are useful in analyzing and monitoring the hospital's resource utilization, performance, and costs. Today, the use of DRGs is virtually synonymous with case-mix measurement, and it has become the standard method to describe hospital outputs for any use.

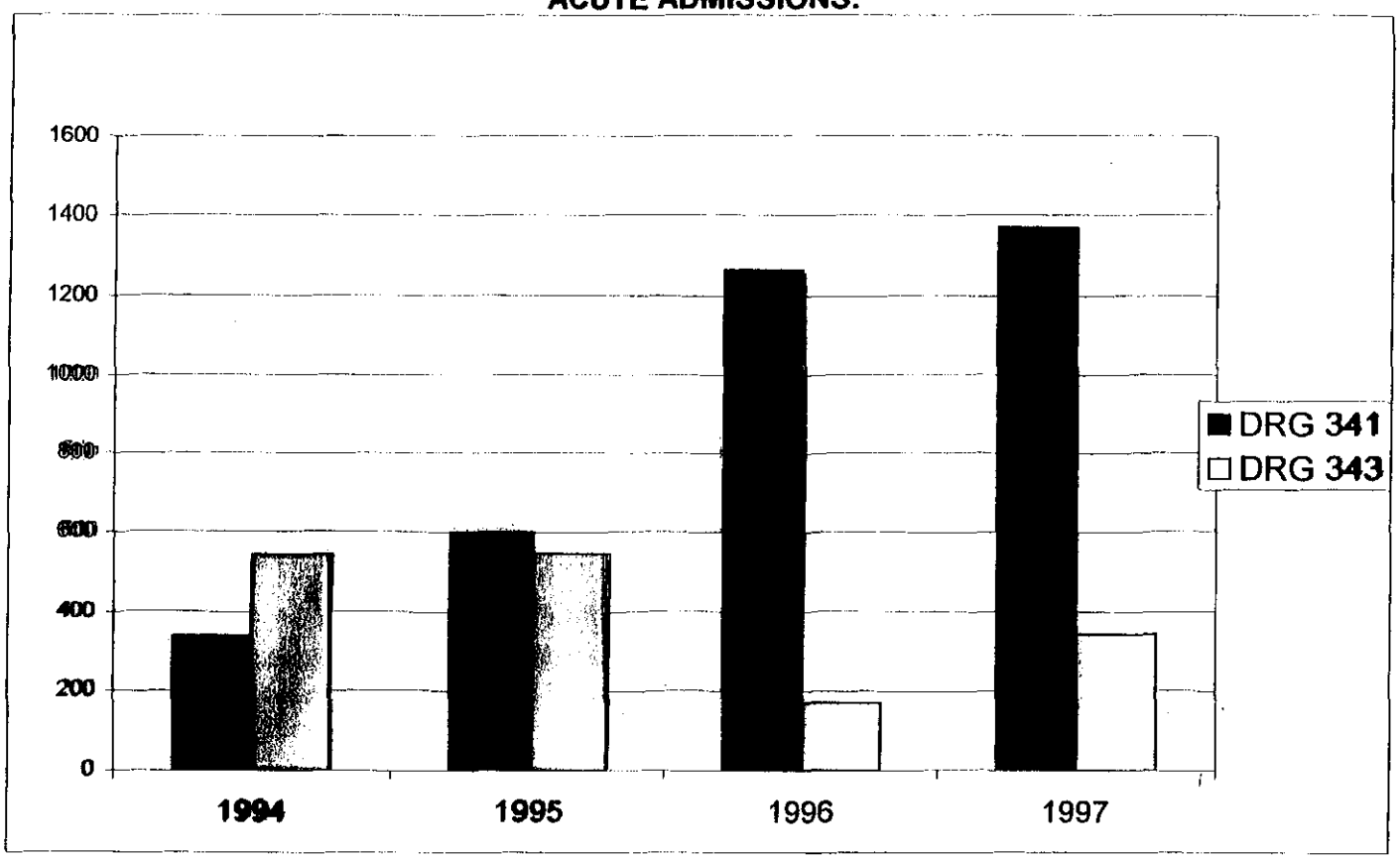
This article is intended to provide a case report of "DRG creep," a new phenomenon that is expected to occur in epidemic proportions in the 1980s. DRG creep may be defined as a deliberate and systematic shift in a hospital's reported case mix in order to improve reimbursement. Some background review is necessary for the non-DRG specialist.

Traditionally, when a patient enters a hospital for a medical problem of any kind, the hospital gets paid by sending an itemized bill or claim to the patient or insurance carrier. These charges, which are individually set by hospitals, bear a variable relation to the hospitals' actual costs. Although certain medical conditions cutoff point (e.g., the 80th percentile was used in 1979-1980) are reimbursed for services rendered to Medicare patients at the cutoff-point rate. The second factor was the advent of state rate-setting agencies, which, like their federal counterparts, adopted methods of limiting reimbursement.

The implementation of these limits led to the demand to recognize the obvious: It costs more to provide similar services to some patients than to others. Furthermore, some hospitals have more of these costlier patients than do others. Not surprisingly, the hospitals whose costs exceeded these allowed began to claim that they had a costlier case mix. These hospitals tended to be teaching hospitals, which have characteristics other than complex case mix that could account for increased costs. Thus, it was not clear to what extent the case-mix argument was valid.

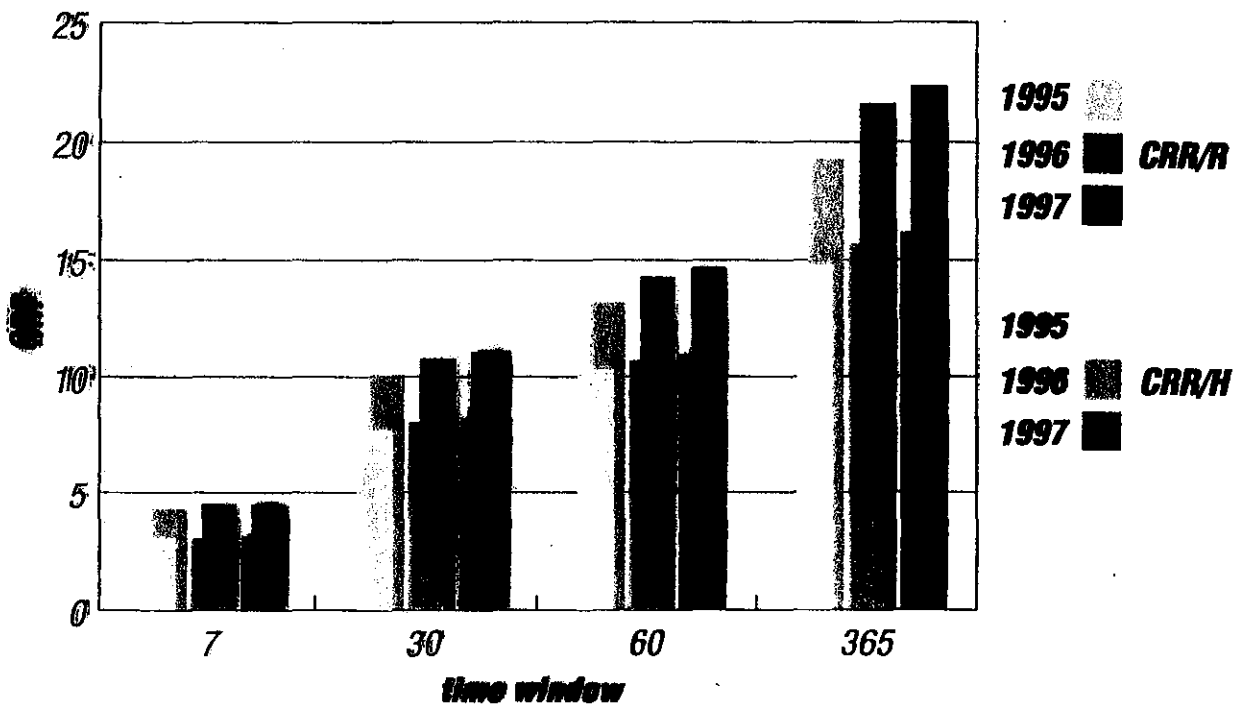
The stage was set for a mechanism to compare the case mix among hospitals; unfortunately, no such mechanism existed. The only readily available means is the information available in hospital discharge abstracts. These documents typically contain demographic information plus a list of diagnoses and procedures that have been coded under a modification of the *International Classification of Diseases* (ICD) coding scheme. However, there are serious limitations in translating differences in ICD patterns to cost implications.[2,3] The ICD code and its modifications

PENIS PROCEDURES (DRG 341) AND CIRCUMCISION AGE 0-17 (DRG 343) ACUTE ADMISSIONS.

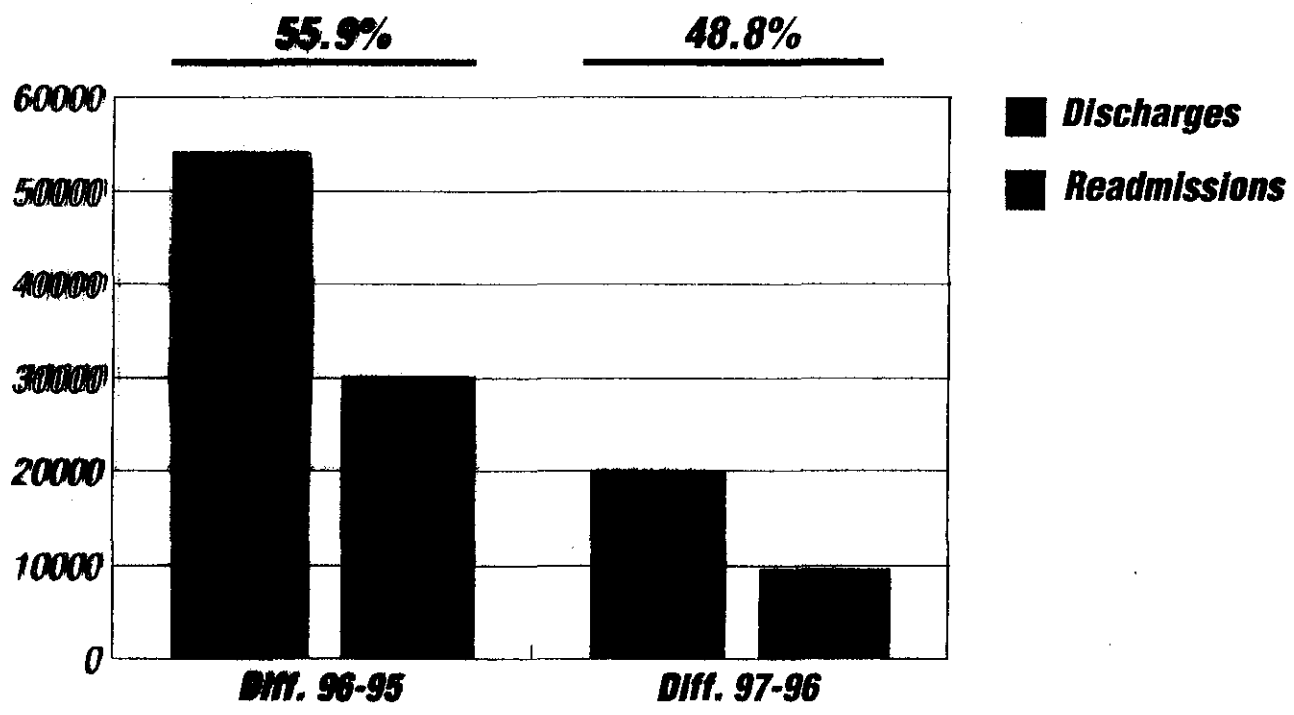


RUDE READMISSION RATES BY TIME WINDOW.

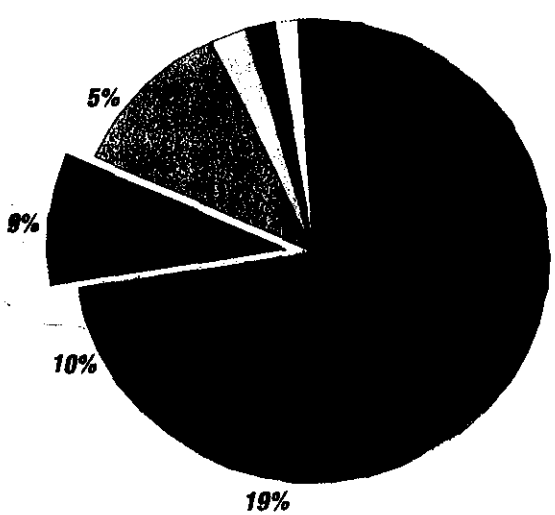
1995-1997



NCREMENTS OF NUMBER OF DISCHARGES AND OF READMISSIONS. ACUTE ADMISSIONS. 1995 - 1997



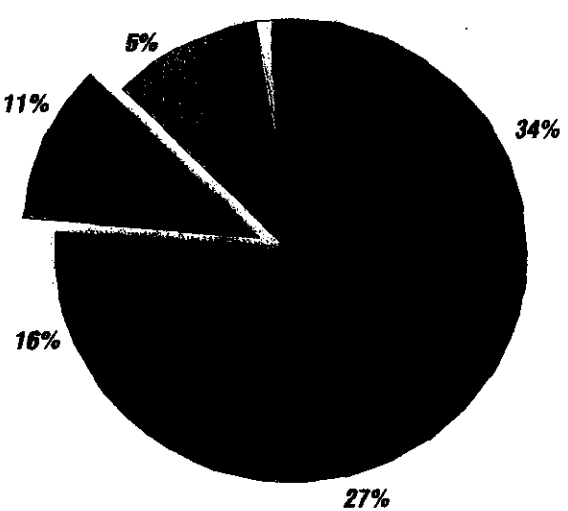
MDC 6
malattie dell'apparato digerente



altre
geriatria
oncologia
chirurgia pediatrica
astanteria
malattie infettive
pediatria
gastroenterologia
medicina generale
chirurgia generale

totale dimessi = 73.474

MDC 7
malattie del fegato, vie biliari e pancreas



totale dimessi = 30.887

CAUSE DI RIAMMISSIONE DOPO COLECISTECTOMIA

ANNO	Ricoveri per colecistectomia	Riammissioni per complicanze	TGR/H
1996	8.225	102	1.23
1997	8.366	138	1.64

$\chi^2 = 4.74$
$p<0.03$

Analisi dei dati del Sistema Informativo Ospedaliero del Lazio (S.I.O.), 1996.

Analisi dei determinanti della mortalità intra-ospedaliera

Modello 3 - regressione logistica

	OR	(95% CI)
Sesso		
maschi	1.00	
femmine	1.82	1.03 - 3.19
Età (OR per incrementi decennali)	1.67	1.24 - 2.26
Residenza		
Roma	1.00	
Lazio escluso Roma	0.79	0.44 - 1.43
Fuori Lazio	0.49	0.24 - 0.98
Tipo di malattia ischemica		
forme acute/subacute	1.00	
angina pectoris	-	-
forme croniche	6.7	1.38 - 32.5
infarto pregresso	4.09	0.75 - 22.3
infarto acuto	[illegible]	8.41 - 317.3
Patologie concomitanti		
altre malattie del cuore	[illegible]95	1.10 - 3.45
nefropatiche croniche	[illegible]42	2.86 - 19.2
arteriopatie periferiche*	[illegible]16	1.02 - 4.56
diabete	0.45	0.19 - 1.03
Altri interventi chirurgici cuore		
altro bypass	[illegible]6.0	1.76 - 385.6
altro	[illegible]29	0.74 - 7.12
Interventi chirurgici vasi arteriosi		
aorta	[illegible]	0.55 - 245.4
vasi del capo e del collo	[illegible]52	0.71 - 9.03
arti	[illegible]64.5	2.02 - 2063.7

* compresi vasi del capo e del collo

tabella 4c

Mortalità intra-ospedaliera (30 giorni), Regione Lazio, 1996.

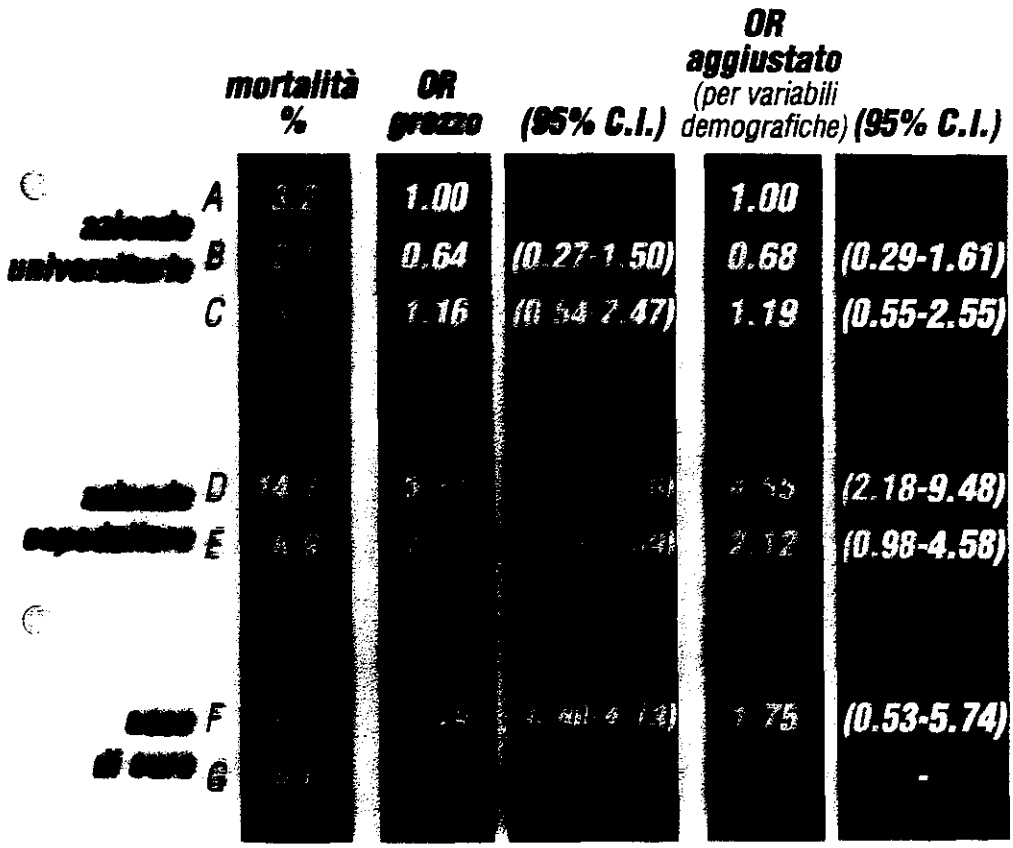


tabella **5a**

Mortalità intra-ospedaliera (30 giorni), Regione Lazio, 1996.

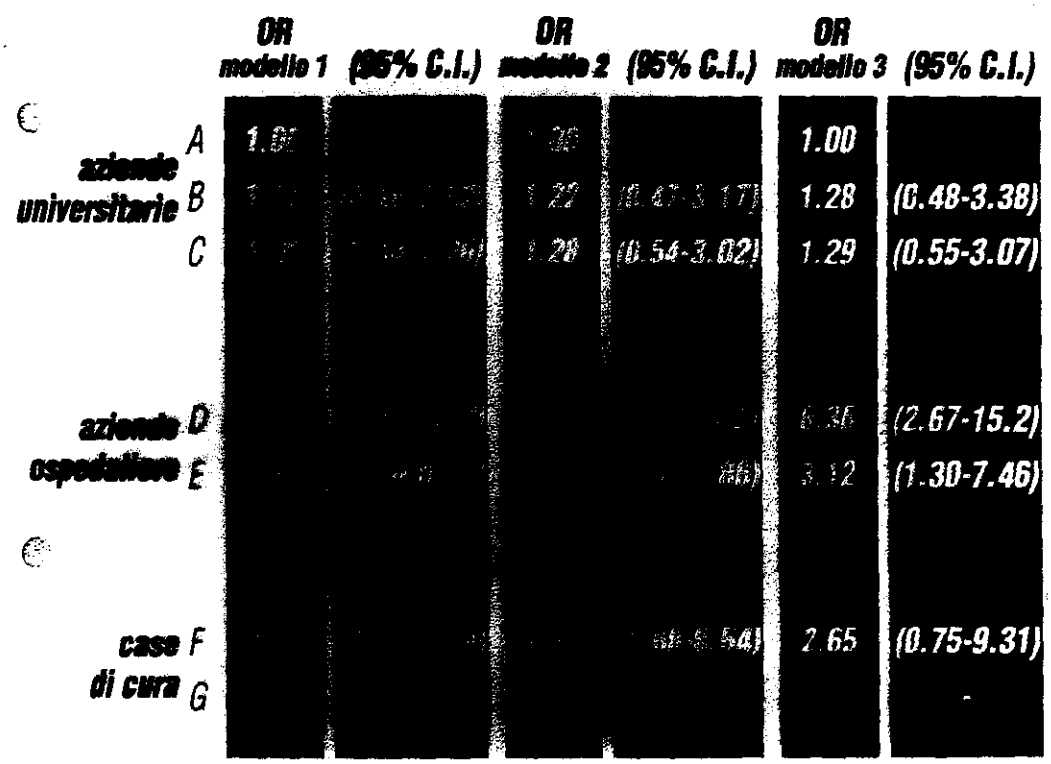


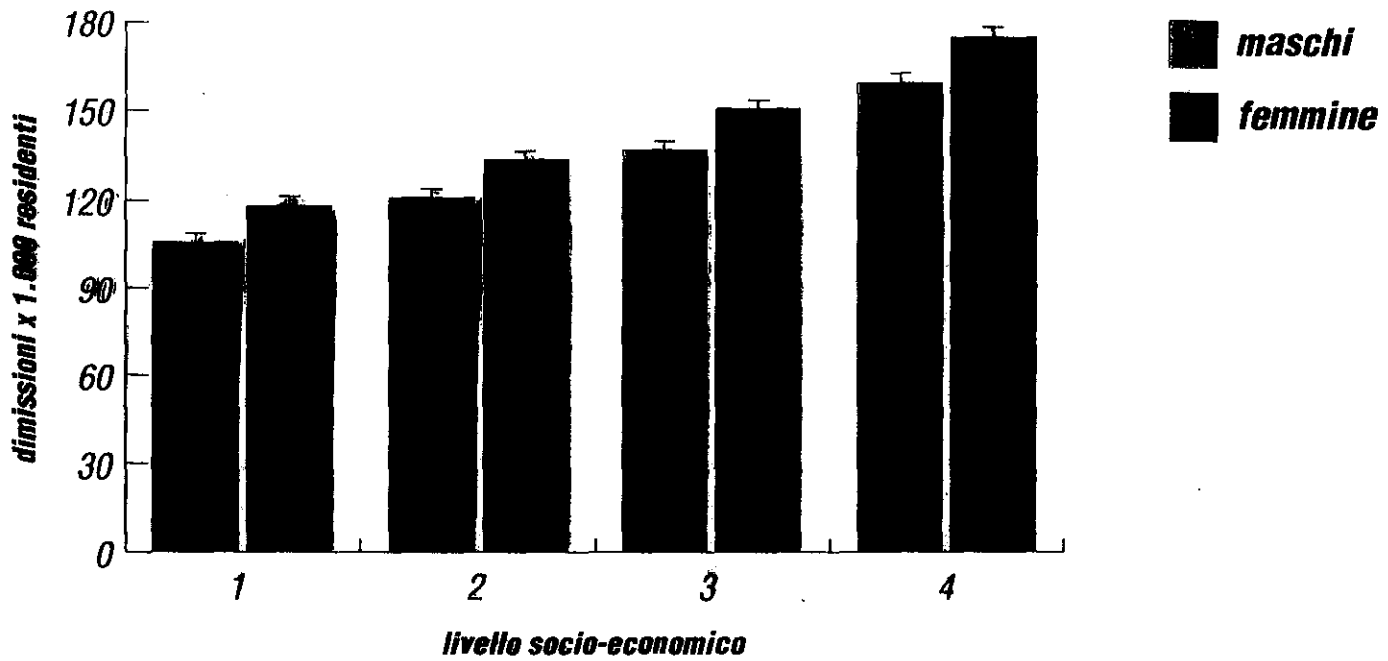
tabella **5b**

APPROPRIATENESS OF HOSPITAL USE

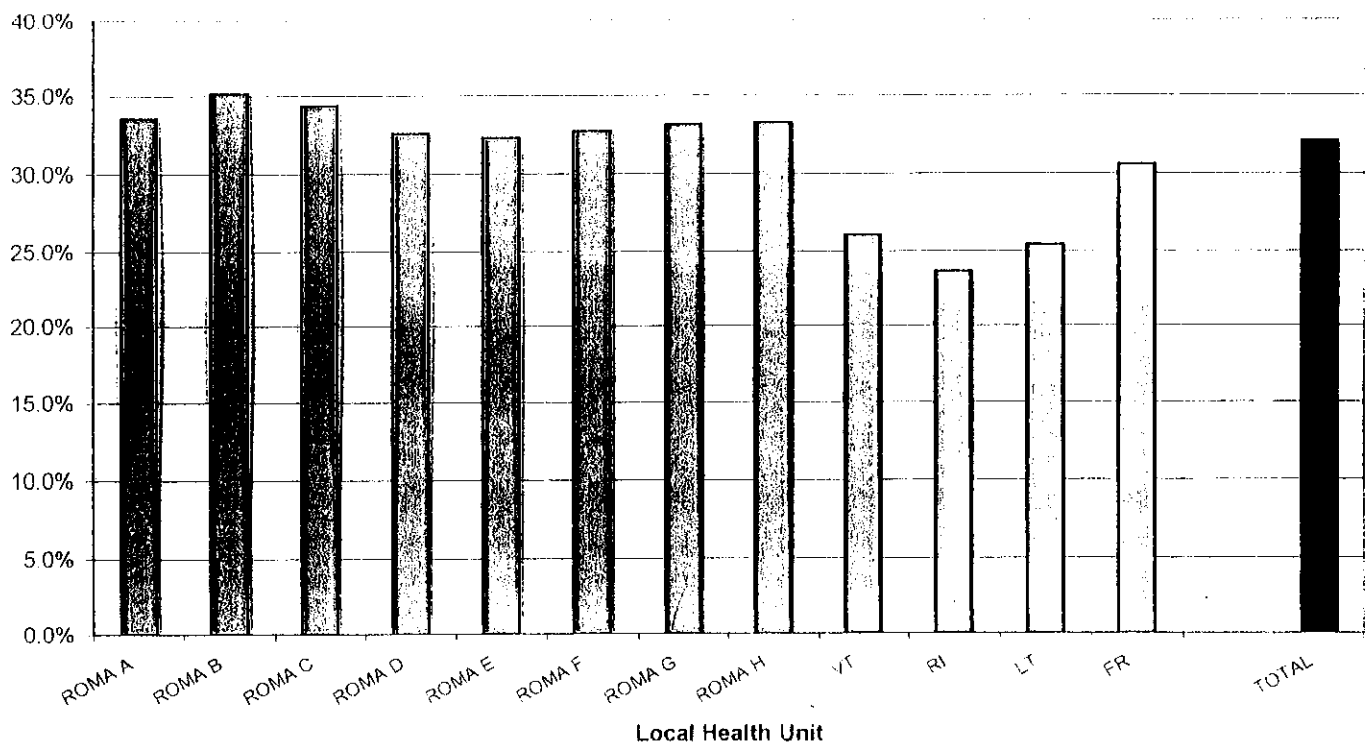
• **GENERIC**	• **SPECIFIC**
It implies an economic evaluation: Could the services be provided, a lower cost (and with a lower jatrogenic risk), elsewhere?	It implies a medical evaluation: Were the services provided to the patient necessary and/or efficient?

TASSI STANDARDIZZATI DI OSPEDALIZZAZIONE PER LIVELLO SOCIO-ECONOMICO.

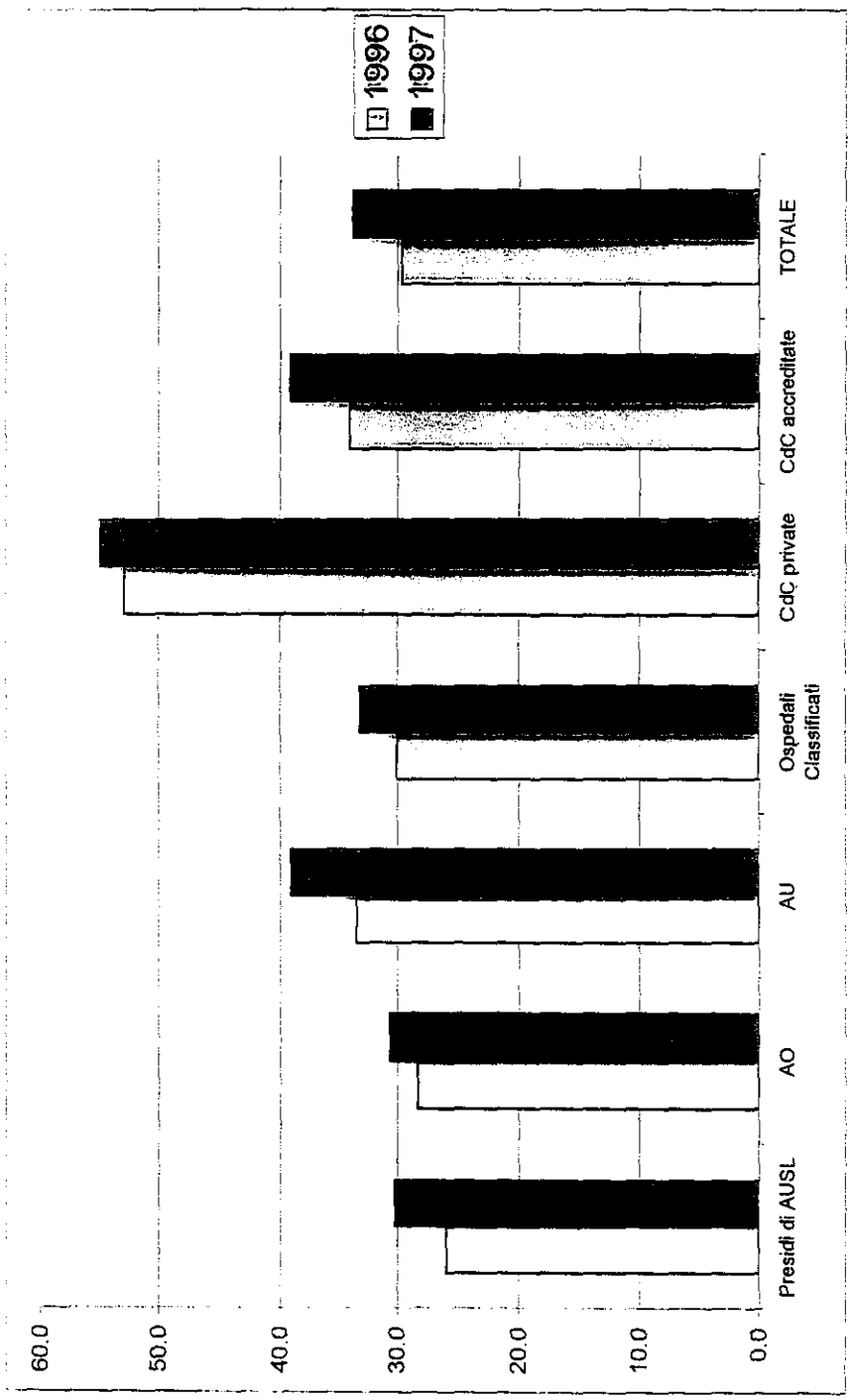
Ricoveri ordinari, 1997.

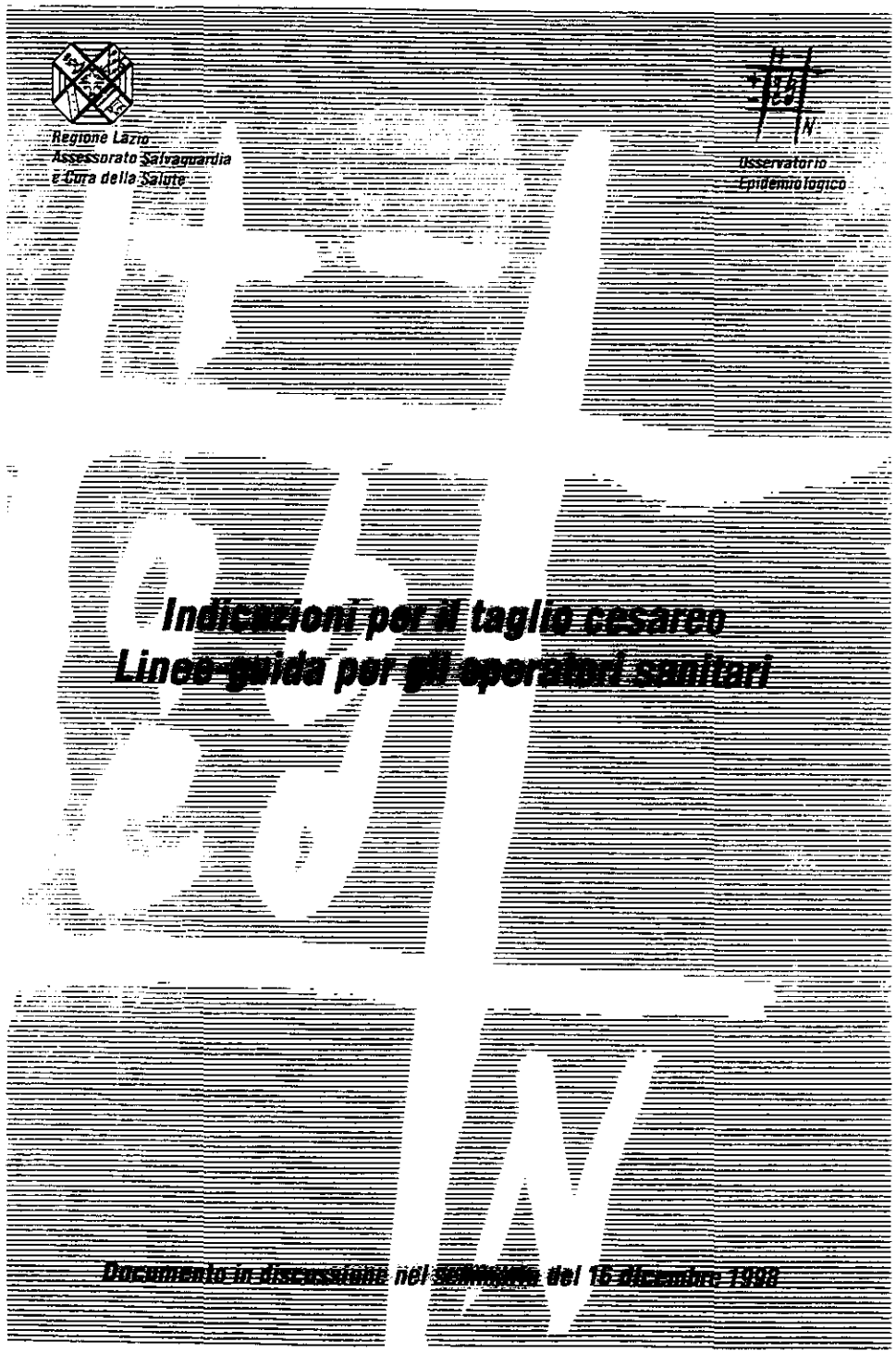


Deliveries w/o CC. Proportion of cesarean sections by area of residence. Lazio 1997



PROPORTION OF CESAREAN DELIVERIES BY TYPE OF HOSPITAL



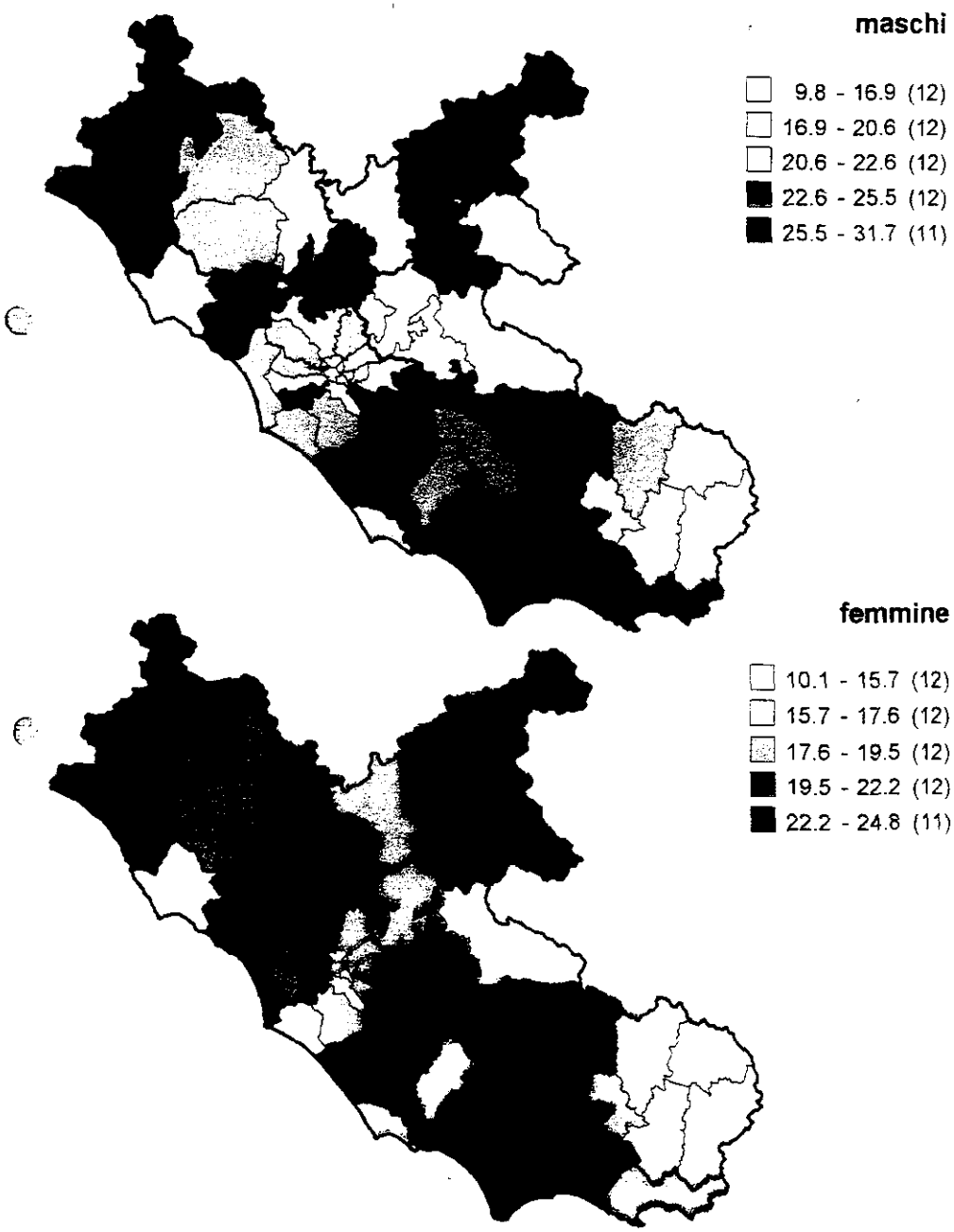

Regione Lazio
Assessorato Salvaguardia
e Cura della Salute
Osservatorio
Epidemiologico
Indicazioni per il taglio cesareo
Linee-guida per gli operatori sanitari
Documento in discussione nel seminario del 15 dicembre 1998

REGIONAL PROGRAM FOR THE PROMOTION OF VAGINAL DELIVERY

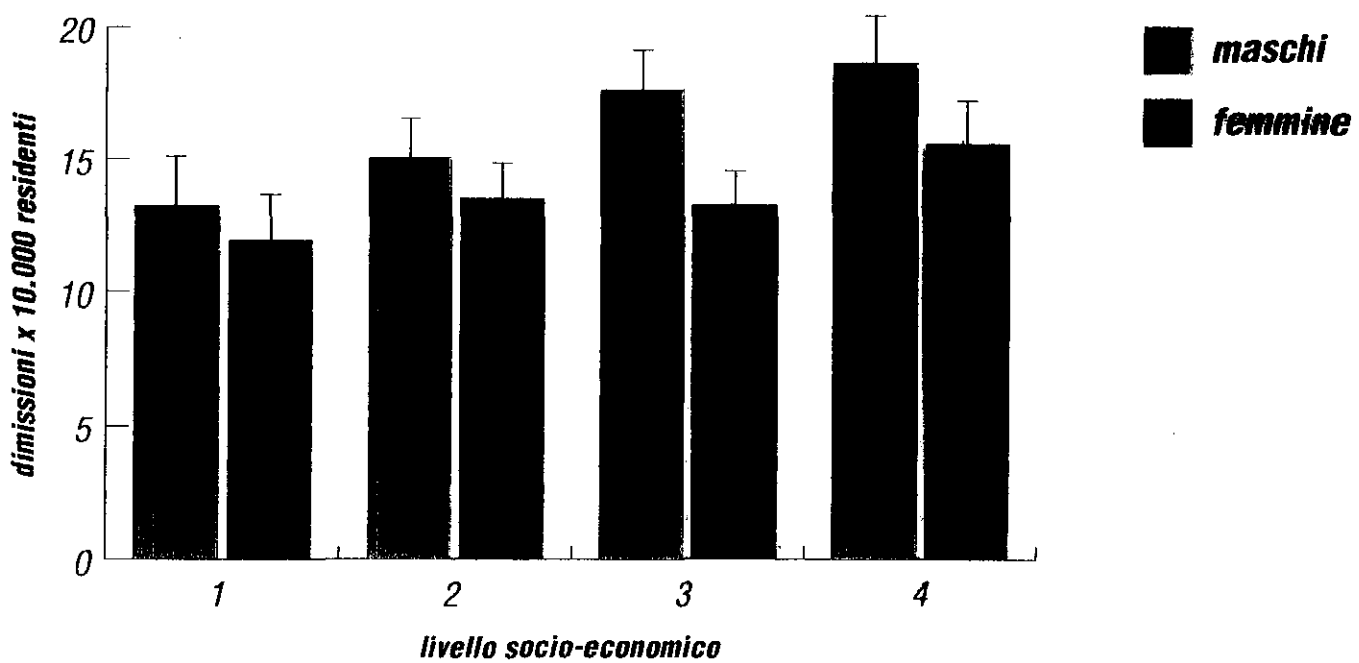
Observed percent of vaginal deliveries among women living in a given LHU	Additional reimbursment for each vaginal deliveriy (USD)
<72.0	0
72.0-73.9	145
74.0-77.9	175
78.0-81.9	205
82.0-86.0	235
>86.0	0

TASSI ... DI OSPEDALIZZAZIONE.

tonsillectomia, 1996.

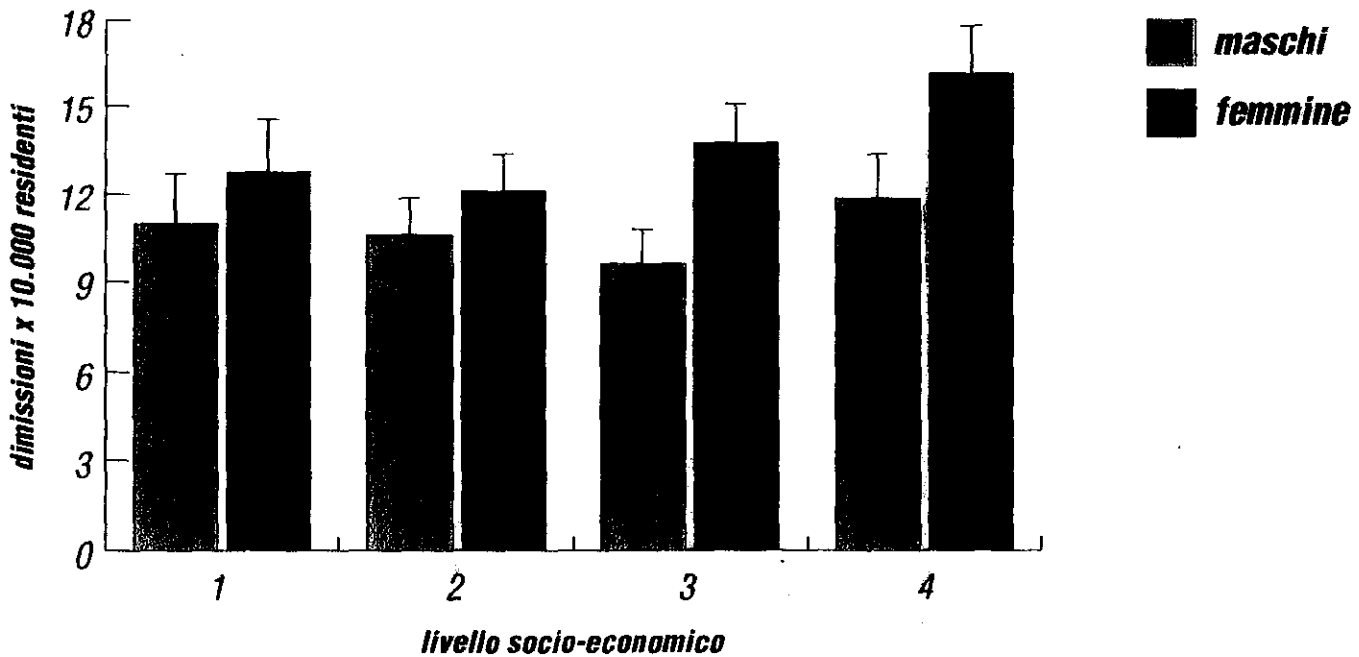


Ricoveri per tonsillectomia, 1996.

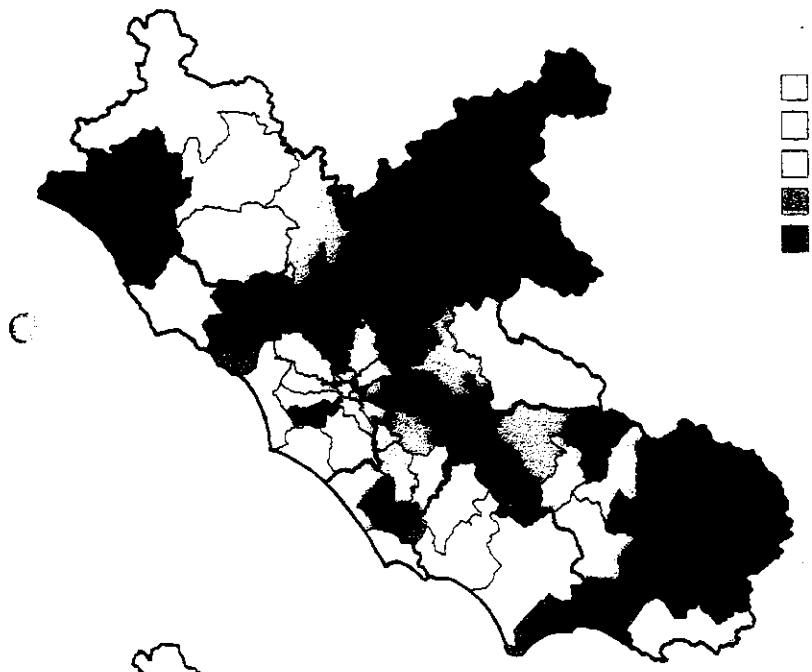


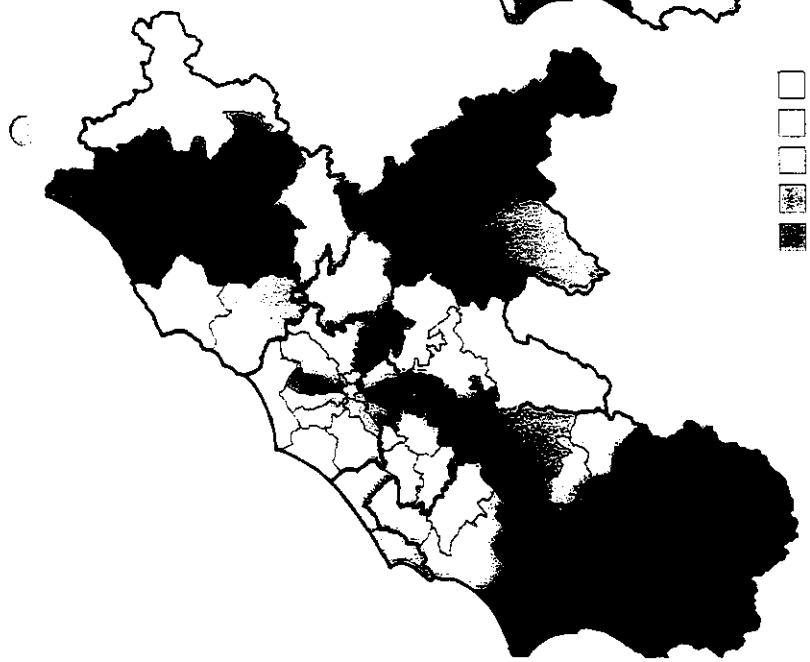
TASSI STANDARDIZZATI DI OSPEDALIZZAZIONE PER LIVELLO SOCIO-ECONOMICO.

Ricoveri per appendicectomia, 1997.



appendicectomia. 1996.





COMPONENT CRITERIA OF THE COMPLEXITY SCORE

	Area	Item	Value/Range	Score
a	Emergency	Class of the Emergency Department	Regional Dept.	3
			Local Dept.	2
			Emergency Room	1
			None	0
b	Perinatal Assistance	Class of the Perinatal Unit	Class A	3
			Class B	2
			Class C	1
			Non classified	0
c	Case mix	Number of DRGs with more than 50 discharges per year	> 150	3
			101 - 150	2
			51 - 100	1
			< 51	0
d	Specialties	Number of different specialties operating in the hospital (at least 200 discharges per year)	> 14	3
			10 - 14	2
			5 - 9	1
			< 5	0
e	Case mix	Proportion of cases assigned to the 30 more frequent DRGs	< 41%	3
			41% - 50%	2
			51% - 60%	1
			> 60%	0
f	Severity	proportion (%) of discharges attributed to a "severe" DRG	> 3%	3
			2.1% - 3%	2
			1.1% - 2.0%	1
			< 1.1%	0

Ordinary acute care. Observed hospital activity in 1997 and programmed services for 1999. DRGs with the largest programmed increases and decreases

	Ricoveri ordinari										
	Classe I		Classe II		Classe III		Classe IV		Totale		
DRG	*Erog. 97*	Prog. 99	*Erog. 97*	Prog. 99	*Erog. 97*	Prog. 99	*Erog. 97*	Prog. 99	*Erog. 97*	Prog. 99	Differenza
391	*5035*	6000	*9544*	10500	*4984*	7500	*6956*	7100	*26519*	31100	*4581*
373	*6545*	6400	*9689*	9600	*5879*	8964	*5922*	6787	*28035*	31751	*3716*
390	*1386*	2750	*1333*	1600	*1053*	1700	*563*	670	*4335*	6720	*2385*
112	*1140*	2400	*442*	600	*63*	0	*31*	0	*1676*	3000	*1324*
14	*2221*	3500	*2388*	3000	*1892*	1598	*2412*	1789	*8913*	9887	*974*
273	*490*	600	*1418*	1950	*130*	220	*97*	217	*2135*	2987	*852*
367	*516*	800	*344*	600	*233*	341	*166*	240	*1259*	1981	*722*
260	*502*	900	*376*	700	*211*	143	*207*	247	*1296*	1990	*694*
145	*693*	825	*715*	825	*445*	667	*714*	927	*2567*	3244	*677*
15	*1306*	2275	*1510*	1950	*1133*	893	*1828*	1290	*5777*	6408	*631*
.											
.											
.											
.											
.											
467	*958*	150	*1950*	675	*368*	318	*180*	338	*3456*	1481	*-1975*
371	*3294*	4400	*4120*	3850	*2752*	1459	*2801*	1230	*12967*	10939	*-2029*
254	*1343*	1100	*2779*	2200	*2407*	1525	*1185*	647	*7714*	5472	*-2242*
468	*1317*	150	*1036*	300	*914*	696	*577*	339	*3844*	1485	*-2359*
127	*2888*	1900	*3101*	2375	*2125*	2091	*3768*	2917	*11882*	9283	*-2599*
65	*1696*	800	*1955*	1280	*1398*	910	*1587*	967	*6636*	3957	*-2679*
162	*3136*	1700	*2528*	1700	*2097*	1888	*3920*	3007	*11681*	8295	*-3386*
243	*3242*	2100	*3393*	2100	*3845*	3660	*3237*	2438	*13717*	10298	*-3420*
134	*3311*	1000	*2561*	1500	*2868*	3002	*4677*	4216	*13417*	9718	*-3699*
39	*3808*	2500	*5704*	4375	*4288*	3219	*3906*	2282	*17706*	12376	*-5330*
389	*2678*	1000	*2378*	1000	*2413*	800	*1015*	226	*8484*	3026	*-5458*
183	*5406*	4000	*5267*	4000	*3878*	2992	*6688*	4720	*21239*	15712	*-5527*
Totale residenti	*240950*	219056	*250296*	227267	*169626*	161956	*185485*	157478.6	*846357*	765758	-80599
		-9.1%		-9.2%		-4.5%		-15.1%			-9.5%

Medical day care. Observed hospital activity in 1997 and programmed services for 1999. DRGs with the largest programmed increases and decreases

Codice Istituto	Totale erogato '97	Programmato 1999	Differenza
DRG			
404	16017	55710	*39693*
410	39750	55710	*15960*
206	17160	32730	*15570*
294	5675	19290	*13615*
490	51446	65000	*13554*
295	1792	13000	*11208*
301	9373	17500	*8127*
137	938	8400	*7462*
473	2432	9780	*7348*
275	7990	15000	*7010*
297	2534	9330	*6796*
367	2128	8570	*6442*
409	2820	9093	*6273*
429	3445	9450	*6005*
298	4412	10000	*5588*
184	4930	10500	*5570*
88	5748	11110	*5362*
241	8027	13330	*5303*
.			
.			
.			
.			
.			
462	3733	1500	*-2233*
273	5074	2625	*-2449*
183	7270	3889	*-3381*
131	7198	2335	*-4863*
317	5789	0	*-5789*
134	7353	1471	*-5882*
395	12321	5726	*-6595*
318	11362	4000	*-7362*
284	10907	2181	*-8726*
467	12132	2426	*-9706*
Totale residenti	490996	694038	*203042*
			41.4%

Day surgery. Observed hospital activity in 1997 and programmed services for 1999. DRGs with the largest programmed increases and decreases

Codice Istituto DRG	Totale erogato '97	Programmato 1999	Differenza
39	513	7500	*6987*
381	6998	10636	*3638*
162	273	2833	*2560*
364	646	2000	*1354*
6	744	2045	*1301*
270	1226	2500	*1274*
40	1172	2400	*1228*
232	154	1167	*1013*
266	2716	3500	*784*
60	1	778	*777*
119	372	1024	*652*
262	430	1000	*570*
.			
.			
.			
.			
.			
211	5	0	*-5*
482	5	0	*-5*
4	6	0	*-6*
114	7	0	*-7*
75	8	0	*-8*
265	10	0	*-10*
461	138	50	*-88*
477	337	100	*-237*
468	464	150	*-314*
Totale residenti	22383	48668	*26285*
			117.4%

Good information systems

need

Human and technical resources

Health care reform and financing in Italy and Lebanon

Tuesday, 16th of February 1999

Issam Fares Hall, AUB

09.30 -10.30 Opening speeches
Minister of Health of Lebanon, **Dr. Karam Karam**
Minister of Health of Italy, **Mrs. Rosaria Binidi**

10.30 - 11.30 Coffee Break
Transfer to the Riviera Conference Room and registration.

Riviera Hotel

Chairmen: Dr. F. Freiha - Prof. G. Benagiano

11.30-12.00 The Italian National Institute of Health.
Prof. G. Benagiano

12.00-12.30 Legislation, policy and practice of the health care reform in Italy.
Prof. M. Zanetti

12.30-13.00 Financing health care in Lebanon.
Dr. W. Ammar

13.00-14.00 Debate

14.00-15.00 Lunch Break

15.00-15.30 Financing health care in Lebanon - The role of the National Social Security Fund
Dr. H. Mallat

15.30-16.00 Financing health care in Italy: principles and practices.
Dr. N. Dirindin

16.00-17.00 Debate

The principles and practices of health care expenditures in Italy and Lebanon

Wednesday, 17th of February 1999

Riviera Hotel

Chairmen: **Dr. R. Sfeir - Prof. M. Zanetti**

09.00-09.30 Resources allocation and ethical issues. Effects of allocation mechanisms on the health reform objectives.
Dr. A. Stafanini

09.30-10.00 Social inequities and mortality.
Dr. G. Costa

10.00-10.30 Public hospital autonomy in Lebanon - Legislation.
Dr. I. Moubarak

10.30-11.00 Coffee break

11.00-11.30 Public providers and health authorities in Italy.
Dr. E. Verdini

11.30-12.00 Third Party Administration in Lebanon: experience and results.
Mr. M. Kharma

12.00-13.00 Debate

13.00-14.00 Lunch break

14.00-14.30 Flat rates development in Lebanon.
Dr. F. Najjar

14.30-15.00 Establishment and management of the DRG system in Italy. Principles, effects and cost.
Dr. M. Braga

15.00-15.30 Information management and DRG system implementation.
Dr. M. Arca'

15.30-16.30 Debate

The Italo-Lebanese Conference On Health Care Financing

List of speakers

Speakers	Business address	Telephone/fax
Mr. Khalil Majed	National Social Security Fund	T. 01-700280/01-819298
Dr Faysal Najjar	American University of Beirut/ Medical centre	T. 01-345247 03-618715 Fax 01-342349
Mr.Mounir Kharma	Med-Net Liban	T.01-485015-494912 Fax:01-601538 E-mail mednte@dm.net.lb
Mr Osman Azzam	MOH-Museum Square Mansour Bldg. POBox 55664 Sin El Fil-Beirut	T. 01-615724-25 C. 03 343515
Prof. Giovanni Benagiano	Istituto Superiore di Sanita' Viale Regina Elena 299 00161 Roma	T. 06-44869455 *Fax 06-44869440*
Prof. Mario Zanetti	Agenzia Sanitaria, Regione Emilia Romagna, Viale Aldo Moro 38 , 40127 Bologna-Italy.	T. 0039-051-283201 283234 283111 Cel. 00336584100 *Fax 0039-051-283715*
Dr. Angelo Stefanini	Dipartimento di Medicina e Sanità Publica, Università degli Studi di Bologna, Via S. Giacomo 12 40126 Bologna, Italy	T. 0039-051-283627 284783 Fax-Univers. 051-243050 E-mail: stefanini@alma.unibo.it
Dr. Eleonora Verdini	Agenzia Sanitaria, Regione Emilia Romagna, Viale Aldo Moro 38 , 40127 Bologna-Italy.	T. 0039-051-283226 283729 Fax 0039-051-283715
Dr. Nerina Dirindin	Minsitero della Sanita' – Piazale dell'Industria 20 00144 Roma	T. 0039-06-59945246 / 5263 / 5332 /5292. C. 0039-338-7041353 Fax 0039-06-58377015 / 5226.

Dr. Mario Braga	Health care quality research unit –Istituto dermopatico dell'Immacolata- Via dei Monti di Creta 104, 00167-Rome	T. 06-57287405 06-66464467 Fax 06-66464464 E-mail: m.braga@idi.it
Dr. Giuseppe Costa	Epidemiology Unit, Piedmont Region, Viale Sabaudia 164 10095 Grugliasco (TORINO)-Italy	T. 0039-0114017688 Fax.0039-0114017687
Dr. Massimo Arca'	Osservatorio Epidemiologico –Regione Lazio-Via di S. Costanza 53-00198 Roma	T. 0039-06-51686488 / 93. Fax 0039-06-51686463.

The Italo-Lebanese Conference
On Health Care Financing

List of invited guests and participants

	NAME	ORGANISATION
1.	Dr. Salwa Makarem	Director School Nursing American University of Beirut (AUB)
2.	Dr. Michel Matta	Pediatrician Ministry of Public Health (MOH)
3.	Nadia Tawtel	Ministry of Social Affairs
4.	Hanadi Youssef	Ministry of Social Affairs
5.	Ziad Itani	Makassed Hospital
6.	Arabia Moh'd Ali	Dept. of Health Sciences Administration - Teacher - AUB
7.	Bernadette Abi Saleh	Dean Faculty of Health Sciences Lebanese University (UL)
8.	Cézare Akoum	Health Sector Rehabilitation Program - MOH
9.	John Jabbour	Health Sector Rehabilitation Program - MOH
10.	Ruba Hamadeh	Health Sector Rehabilitation Program - MOH
11.	Osmat Azzam	Health Sector Rehabilitation Program - MOH
12.	Dr. R. Abu Haka	Health Sector Rehabilitation Program - MOH
13.	Colonel Hafez Ahmadié	Director of the Dept. of Health General Security
14.	Dr. Alfonso Gastaldi	C.I.S.P. - Italian NGO
15.	Dr. Riad Khalifeh	Director of care - MOH
16.	Dr. Nabil Kharrat	Director of the Secours Populaire Libanais NGO
17.	Dr. Wanda Barakat	Director of the Central Laboratory - MOH
18.	Asma Kurdahi	UNFPA
19.	Rafic Fayad	Secours Populaire Libanais

20.	Dr. Mara	Italian Embassy
21.	Dr. Ali Hajjar	Dr. Mohammad Khaled Foundation - NGO
22.	Caroline el-Rayess	Health Sector Rehabilitation Program - MOH
23.	Michele Asmar	Health Sector Rehabilitation Program - MOH
24.	Mohamad Ali Hamadani	Makassed Hospital
25.	Jihad Takkouch	Makassed Hospital
26.	Dr. G. Hammoud	Hammoud Hospital
27.	Lina Taher	Director of the Private Insurance's Dept. Ministry of Economy & Trade
28.	Ahmad Nasrallah	Al Rassoul Al Ahzam Hospital
29.	Ibtisssam Massalthi	Makassed General Hospital
30.	Michele Abi Saad	Chronic Care Center
31.	Rita Ricci	MOLISU
32.	Nour Baltagi	Pediatrician
33.	Dr. Mohammad Assaf	Al Rassoul Al Ahzam Hospital
34.	Jenny Saad Romanos	Health Sector Rehabilitation Program - MOH
35.	Salman A. Chalek	Iman Hospital - Aley
36.	Mohammad Arnhi	General Security
37.	Tania Jabara	Health Sector Rehabilitation Program - MOH
38.	Hanna Kobeissi	Dept. of Health Sciences Administration - Teacher - AUB
39.	Hanadi Tabsh	Makassed Hospital
40.	Sawsan Ezzedine	President Federation of Nursing Associations'
41.	Dr. T. Zakkhia	Director of the Institute of Health & Social Protection - St. Joseph University (USJ)
42.	Dr. R. Chahine	Dean of the Faculty of Medicine (UL)
43.	Dr. Ali El Zein	UNICEF - Health Officer
44.	Dr. Alissar Rady	WHO
45.	Dr. W. Yehian	Director of Shahhar Governmental Hospital
46.	Dina Ansari	Student of Public Health - AUB

47.	Dr. M. Khalidi	WHO
48.	Randa Turk	WHO
49.	Reem Chaarani	Child and Mother Welfare Hospital
50.	Prof. E. Chalouhi	Director of Dahr el Bashek Public Hospital
51.	Fida Shaheem	Student of Public Health - AUB
52.	Anastasia Sayegh	Khayat - Kanaan - Medical Supplies Co.
53.	Dr. M. Bashir	Al Rassoul Al Ahzam Hospital
54.	Lt. Col. A. Allaw	Director of Tyre Governmental Hospital
55.	Dr. Nouhad Sarkis	Pharmacist at the Central Pharmacy Ministry of Health
56.	Dr. Tony Bazi	Councilor to the Minister of Health
57.	Mona Khoury	MOH
58.	Nassim Abdel Samad	Health Sector Rehabilitation Program - MOH
59.	Dr. Sima Ramadan	Health Economics Health Services Admnistration Dept. - AUB
60.	Rolla Shehab	Makassed Hospital
61.	Zeina Fathallah	Institut de Gestion de la Santé et de la Protection Sociale - USJ
62.	N. Ballagi	Najjar Hospital
63.	Lina Jaber	Council of Development & Reconstruction
64.	Georges Khoury	Council of Development & Reconstruction
65.	Dr. F. Shammas	Councilor to the Minister of Health
66.	Joelle Obeid	Health Sector Rehabilitation Program - MOH
67.	Susanna Topakian	Italian Embassy
68.	Mr. M. Firkh	Director of Makassed Hospital
69.	Zeina Zeidan	Hotel Dieu de France Hospital
70.	Dr. Iman Nuwayhid	Teacher - Dept. of Environmental Health - AUB
71.	Helen Samaha	AUB
72.	Michel Romanos	C.I.S.P (Italian NGO)
73.	Dr. Nadim Karam	Dean of the Faculty of Health Sciences Balamand University

74.	Saydeh Nassar	Assistant Director for finance American University Hospital
75.	Mayssoun Demachkieh	Public Health student - AUB
76.	Rola Baydoun	Public Health student - AUB
77.	Elie Mekhael	Teacher - Lebanese University
78.	Dr. K. Kassak	Chairman of the Health Sciences Dept. - AUB
79.	Prof. H. Zreik	Dean of the Faculty of Health Sciences - AUB
80.	Amal Hani	Health Sector Rehabilitation Program - MOH
81.	Dr. A. Mechbal	WHO Representative in Lebanon
82.	Suzanne Azar	Health Economics teacher - U.S.J.
83.	May Awar	Health Sector Rehabilitation Program - MOH
84.	Rita Freiha	Health Sector Rehabilitation Program - MOH
85.	Samer Breiche	ISF
86.	Khaled Kaskas	NGO
87.	Dr. Bahij Arbid	Director of the Planning Unit - MOH
88.	Dr. Ajouz Abdallah	Head of the Hospitals' Dept. - MOH
89.	Paola Zampillo	AVSI
90.	Dr. S. Abdel Hassan	Director of Tripoli Governmental Hospital
91.	Marie-Hélène Kassoufi	MOVIMONDO MOLISU
92.	Roy Wakim	Health Sector Rehabilitation Program - MOH
93.	Samar Hammoud	WHO
94.	Rania Al Darwich	Consultation and Research Institute

ANNEXES

I. HEALTH SECTOR REFORM IN LEBANON
Dr W. Ammar et al .

2. LE FINANCEMENT DE LA SANTE AU LIBAN. 1
Dr W. Ammar et al .

3. LE FINANCEMENT DE LA SANTE AU LIBAN. 2
Dr W. Ammar et al .

4. PUBLIC SECTOR REVIEW –HEALTH SECTOR
World Bank report 2-1999

HEALTH SECTOR REFORM IN LEBANON

Walid AMMAR, Albert JOKHADAR, May AWAR*

INTRODUCTION

Lebanon is a small country of 4 million inhabitants, witnessing a demographic transition. 28% of the population falls under 15 year of age, and 10% over 60 [1]. The demographic annual growth rate is 1.6%. The total fertility rate is 2.5, and the infant mortality rate is 28 ‰. 80% of the population resides in urban areas.

This demographic transition is accompanied by an epidemiological transition : while important health problems are still related to infectious diseases, chronic and degenerative diseases are becoming more and more prevalent, with the aging of the population, the changing of dietary trends and the acquiring of new life-styles related to urbanization.

An increasing incidence of chronic diseases is witnessed [2, pp 465-7]. 55% of males and 67% of females were found obese (*Obesity : Body Mass Index > 27 for males, > 25 for females*). The prevalence in adult population is 13% for diabetes and 26% for hypertension (*Hypertension : systolic blood pressure ≥ 140 and/or distolic blood pressure ≥ 90*). Along with a high incidence of cancer, with 4000 new cases occurring yearly.

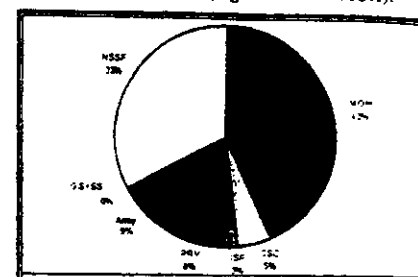
This transition is putting the health system under serious constraints ; to support financially, the double burden of disease and to adapt the supply of services and manpower to the emerging needs.

THE SOCIAL SECURITY SYSTEMS

There are three employment based social insurances : The National Social Security Fund (NSSF) covering the employees of the formal sector which includes the private sector as well as contractuals and wage earners of the public sector, the Civil Servants Cooperative (CSC) and four different military schemes. The portion of the population covered by these funds is consecutively 33% for NSSF, 6% for CSC and 11% for military schemes.

There is a growing market for private insurance. Private insurance is purchased either as a whole cover for health care by 8% of the population, or as a supplement to other social insurance programs by an additional 5% of the population.

The remaining 43% of the population are entitled to the coverage of the Ministry of Health (MOH), making it an insurer of last resort (Fig. 1 – *Source : MOH*).



PRV : Private insurance. ISF : Internal Security Forces
GS : General Security. SS : State Security

Figure 1

The separation between financing and provision of health care, the fragmentation and overlapping of sources of funding together with the institutional weaknesses of financing agencies constitute a major impediment for monitoring and controlling cost and quality.

THE HEALTH CARE MARKET

The provision of health services by the government has witnessed a meaningful decline, during the seventeen years of civil unrest that has affected the institutional and financial capacities of the public sector.

Instead, the NGOs and the private for profit sector grew up in both number and capacity.

As a result, today 90% of hospital beds are in the private sector. The majority of the existing 850 Primary Health Care Centers and dispensaries belong to NGOs [3].

Lebanon follows the free market economy. Whereby licensing is based on outdated standards with poor monitoring, the private sector continues to grow in a largely unregulated environment, allowing uncontrolled investment and generating a supplier-induced demand.

Health services are curative oriented with an exceeding number of hospitals and high technology equipment, such as scanners and magnetic resonance machines, and sophisticated services, such as open-heart surgery and in-vitro fertilization [4, pp 149-151]. This oversupply is in contrast with weak Primary Health Care services and almost inexisting mental health and geriatric services.

*From the Ministry of Public Health, respectively Director General, Advisor to the Health Minister and Assistant Director general.

Mailing address and reprint requests : Walid Ammar, M. D. Ministry of Public Health, Museum Street, Beirut, Lebanon. Fax : 961 1 615730.

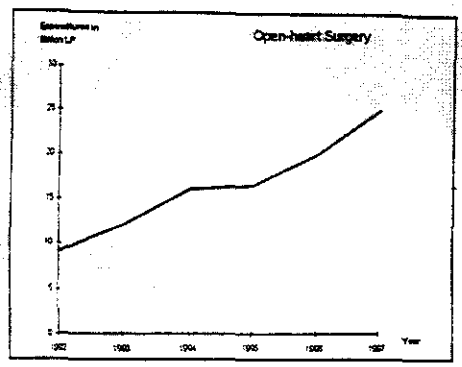


Figure 2

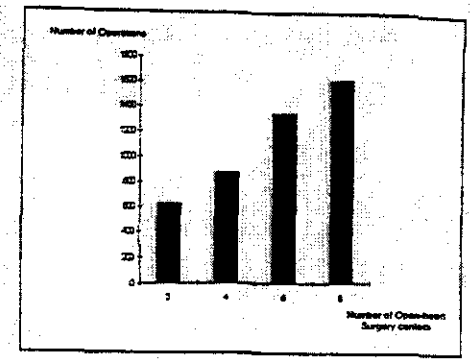


Figure 3

The same discrepancy in human resources is noticed with an oversupply of physicians and a shortage of nurses. The number of physicians has grown by 3.3% per year over the last 10 years, in comparison with a population growth rate of 1.6%. The number of registered physicians is 8250, which represents 2 physicians per thousand inhabitants [5]. When all categories of nurses together with midwives amount only to half of this number.

The first graph (Fig. 2) is an illustrative example of supply induced demand. It shows how open heart surgery expenses are steadily increasing, year after year except for 1995. No waiting lists are made since 1994 indicating that the existing centers were sufficient enough to meet the needs. this is revealed by the insignificant increase in expenditures in 1995, where the number of centers remained the same as 1994. The picking up in the curve, since 1996, is due mainly to the increasing number of centers.

The second graph (Fig. 3) illustrates clearly the strong direct relationship existing between the number of operations performed and number of existing centers (*Source : MOH*).

The private provider invests in areas that can maximize profit, consequently poor regions are not attractive, they remain underserved creating equity problems. The highest per capita availability of beds is found in Beirut and the surrounding localities of Mount Lebanon. In addition, private hospitals are not delivering the same quality of services to the rich and poor, and are frequently imposing extra fees.

The selection of providers by the insurer is not based merely on cost and quality : regional and confessional considerations must also be taken into account, and political interferences play a big role. This impediment for free competition is responsible for the escalation of cost, making private services hardly affordable by public funds, and thus threatening the sustainability of the present system. In addition, consumer perception of quality of care has pushed for more inefficiency.

HEALTH EXPENDITURES

Hence, the war accelerated the process of privatization that found flourishment in the free market environment. The weakening of public health services during the war years left the Government with no other alternative than contracting out with the private for a yearly widening range of services.

The bulk of government health expenditures (Fig. 4) goes for purchasing hospital-based services from the private sector. The Ministry of Health's expenditures on private hospitals amounted to 14 million US $ in 1991, 60 million US $ in 1994, 138 million US $ in 1996, and has reached 160 million US $ in 1997.

Private hospitals depend heavily on public financing which represents 64% of their income. 80% of private hospitals financial resources are derived from the MOH.

From MOH's expenditures on curative care, 30% goes to cover only three narrow specialties : kidney dialysis and transplant, cancer treatment and open-heart surgery. These services, 100% reimbursed by MOH, were added in 1992 to the package of covered services.

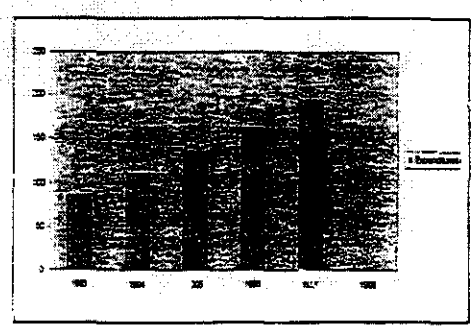


Figure 4

adards, and would hopefully lessen the dependence the private sector, thus leading for a better position control. It has yet to overcome the disadvantages inent to the public sector such as irrational recruitits and political interferences.

There will be no government budget allocation for blic hospitals. These are instead allowed to contract h financing agencies including MOH. Consequently, r revenues will become directly linked to their proivity [9]. Similarly to private hospitals, public hosls would be subjected to a selection policy based on and quality standards, and to regulation measures ding the control of supply and demand.

goes without saying that high expectations conning public hospitals cannot be achieved apart from overall reform plan of the public administration.

financing role

he government is currently taking part in health fiing, with the purpose of ensuring a universal health rage. Historically, to be eligible to MOH coverage, tificate of indigence was requested. This certificate, idered humiliating, was abolished, in 1971 [10]. then, any Lebanese citizen is considered eligible OH coverage, if he accepts to be treated in third on the only condition of not being covered by any nce scheme, regardless of his financial status [11]. e Ministry of Health is contracting with almost all ivate hospitals operating in the country [12]. Acg to the contract, a predetermined number of beds rved for patients sent by the MOH with prior auation.

MOH reimburses hospitals after reception of debills based on itemized tarification. A discharge ary form has been introduced in order to get medformation on the patient's status for quality moni-This case-based reimbursement led to unnecesspitalizations and overprescription of diagnostic tment procedures.

MOH has been taking part in financing health for the sole purpose of equity. However, cost ment and quality assurance are becoming conit objectives for the MOH to fully integrate in its g role.

ntly, the MOH is trying to make proper use of er of being the major financer for hospitals, in strengthen its regulatory role and promote the [13].

ulatory role

rnment intervention in regulating the health care becomes more and more imperative as privatizaands. Lebanon, illustrates best, how inefficient te sector could be in the absence of regulation. subsequent negative effect on both cost and ublic spending on health is increasing at a rate percentage points above real GDP growth. out any gain in terms of extent and quality of health services, results in no significant additional impact on the health status of the population.

Whereby, the private sector including NGOs was encouraged to intervene more in health care. Governments in developing countries have been advised for a long time, to minimize their intervention in providing health services. This has been the slogan of the World Bank as well as other international agencies. Consequently, and mainly because of inherent market failure, the regulation of the health sector becomes imperative and these governments are invited to play this role. As a result, governments have to intervene more in regulation because they had to be less involved in provision. But what was the rationale behind minimizing public provision in the first place ? Wasn't it the lack of capabilities and the inefficiency of the public sector ? While this rationale prevails, the public sector is expected to play an important role in the area of regulation which necessitates more sophisticated skills and manpower categories !

Regulation needs constraining laws. Tentatives of issuing such laws failed many times in Lebanon, being considered as contradictory to the free market principle [14]. This reveals an evident problem at the conceptual level in matching constraints with liberalism.

Anyway, if pertinent laws are legislated, made available and applicable, institutional capabilities are still needed for licensing, authorizing, controlling of supply and demand, supervising and taking appropriate coercive measures.

However, we are now considering more "institution-light options" : Contracts between financer and provider present an effective available mean for regulation. This has the advantage of being based on common understanding of concerned parties, and of being more flexible than laws, and easier to modify and adapt.

It is generally believed that who has the money sets the rules. This puts the financer such as the MOH, in a privileged position when negotiating the contract. However, money ownership is not enough to monitor and implement regulation policies (i.e. to detect poor and good performers and to take necessary sanctioning or rewarding actions). For that, the one who possesses the information masters the game, which gives the provider a far greater advantage.

Based on our experience, countries like Lebanon where information systems are not well structured and sophisticated enough, need rather simple indicators on what has been done that are easy to get and to analyze. The more regulation depends on details on how things are done, the more powerful the provider becomes, and consequently the lesser is regulation's effectiveness. A thorough work is being done for determining these indicators that could be generated by the ongoing activities, the MHO is not betting on major changes in the system for getting sophisticated indicators.

Whereas, process indicators need much details and are cumbersome, outcome or impact indicators are difficult to get and not easily attributed to only one activity of interest.

Therefore, output indicators linked to quality and based on product specifications are practical, easy to get, better defined and more relevant.

In order for regulatory intervention to be manageable within the institutional constraints, the MOH considers sacrifying some degree of precision for the sake of practicality. Procedural monitoring is left to self-regulation by group of peers, that is encouraged to be developed at two levels : internally by colleagues from the same institution, and externally by professional associations.

In this context, the MOH started working with the Order of Physicians on consensus building for the elaboration of clinical protocols, but this is a long process that requires a certain level of maturity.

In conclusion, maintaining an important role for MOH in the financing of health services is not only necessary for equity purposes, but is also a powerful leverage for regulating the sector.

THE HEALTH SECTOR FINANCING REFORM

Hospital care inefficiency and payment mechanisms [15]

The main reasons leading to private hospitals inefficiency are :

- The lack of competitiveness in the health care market.
- The institutional weaknesses of public financing agencies.
- The public financing fragmentation.
- The consumer perceptions confusing quality with high technology and pharmaceuticals.

One common aggravating factor is the case-based reimbursement and the itemized bills auditing which generate a tremendous workload preventing the MOH and other financers from evaluating the product being paid for.

The MOH is working on a new payment mechanism based on flat rate reimbursement linked to product specifications. It will be less complicated than the DRG system yet enhanced by integrating simple quality indicators. This quality related payment system (QRP) will make the contractual relationship with private providers easier to manage and will allow incentive-based regulation and quality assurance.

An example of simple indicators of product quality would be in the case of cholecystectomy : a complete blood count indicating the absence of infection or anemia, a serum bilirubine level indicating that the bile flow was reestablished, and the pathology report to verify that the operation was really performed and the diagnosis was accurate.

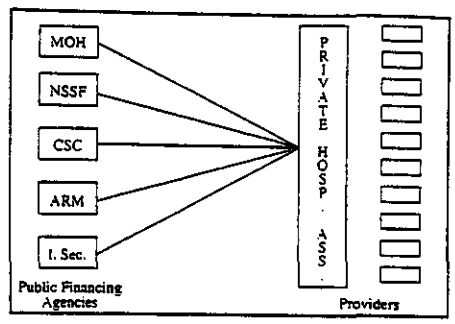
Statistical analysis will provide the frequency of wrong diagnosis and complications, which will represent thus a strong quality argument when discussing the renewal of contracts.

The flat rate constitutes a disincentive for unnecessary investigations and procedures, and output indicators give incentives for doing all what is necessary in order to satisfy quality criteria.

Managing financer-provider relationships

Overcoming financing fragmentation constitutes the centerpoint of the reform plan and deserves particular attention.

The fragmentation of public financing has always been identified as a major cause for cost escalation of medical services [16]. Private providers are dealing through their association with each fund separately, which put them in a better bargaining position, allowing them practically to impose their terms.

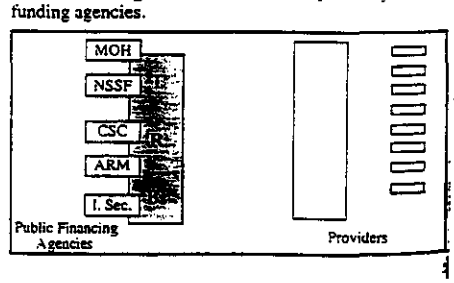


Many attempts to unify public funds have been made before, with no success [17]. Besides the technical and administrative aspects, the main reasons for the failure of merging these funds remain the same as those leading to their creation [18]. These are political, social and historical.

Additional betting on this alternative under the present circumstances is obviously a waste [17, pp 509-24].

However, the situation would definitely improve with access of these funds to pertinent information, credible technical assistance and adoption of a common approach to dealing with providers.

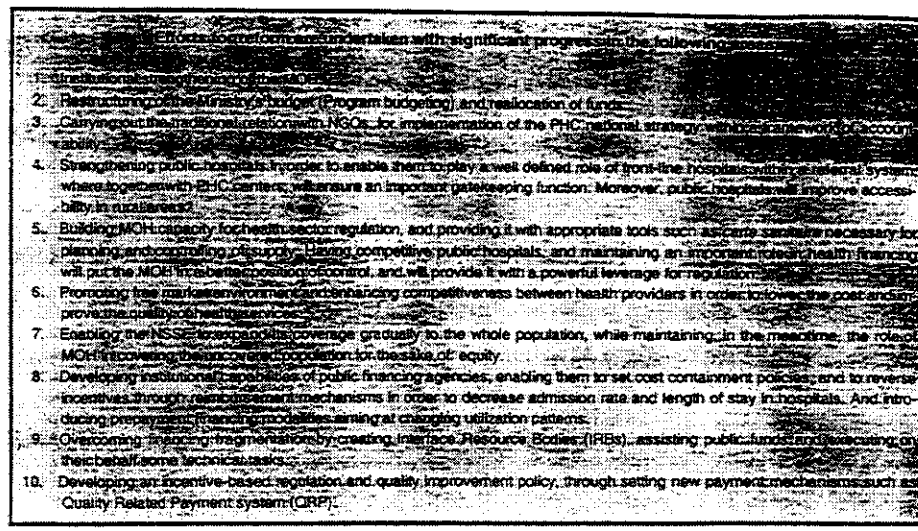
Any solution to be implemented has to be administratively and politically feasible, and thus has to carefully respect the independence of each fund. Therefore, creating an interface and resource bodies (IRBs) assisting these public funds and executing on their behalf some technical tasks, would be a feasible alternative, on condition that their prerogatives do not englobe functions which might threaten the identity of any of the funding agencies.



of physicians and other paramedical professional associations, and all concerned ministries. Key officials and political leaders are involved in this process.

The MOH launched the debate by issuing a working paper for discussion. Several meetings will be held with major players in the sector and will be followed by consensus-building conferences.

The national strategy for health reform and a plan of action will be elaborated, by the end of this consensus-building process.



REFERENCES

1. Central Administration of Statistics. Conditions de vie des ménages en 1997.
2. Saleh I, Khogali M, Alam S, Abu Haidar N, Masri A. Epidemiology of diabetes mellitus in relation to other cardiovascular risk factors in Lebanon. La Revue de Sante de la Méditerranée orientale 1997 ; 3 (3) : 462-471.
3. Centre d'études hospitalières (CEH). Carte sanitaire. 1997.
4. Ammar W, Mechbal AH, Awar M. Organisation des services de soins, système de couverture et contribution du ministère de la Santé publique. Leb Med J 1998 ; 46 (2) : 49-55.
5. Daher M, Husseini H, Kasparian R, Kasparian C. La demographie medicale au Liban, plethore, féminisation et rajeunissement. J Méd Lib 1998 ; 46 (1) : 45-9.
6. Jurjus A. Hospital and Heavy Medical Technology Utilization in Lebanon. WHO 1995.
7. Van Lerberghe W, Ammar W, Mechbal A. De l'impasse à la reforme : La crise du secteur de santé au Liban. Studies in Health Services Organization and Policy 1997 ; 2.
8. Decret no. 544. Le Journal officiel libanais, July 1996.
9. Decree no. 12399. Le Journal officiel libanais, June 1998.
10. Decree no. 325. Le Journal officiel libanais, January 1971.
11. Bitar E, Qadiyat Al Sohat Fi Loubnan. Beirut : Dar Al Nahar Publications, 1973.
12. Decree no. 11763. Le Journal officiel libanais, February 1971.
13. Ammar W. Health Sector Reform in Lebanon, the changing role of government. Paper prepared for the World Bank and presented in the regional seminar on Health Sector Development in the MENA Region. Cairo, 1997.
14. Council of State. Decision no. 16/93-94, 1994.
15. Ammar W. Role of Private and Public Sectors in the Health Care System in Lebanon - Reform Proposals. Paper prepared for the 45th Regional Meeting of WHO. Beirut, 1998.
16. Jeffers JR, Zukin P. Lebanon Health Sector Financing. USAID, 1983.
17. Mroueh A, Kronfol N, Al Riaaya Al Sohiya Fi Libnan. 1985.
18. Hamdan H. A. Daman Al Jumali Falsafah wa Tatbik. Al Dar Al Jamiyaa, 1986.

ECONOMIE DE SANTE/HEALTH ECONOMICS
LE FINANCEMENT DE LA SANTE AU LIBAN
I. Organisation des services de soins, système de couverture et contribution du ministère de la Santé publique

Walid AMMAR[1], Abd El Hay MECHBAL[2], May AWAR[3]

Ammar W, Mechbal A, Awar M. Le financement de la santé au Liban. J Méd Lib 1998 ; 46 (3) : 149-155.

RESUME : Cette étude consiste en une analyse du système de santé au Liban, des points de vue organisationnel et financier. Elle vise à clarifier les mécanismes du marché des soins en les traitant de différentes perspectives ; l'offre et la demande des soins, le rôle du secteur public vis-à-vis du privé, l'importance du curatif relativement au préventif et l'hospitalisation par rapport aux services ambulatoires.

Cette recherche a nécessité la revue de toutes les enquêtes entreprises dans ce domaine dans la période d'après-guerre. Une collecte et un traitement de données pertinentes, auprès des agences publiques et privées et des ministères concernés, a été accomplie pendant toute une année. La fin de cette collecte a coïncidé avec la publication par la Direction générale de la Statistique de l'enquête « Conditions de vie des ménages en 1997 ». Une analyse critique de cette enquête, qui concerne la même période de référence couverte par notre étude, nous a permis de consolider certaines données et de les compléter, notamment celles relatives aux dépenses des ménages.

Le secteur privé domine le marché des services de soins aussi bien au niveau primaire qu'aux niveaux secondaire et tertiaire. Tandis que les hôpitaux privés prospèrent grâce au financement public, les soins ambulatoires dépendent surtout du financement direct des ménages.

Il est désormais bien établi que le système de santé au Liban a réussi à résoudre les problèmes d'accessibilité aux services de soins, répondant ainsi à la valeur d'équité à laquelle s'attache notre société. Mais ceci n'a pu être réalisé que grâce à une augmentation insoutenable du coût, d'année en année. Les dépenses pour la santé ont atteint ainsi une proportion alarmante du PIB.

Notre but est de fournir des donnés solides et des arguments irréfutables en faveur de la réforme du système de santé.

Ammar W, Mechbal A, Awar M. Health financing in Lebanon. Leb Med J 1998 ; 46 (3) : 149-155.

ABSTRACT : This paper intends to analyze the health care system in Lebanon from the organizational and financial points of view.

It allows for an understanding of the health services' market by tackling it from different angles : supply versus demand, private versus public sectors, curative versus preventive services, hospital versus ambulatory care.

This study necessitated a review of all previous surveys made in this field, during the after-war period. It also needed the daily collection and follow-up of pertinent data with all private and public agencies and concerned ministries, over a one-year period. In addition, a critical analysis has been made to the survey *Conditions de vie des ménages, en 1997*, that was carried out by the Central Administration of Statistics, that came to complete the missing data concerning household expenditures on insurance and health services. Especially that this survey covered the same period (1997), subject of this study.

The paper reveals that, although the private sector is the main provider of both hospital and ambulatory care, private hospitals are flourishing on public money, whereas outpatients care is mainly financed by the households.

Evidence shows that the Lebanese health care system succeeded in resolving the problem of accessibility to primary, secondary and tertiary health care, responding thus to the value of equity. But, at the price of an ever escalating cost, threatening the sustainability of the system. This is what is attained in this paper, as it shows clearly that expenditures on health have reached an alarming level of the GDP share.

Our purpose being providing solid arguments in favor of reforming the health system.

A. ORGANISATION DES SERVICES DE SOINS

Les services de soins peuvent être divisés schématiquement en deux parties, chacune d'elles se caractérise par des notions qui se chevauchent. D'un côté, l'hospitalier qui est synonyme de curatif, privé et onéreux. D'un autre côté, l'ambulatoire qui est plutôt l'équivalent de préventif, abordable, public et non lucratif mais dépend de plus en plus du nombre croissant des cabinets de médecins. Cette approche permettra d'éclairer la prestation des soins afin de mieux comprendre le système de couverture sociale avant d'aborder la question du financement de la santé.

A.1 Soins hospitaliers

La prestation des soins de santé par le gouvernement a connu un déclin considérable pendant les longues années de guerre civile et de troubles socio-économiques qui ont affecté les capacités institutionnelles et financières du secteur public. Au début des années soixante-dix, des hôpitaux publics comme Baabda, la Quarantaine, Zahlé et Saïda, recevaient des stagiaires des facultés de médecine de l'USJ et de l'AUB et avaient chacun,

1. Directeur général de la Santé. Directeur du Projet de réhabilitation du secteur de la santé - Banque mondiale.
2. Représentant de l'Organisation mondiale de la santé au Liban.
3. Assistante directeur du Projet de réhabilitation du secteur de la santé.
Correspondance et tirés à part (français ou anglais) : Dr W. Ammar. Ministère de la Santé. Rue du Musée. Beyrouth. Liban. Fax : 961 1 615730.

A.2 Soins ambulatoires

Les soins médicaux ambulants dans le pays sont essentiellement privés, en raison notamment du grand nombre de cabinets de médecins. Les organisations non gouvernementales (ONG) sont particulièrement actives dans ce domaine grâce à un vaste réseau englobant la majorité des 110 centres de SSP et 734 dispensaires existants et répartis sur l'ensemble du territoire libanais [6]. Vingt-six pour cent des ménages s'adressent aux dispensaires qui sont souvent la seule option accessible pour les plus démunis [7]. Les centres des ONG ont fait preuve d'efficacité dans les soins préventifs grâce à l'application réussie de programmes conjoints entre le ministère de la Santé et les agences des Nations unies, comme le programme d'immunisation, la lutte contre le Sida, le contrôle des diarrhées et des infections respiratoires. Ces centres constituent une gamme hétérogène qui va des centres bien dotés en personnel qualifié et équipements modernes, aux dispensaires d'une seule pièce ayant peu de personnel et des horaires d'ouverture irréguliers. En plus des soins curatifs offerts par tous les dispensaires, des actions de prévention sont entreprises par des centres engagés dans les programmes susmentionnés. Les activités de ces centres dépendent fortement des donations en médicaments. Ces donations ont longtemps été utilisées par l'UNICEF comme seule motivation pour engager les centres de SSP dans des programmes de prévention. Le MSP a repris en main ces programmes et essaye, moyennant un contrat, de développer un nouveau système d'incitation [4]. Les médecins, pour la majorité des spécialistes, travaillent dans ces centres à temps partiel. Aucun personnel médical n'y est disponible à plein temps et la présence d'infirmières qualifiées (diplômées ou licenciées) est exceptionnelle.

Tous les soins ambulatoires, y compris ceux assurés dans les centres des ONG, sont organisés de façon à satisfaire les besoins exprimés par les bénéficaires et répondent directement à leurs demandes, mais le suivi et la prise en charge globale sont faibles. L'assurance qualité est généralement absente ainsi que l'engagement à délivrer un paquet homogène de services à une population bien définie. De même la participation communautaire demeure faible et la pérennité du système est mise en cause. Quelques centres sont équipés d'appareils d'électrocardiographie et de radiologie et possèdent des laboratoires d'analyses médicales. Plus de 200 centres affiliés au programme de santé reproductive, assurent des activités de planning familial, suivent les femmes enceintes et disposent à cet effet du matériel approprié y compris l'échographie pour certains d'entre eux.

Les activités des ONG dans le secteur de la santé ne se limitent pas à la prestation des soins. Certaines ONG jouent un rôle très important de soutien au système de santé en participant à des études de terrain, ou à des programmes de formation continue, ou encore en gérant la distribution des médicaments essentiels à un grand réseau de centres de SSP, tout en assurant un système de suivi des malades chroniques qui en bénéficient [8].

En plus des dispensaires et des centres de SSP appartenant au secteur public et aux ONG, les soins ambulatoires sont délivrés principalement par les cabinets de médecins praticiens, les polycliniques et les hôpitaux privés. Actuellement, une réorganisation du secteur primaire est en cours ; se basant sur les recommandations de l'OMS, un réseau de centres de soins de santé primaires couvrira tout le pays grâce à une collaboration étroite entre le ministère de la Santé publique, le ministère des Affaires sociales, et les ONG. Un système de transfert adéquat serait à la base d'une rationalisation de l'offre des soins où les centres de soins de santé primaires constitueront les portes d'entrée au système et où les hôpitaux publics assureront surtout les soins secondaires *front line hospitals*, le secteur tertiaire restant en grande partie dépendant du secteur privé.

B. REGIMES DE COUVERTURE

Il existe au Liban plusieurs régimes de couverture sociale (Tableau II) : Le plus important est la Caisse nationale de sécurité sociale (CNSS) qui couvre les employés du secteur formel (le privé ainsi que les contractuels et travailleurs journaliers du public). La Coopérative des fonctionnaires (CF) qui couvre les cadres de la Fonction publique. Les différents régimes de couverture des forces armées (Armée, Forces de sécurité intérieure, Sûreté générale et Sûreté de l'Etat).

TABLEAU II
REPARTITION DE LA POPULATION
PAR AGENCE DE COUVERTURE PUBLIQUE*

Organisme	*Adhérents*	*Nombre total des bénéficiaires*
CNSS	341 330	1 200 000
CF	59 500	200 000
Armée	85 000	325 000
FSI	23 100	78 100
SG	3 800	13 000
SE	1 463	3 900
Total	**514 193**	**1 820 000**

**Chaque donnée a comme source l'organisme correspondant. Pour les organismes ne disposant pas d'un registre des bénéficiaires leur nombre a été estimé à partir du nombre d'adhérents.*

A ces caisses publiques viennent s'ajouter les assurances privées qui assurent une couverture soit totale, soit complémentaire à un des régimes existants (Tableau III).

L'assurance privée témoigne une expansion rapide qui a atteint 23% en 1997 [9]. L'ensemble de la population couverte par les assurances privées ne dépasse pas 500 000 assurés [10]. Si on considère l'assurance maladie, ceux qui sont couverts uniquement par ces assurances sont estimés à 300 000 personnes (Source : Med Net).

une capacité dépassant 150 lits. Ces hôpitaux se sont retrouvés après la guerre avec une capacité d'une vingtaine de lits chacun et un niveau médiocre de prestations. Par contre, le secteur privé s'est développé tant en nombre qu'en capacité pour représenter aujourd'hui 90% du total des lits hospitaliers dans le pays.

Le système de santé au Liban obéit aux principes de l'économie de marché. Les mesures de régulation sont inefficaces et le secteur privé continue à croître de façon anarchique, générant une demande qui dépasse de loin les besoins réels [1].

Les services de santé sont surtout de nature curative avec une pléthore d'hôpitaux et d'équipements sophistiqués dont le nombre dépasse les moyennes européennes. Le manque en équipement se limitait au seul domaine de la radiothérapie jusqu'en 1996 où 3 accélérateurs linéaires ont été installés simultanément, tous les trois à Beyrouth (Tableau I). Par contre, le système de soins de santé primaire est très faible malgré le grand nombre de centres qui sont en majorité des petits dispensaires avec un champ d'action limité centré sur le traitement. Le même déséquilibre existe dans les ressources humaines, le surplus en nombre de médecins s'accompagne d'un manque d'infirmières qui pèse de tout son poids sur la qualité des soins. En effet, le nombre de médecins a augmenté à raison de 8,3% par an durant les dix dernières années, par comparaison avec le taux d'accroissement de la population qui est de 1,5% [2]. Il y a 8 250 médecins inscrits aux 2 ordres des médecins soit plus de 2 médecins pour 1 000 habitants [3]. Tandis que les infirmières, toutes catégories confondues y compris les sages-femmes, ne représentent que la moitié de ce chiffre soit une infirmière pour mille habitants [3].

Ces chiffres sont parlants quant à leur impact aussi bien sur le coût que sur la qualité des soins. Tout effort de rationalisation du système se limitant à des recommandations, à l'établissement de standards ou de protocoles thérapeutiques devint infructueux en l'absence d'outils puissants de mise en vigueur des mesures de régulation [4].

Les fournisseurs privés investissent dans des régions où ils peuvent maximiser leurs profits, les régions pauvres sont peu attrayantes et ne bénéficient pas d'assez d'attention, tandis que d'autres régions sont excédentaires. En outre, les hôpitaux privés n'offrent pas la même qualité de soins aux riches et aux pauvres, et imposent très souvent des frais supplémentaires au ticket modérateur. La majorité des hôpitaux privés sont petits avec une capacité inférieure à 70 lits tout en étant des hôpitaux généraux polyvalents, ce qui pose un problème d'efficience évident (Figure 1) [5].

Les hôpitaux publics très affaiblis par la guerre, souffrent d'une mauvaise gestion et délivrent des soins de qualité médiocre. Ceci n'a cependant pas empêché le gouvernement de décider la construction de 12 nouveaux hôpitaux. Toutefois, la récente loi sur l'autonomie offre aux hôpitaux publics une réelle opportunité d'être mieux gérés et équipés, et par conséquence, de pouvoir assurer des services à la fois complémentaires et concurrentiels avec les hôpitaux privés. Ils pourront ainsi contribuer à résoudre aussi bien des problèmes d'équité que d'escalade du coût. Ces hôpitaux pourraient jouer le rôle de *gate keeper*, et participeraient ainsi au contrôle de la demande dans le cadre d'un système de transfert clairement défini.

TABLEAU I
DISTRIBUTION PAR REGION ET PAR POPULATION
DE CERTAINS SERVICES DE POINTE ET EQUIPEMENTS LOURDS*

Service	*Nombre des centres*		*Concentration par 1.000.000 habitants*
	Beyrouth et Mont-Liban	*Total Liban*	
Chirurgie cardiaque	6	12	3
Cathétérisme cardiaque	12	19	4,75
Radiothérapie par accélérateur linéaire	4 + 2 projets en cours	Idem	1 1,5
Transplantation de moelle osseuse	2	2	0,5
Lithotripsie	14	27	6,75
Centre de dialyse	19	39	9,75
Transplantation rénale	3	3	0,75
Centre spécialisé pour brûlés	2	2	0,5
Fertilisation in vitro	6	12	3
CT Scan	28	54	13,5
IRM	7	12	3

**CEH, Carte sanitaire, 1997.*

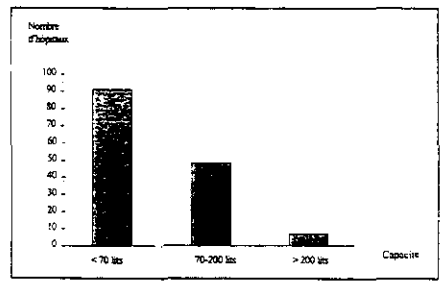


Figure 1
Répartition des hôpitaux selon la capacité en nombre de lits. (Source : Syndicat des hôpitaux privés.)

C. FINANCEMENT DU SECTEUR

C.1 Financement public des soins de santé

Le financement public englobe aussi bien les attributions budgétaires de l'Etat que le financement collectif par contribution obligatoire à la CNSS et les autres fonds.

C.1a Dépenses du ministère de la Santé publique

La majorité des dépenses de l'Etat pour la santé est destinée à rembourser des soins hospitaliers du secteur privé (Figure 3). Les dépenses du MSP pour les hôpitaux privés étaient de 14 millions de dollars EU en 1991, 60 millions en 1994, 105 millions en 1996 pour atteindre 128 millions en 1997 (Source : Ministère de la Santé publique).

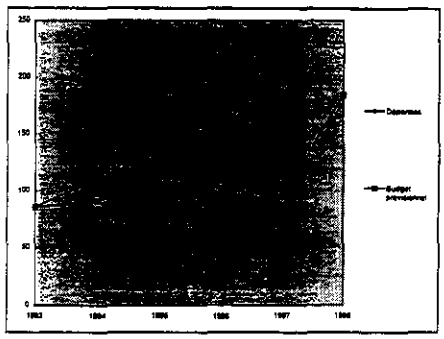


Figure 3
Budget prévisionnel et dépenses effectives du MSP pour les soins hospitaliers dans le secteur privé de 1993 à 1997 (en milliards de LL).*

**Sources : Ministères de la Santé publique et des Finances (comptes de régularisation).*

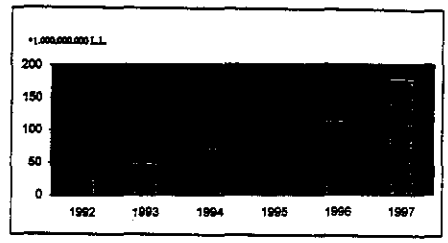


Figure 4
Evolution des dépenses du MSP pour les soins hospitaliers du secteur privé 1992-1997.

En l'absence d'une politique sérieuse de maîtrise des coûts, le déficit n'a cessé de s'amplifier d'année en année. Les restrictions budgétaires imposées par le ministère des Finances, depuis 1994, se sont montrées inefficaces à freiner l'escalade des dépenses. La tentative la plus ingénieuse pour combler l'écart entre les dépenses réelles et le budget prévisionnel consistait à accroître, presque doubler, ce dernier en 1998.

Des grandes sommes représentant 30% des dépenses du MSP couvrent quelques spécialités restreintes comme la chimiothérapie, la chirurgie cardiaque, la dialyse et la transplantation rénale : ce phénomène s'aggrave depuis la prise de décision par le ministre de la Santé de couvrir ces pathologies à 100% en 1992. Un ticket modérateur de 15% prévaut toujours pour les autres disciplines sauf exceptions décidées par le ministre de la Santé (Fig. 4 & Tableau V).

78,5% du budget du MSP est dépensé pour couvrir les soins de 3,2% des citoyens. 0,2% de ceux-ci bénéficient de 23% du budget du MSP.

Les dépenses du MSP pour les soins hospitaliers et les médicaments ne cessent d'augmenter tandis que les salaires stagnent. Par contre, les sommes réservées à la prévention diminuent. A partir de 1994, un budget annuel de 2,4 milliards de LL a été attribué aux SSP. Ces sommes, ne pouvant être dépensées pour des raisons liées à la bureaucratie et aux manques de compétences, ont été recyclées et se sont accumulées d'année en année avant d'être virées pour alimenter la construction des hôpitaux (Fig. 5-6 & Tableau VI).

TABLEAU V
DEPENSES DU MSP POUR LES SOINS CURATIFS EN 1997
VENTILATION PAR SPECIALITE*

Service	Dépenses (1000 LL)	Nombre de cas
Hospitalisation court séjour à l'exclusion des spécialités sous-citées	139 276 162	122 014 admissions
Hémodialyse	13 615 918	1 022 patients dans 32 centres
Médicaments pour affections chroniques	18 500 000 (Bureau d'aide sociale rattaché au ministre) + 6 700 000 (Pharmacie centrale)	6 184 bénéficiaires dont: 1 352 patients hémodialysés et transplantés rénaux + 2 521 patients cancéreux
Chirurgie cardiaque	18 832 314	1 400 opérations dans 9 centres
Dépenses totales sur les trois services	57 648 232 = 29,3% du budget de soins	8 606 bénéficiaires 6,6% des patients
	23% du budget du MSP	= 0,2 % de la population

**Source : Ministère de la Santé publique.*

REFERENCES

NDLR : Les références seront listées dans la deuxième partie de cet article à paraître dans le Journal Médical Libanais, Volume 46, Numéro 4.

TABLEAU III
REPARTITION DES BENEFICIAIRES PAR ASSURANCE PRIVEE SELON LE TYPE DE COUVERTURE

Type de couverture / Assurance	*Nombre de bénéficiaires avec couverture complète*	*Nombre de bénéficiaires avec couverture complémentaire à un régime public*	*Nombre total des bénéficiaires*
Réseau Med Net	110 000	65 000	175 000*
Ensemble des assurances privées	300 000	173 000	473 000**

**Source : Med Net.*
***Calculé à partir de * en estimant que le réseau Med Net couvrait en 1997, 37% de la masse des assurés par le privé.*

Les primes d'assurance sont soumises à une taxation de 11% à l'exception de l'assurance-vie qui n'est pas imposée. Une réserve technique représentant 40% des primes doit être bloquée à la disponibilité du ministère de l'Economie [11].

Tout citoyen ne possédant pas une assurance maladie, donc n'appartenant à aucun des régimes susmentionnés, peut bénéficier d'une couverture de ses frais d'hospitalisation par le ministère de la Santé publique (MSP), ceci indépendamment de ses capacités de payer[12].

Le nombre total de la population couverte par une agence publique et/ou privée s'élevant à 2 120 000 à retrancher du nombre total des citoyens libanais qui est de 3 720 645 (4 005 000 dont 7,1% étrangers) [7], il reste donc 1 600 645 personnes ayant droit à la couverture du MSP (Figure 2).

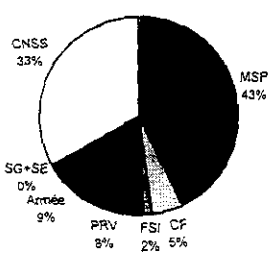
En plus, nous assistons à une prolifération de caisses mutuelles. Celles-ci posent une problématique de deux ordres : Le premier est l'objet d'accusation des assurances privées qui considèrent que les mutualités utilisent le statut d'organisations non gouvernementales sans but lucratif pour échapper au paiement des impôts ; un biais par lequel elles entrent dans le marché en concurrence illégale avec les assurances privées [10]. Le deuxième est relatif à la couverture par la mutuelle du ticket modérateur (il y en a qui n'ont pour mission que cette fonction précise), ce qui libère la demande d'un frein qui était supposé contribuer à sa maîtrise. Etant conscient de ce fait, le Syndicat des hôpitaux privés a fortement encouragé la mutualité pour faciliter la surconsommation de services notamment de technologie lourde, permettant ainsi une meilleure rentabilisation de leurs investissements.

La multitude des régimes de couverture diminue l'efficience du système de financement des soins de la santé tout en le compliquant. Cette situation est aggravée par l'absence d'une référence officielle unique, puisque chaque régime se réfère à un ministère de tutelle différent (Tableau IV).

TABLEAU IV
REGIMES DE COUVERTURE ET MINISTERES DE TUTELLE CORRESPONDANTS

Régime de couverture	*Ministère de tutelle*
MSP	Santé publique
CNSS	Travail
CF	Présidence du Conseil des ministres
FSI, SG, SE	Intérieur
Armée	Défense nationale
Mutuelles	Habitat et Coopératives
Assurances privées	Economie et Commerce

On ne peut que citer, mais avec beaucoup de réserves, les taux avancés par l'Administration centrale de la Statistique à ce sujet : « ... 42% des résidents sont assurés, dont 15,2% à la Sécurité sociale et 13,1% à la mutuelle des fonctionnaires, 8,7% des personnes sont assurées à leur propre compte et 2,9% tout en profitant d'une assurance gratuite sont aussi assurées à leur propre compte. On note quelques rares cas d'assurance sur le compte de l'employeur (1,9%) ». Il suffit de regarder le chapitre consacré à la santé dans le questionnaire de l'enquête « Conditions de vie des ménages » pour constater un manque de précision qui ne pouvait aboutir qu'à des chiffres très approximatifs, voire incorrects [7].



Organisme de couverture	% de la population couverture
CNSS	32.43%
CF	5.40%
Armée	8.78%
FSI	2.11%
SG + SE	0.46%
MSP	42.7%
Assurances Privées	8% couverture complète + 4.6% couverture complémentaire

Figure 2 : Répartition de la population par organisme financeur des soins hospitaliers.

TABLEAU VI
VENTILATION DES DEPENSES EN 1000 LL DU MINISTERE DE LA SANTE PUBLIQUE
1993-1997
(Comptes de régularisation)

Ligne budgétaire	1993	1994	1995	1996	1997
Salaires et indemnités	7 658 126	11 623 465	13 141 246	15 521 042	14 252 340
Médicaments	4 342 650	7 493 945	12 559 985	14 658 936	20 300 000
Contributions et soutiens aux ONG	1 076 00	4 252 000	5 240 000	4 723 000	11 519 548
Hospitalisation (Court et long séjour)	85 295 000	106 133 000	131 767 000	162 360 000	195 473 512
Autres	3 312 597	10 567 039	19 716 750	13 817 736	9 287 835
Total	**101 684 373**	**140 069 449**	**182 424 981**	**211 080 714**	**250 773 235**

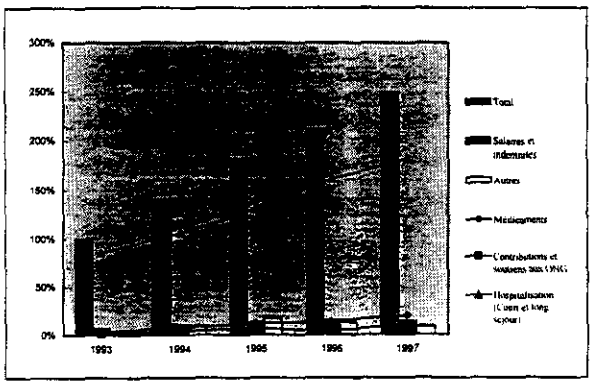


Figure 5
Evolution des dépenses par ligne budgétaire de 1993 à 1997.

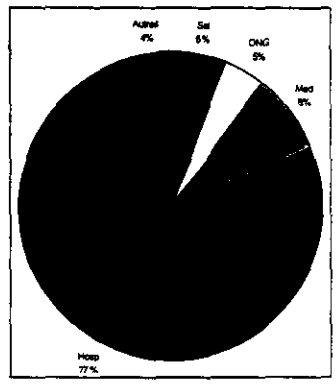


Figure 6 : Ventilation des dépenses du MSP (comptes de régularisation, 1997).

Prochain numéro :

LE FINANCEMENT DE LA SANTE AU LIBAN
II. Sources de financement et dépense globale pour la santé

ABREVIATIONS

AUB	American University of Beirut
CF	Coopérative des fonctionnaires
CNSS	Caisse nationale de la sécurité sociale
$ EU	Dollar des Etats-Unis
FSI	Forces de sécurité intérieure
GDP	Gross Domestic Product
LL	Livres libanaises
MF	Ministère des Finances
MSP	Ministère de la Santé publique
OCDE	Organisation de coopération et de développement économique
OMS	Organisation mondiale de la santé
ONG	Organisation non gouvernementale
PIB	Produit intérieur brut
SE	Sûreté de l'Etat
SG	Sûreté générale
SSP	Soins de santé primaire
UNICEF	United Nations Children's Fund
USJ	Université Saint Joseph
YMCA	Young Men's Christian Association

التمويل الصحي في لبنان

مـوجـز: يتضمن هذا البحث تحليلا لسوق الخدمات الصحية ونظم التغطية الاجتماعية في لبنان، اضافة الى دراسة حول حجم ومصادر التمويل بشقيه العام والخاص، والإنفاق المباشر من الأسر. مما تطلب تجميع ومعالجة المعلومات والأرقام العائدة لعام ١٩٩٧ من مختلف الجهات الضامنة الرسمية والخاصة. تلازم ذلك مع نشر الدراسة التي أعدتها إدارة الإحصاء المركزي عن الأوضاع المعيشية للأسر في عام ١٩٩٧ . مما أتاح مقارنة المعلومات واستكمالها خاصة وانها تعود لنفس الفترة الزمنية.

وتبين أن الصناديق العامة تغطي نسبة ٤٩,١٧٪ من المواطنين بمن فيهم ٣٢,٤٪ منتسبين الى الصندوق الوطني للضمان الاجتماعي، بينما شركات التأمين الخاص تغطي بشكل كامل او جزئي ١٢,٦٪ فقط من السكان. اما المواطنون الذين يحق لهم الإستفادة من تقديمات وزارة الصحة العامة فيشكلون نسبة ٤٢,٧٪ من اللبنانيين.

إن الخدمات الاستشفائية تقدم في غالبيتها العظمى من القطاع الخاص، إلا ان تمويلها يرتكز بشكل أساسي على المال العام. أما الخدمات الخارجية فتقدم جزئيا من المراكز الصحية والمستوصفات التابعة للقطاعين العام والأهلي، وتعتمد بشكل كبير على الأعداد المتزايدة من عيادات الأطباء وأطباء الاسنان والصيدليات والمختبرات، في حين يقع القسم الأكبر من تمويلها على كاهل الأسر.

وتشير الأرقام إلى أن إجمالي الإنفاق العام بلغ عام ١٩٩٧، ٦٥٩,٢٦٦ مليار ليرة لبنانية بما في ذلك ٢٠٠,٤١٠ ملياراً من الصندوق الوطني للضمان الإجتماعي. كما بلغت كلفة التأمين الخاص ٣٧٢,١٦ مليار ليرة لبنانية منها ١٢,٥٣٩ ملياراً تعود لصناديق التعاضد. أما القسم الأكبر والبالغ ١١٩٨,٩٠٣ مليار ليرة لبنانية فتم دفعه مباشرة من قبل الأسر.

يكون بذلك قد بلغ الإنفاق الإجمالي على الصحة لعام ١٩٩٧، ٢٢٣,٣٢٩ مليار ليرة لبنانية، أي حوالي ١٠٪ من الناتج المحلي القائم. تعتبر هذه النسبة عالية جدا، حتى الدول الغنية عندما وصل بعضها إلى هذا الحد من كلفة الخدمات الصحية بادرت على الفور إلى خفض هذا الإنفاق عبر سياسة إصلاحية شاملة.

يهدف هذا البحث، إضافة إلى الإشارة للنسبة الحالية المرتفعة للإنفاق على الصحة، إلى تبيان التصاعد الحاد لهذه الكلفة من سنة إلى أخرى، دون أي مردود إضافي، بسبب الخلل القائم في نظم التغطية الصحية. وذلك بغية التأكيد على ضرورة إصلاح النظام الصحي ودعم موقف قوى التغيير.

LE FINANCEMENT DE LA SANTE AU LIBAN
II. Sources de financement et dépense globale pour la santé

Walid AMMAR[1], Abd El Hay MECHBAL[2], Osmat AZZAM[3]

Nous avons publié sous cette même rubrique la première partie de cet article - Organisation des services de soins, système de couverture et contribution du ministère de la Santé publique - dans le numéro précédent (Vol. 46, N° 3, pp. 149-155). La deuxième partie vient compléter le chapitre concernant le financement du secteur.

C.1b Dépenses de l'ensemble des régimes publics

Toutes les agences publiques contractent avec le privé pour les soins hospitaliers. 85 à 90% de la facture est à la charge de l'agence et payé directement à l'hôpital. La facturation est faite selon une tarification de base qui est établie par le MSP et la CNSS pour la 3e classe. Les officiers et les fonctionnaires de 2e et 1re catégories ont droit à un traitement spécial et un tarif plus élevé. Les tests et soins extrahospitaliers sont payés par le patient qui sera remboursé après présentation des documents justificatifs (Tableau VII).

Selon l'Administration centrale de la Statistique « les dépenses d'hospitalisation sont en moyenne égale à 1 167 000 LL par ménage, et concernent 28,8% des ménages » ! Si 28,8% des ménages ont payé des frais d'hospitalisation durant les 12 derniers mois précédant l'enquête et puisqu'une personne au moins devrait être hospitalisée par ménage, on devrait s'attendre à un taux d'hospitalisation d'au moins 28,8% des Libanais durant une année. Or cette même enquête révèle que seulement « 11% des individus sont entrés à l'hôpital durant les douze derniers mois » [7, pp 59-60].

Le prix de journée et le coût d'un épisode d'hospitalisation sont les plus élevés à la Coopérative des fonctionnaires et à la Sûreté générale. La CNSS a un prix de journée comparable à celui du MSP mais le coût moyen d'une admission est moins cher parce que la durée moyenne de séjour est plus courte. Le MSP couvre une population en moyenne plus âgée que toutes les autres agences, ce qui explique en partie une durée de séjour plus importante (Figure 7).

Les hôpitaux privés dépendent fortement des sources publiques de financement qui couvrent 63,75% de leurs revenus. Le MSP à lui seul couvre 30% de leurs ressources [13].

Le financement de la CNSS est assuré par des contributions proportionnelles au salaire jusqu'à un plafond équivalent à trois fois le salaire minimum de base. Ces contributions alimentent les différentes caisses de la façon suivante : 15% du salaire pour les allocations familiales, 8,5% du salaire pour les indemnités de fin de service, et 15% du salaire pour la caisse maladie, cette dernière est partagée entre l'employeur 12% et l'employé 3% [14-15].

L'employeur peut décider d'inscrire ses employés à une assurance privée pour une couverture complémentaire, et ceci en payant un tarif réduit établi pour ce type de bénéfice. Comme il peut les inscrire pour une couverture complète et payer le plein tarif, dans ce cas il a droit à un remboursement forfaitaire par la caisse d'une somme de 170 000 LL par bénéficiaire. La CNSS se désengage ainsi de tous les frais des soins ambulants ou hospitaliers à l'exception de la chirurgie cardiaque, la dialyse et la transplantation rénale (Source : Caisse nationale de sécurité sociale).

Un grand nombre de personnes adhérentes à la CNSS ou à la CF présentent des attestations signées par ces deux organismes certifiant que l'intéressé n'est pas couvert, pour pouvoir bénéficier frauduleusement de la couverture du MSP. Depuis 1996, la CF disposant d'une liste incomplète, limitée aux fonctionnaires membres, sans leurs dépendants, a cessé de délivrer de telles attestations. Tandis que la CNSS continue à fournir, sur demande, des attestations dont l'incrédibilité a été prouvée à plusieurs occasions. En effet, le patient préfère la couverture du MSP qui est de 100% pour certaines interventions coûteuses, comme la chirurgie cardiaque, à la couverture de la CNSS qui est de 90%. Cette tendance s'est accentuée depuis que le bureau du ministre a généralisé la couverture à 100% à un grand nombre d'interventions. De même, le patient préfère obtenir gratuitement les médicaments de chimiothérapie auprès de la pharmacie centrale du MSP plutôt que de les acheter d'une pharmacie privée où ils ne seront remboursés par la CNSS ou la CF qu'à 85% quelques mois plus tard. D'autre part, délivrer de fausses attestations permet le transfert d'un grand nombre de malades à la charge du MSP, et permet ainsi à la caisse de faire des économies considérables. Par ailleurs, les accidents du travail et les maladies professionnelles n'étant pas couverts par la CNSS, ses adhérents sont traités aux frais du MSP quand il s'agit de ces affections [16].

1. *Directeur général de la Santé. Directeur du Projet de réhabilitation du secteur de la santé - Banque mondiale.*
2. *Représentant de l'Organisation mondiale de la santé au Liban.*
3. *Membre du Projet de réhabilitation du secteur de la santé - Banque mondiale.*

Correspondance et tirés à part (français ou anglais) : Dr W. Ammar. Ministère de la Santé. Rue du Musée. Beyrouth. Liban. Fax : 961 1 615730.

TABLEAU VII
COUTS ET TAUX D'HOSPITALISATION PAR ORGANISME PUBLIC EN 1997*

AGENCE	*Nombre d'admissions*	*Taux d'hospitalisation*	*Nombre des journées d'hospitalisation*	*Durée moyenne de séjour*	*Coût moyen par admission (1000 LL)*	*Prix moyen de journée (1000 LL)*
MSP**	122 014	7,62	571 001	4,68	1 141	244
CNSS	105 000	8,75	420 000	4	950	238
CF	20 000	10	70 000	4	1 617	462
Armée	44 100	13,5	120 600	3	1 075	394
Forces de sécurité intérieure	34 000	43,5	124 500	3,6	1 382	377
Sûreté générale	1 650	12,6	4 970	3	1 624	539
Sûreté de l'Etat	1 187	30,4	3 560	3	1 188	396
Total	**327 951**	**8,3%**	**1 314 631**	**4**	**1 257**	**314**

**Sources : Pour chaque donnée l'organisme correspondant. 1 $ EU = 1 527 LL.*
***La chirurgie cardiaque et l'hémodialyse ont été exclues pour ne pas fausser le calcul des moyennes.*

La population couverte par la CNSS est une population relativement jeune puisque l'adhérent à l'âge de la retraite touchera ses indemnités et ne bénéficiera plus de la couverture de la caisse. Par conséquence, la CNSS se décharge de ses adhérents au moment où leurs besoins de soins de santé augmentent et deviennent très coûteux.

En plus, les citoyens non couverts par la CNSS appartiennent généralement aux tranches les plus défavorisées de la population (travailleurs saisonniers, paysans, chômeurs...). Donc, par comparaison à la CNSS, le MSP couvre une population en moyenne plus pauvre et plus âgée. Par conséquent, il faut s'attendre à un taux d'hospitalisation et une durée moyenne de séjour plus élevés et à des interventions plus compliquées et plus coûteuses.

Sans oublier qu'en cas de guerre (attaques militaires israéliennes), de catastrophe ou d'épidémie, le MSP lance un appel aux hôpitaux privés pour soigner tout citoyen en détresse, 100% aux frais du ministère, sans autorisation préalable.

Sont aussi financées par le budget de l'Etat, certaines caisses d'associations professionnelles comme les caisses mutuelles des parlementaires, des juges et des professeurs de l'Université libanaise. La caisse des juges est en plus alimentée par des taxes spécifiques (Tableau IX).

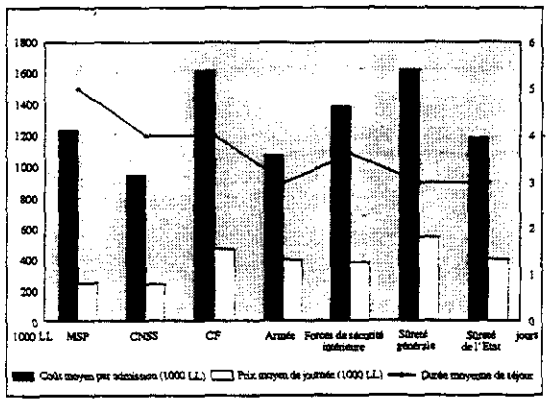


Figure 7

C.2 Dépense globale pour la santé et sources de financement

La CNSS n'est pas la seule à exclure certaines catégories de la population. La sélection adverse est une pratique courante des assurances privées qui trouve un terrain propice dans le système de santé au Liban.

Les malades chroniques (diabétiques, cardiaques, insuffisant rénaux, cancéreux...) sont dissuadés de joindre l'assurance privée par des primes prohibitives. L'exclusion des interventions coûteuses (chirurgie cardiaque, chimio- et radiothérapie, transplantation, hémodialyse...) est souvent de règle rejetant ainsi une grande partie des dépenses sur le MSP. Le mode de couverture inconditionnel du MSP et le laxisme du ministère de l'Economie et du Commerce, qui a la tutelle des assurances privées, encouragent cet abus.

L'adhérence à l'assurance privée est faite dans 26% des cas directement par les ménages payant la totalité des cotisations, et dans 74% des cas par les employeurs qui payent en moyenne les 9/10 des primes et déduisent le 1/10 des salaires des employés. Par conséquent, 33,4% des primes sont payés par les ménages, et 66,6% par les employeurs (Source : Med Net).

En se basant sur les registres fiscaux, les revenus des assurances privées en 1997, à l'exclusion des primes de l'assurance-vie qui est exempte d'impôts, s'élevaient à 266 386 000 $ EU [9, pp 68-9]. Ce chiffre est probablement in-

férieur à la réalité à cause de la sous-déclaration qui est estimée à 1/3 des revenus. Dans ce cas, les revenus seraient probablement de l'ordre de 399 579 000 $ EU. Les primes pour couverture médicale représentent 60% de l'ensemble des cotisations (assurance-vie exclue) et s'élèveraient donc à 239 747 400 $ EU, soit l'équivalent de 359 621 100 000 LL. Ce chiffre n'est pas loin de celui de l'enquête faite par l'Administration centrale de la Statistique sur les conditions de vie des ménages en 1997. En effet, cette enquête révèle que 14,8% des ménages ont payé des cotisations aux assurances privées. La cotisation moyenne par famille est de 1 719 000 LL ce qui fait une somme globale de 228 155 994 000 LL payée par les ménages en 1997 [7]. Si on est conscient du fait que les Libanais, non habitués à ce type d'enquêtes, ont tendance à exagérer leurs dépenses pour la santé, et si on ajoute la contribution payée par l'employeur, on obtiendrait un total des cotisations assez proche du chiffre estimé plus haut. D'un autre côté, il ne faut pas sous-estimer le biais de mémoire introduit par cette enquête, où il a été demandé aux ménages de déclarer leurs dépenses des douze derniers mois ; cette période de référence peut être acceptable pour les épisodes d'hospitalisation mais introduit un biais de mémoire évident quand il s'agit des consultations et des examens en ambulatoire (Cf. Tableau X).

Le total des dépenses nationales pour la santé au Liban est de l'ordre de 2 230 329 555 000 LL soit l'équivalent de 1 460 595 648 $ EU. Le PIB est estimé à 14,959 milliards $ EU en 1997 [17]. Les dépenses globales pour la santé représentent donc 9,76% du PIB. Cette proportion dépasse de loin celles des pays de niveau socio-économique comparable au Liban, elle est plutôt semblable à celles des pays de l'OCDE (Tableau XI).

Si on extrapole les données de l'enquête de l'Administration centrale de la Statistique en considérant que les sommes déclarées par les ménages représentent 33,4% des primes d'assurances (66,6% étant payés par les employeurs), le total des encaissements des assurances privées pour couverture médicale serait de l'ordre de 683 milliards de dollars EU au lieu de 359,6. Dans ce cas, les dépenses globales pour la santé atteindraient le chiffre de 2 553 708 455 000 LL soit l'équivalent de 1 672 369 649 dollars EU ce qui représente 11,18 % du PIB (Figure 8).

Ces dépenses concernent à la fois l'hospitalisation et les soins ambulatoires (tels que : les consultations, les examens de laboratoire et de radiologie, les médicaments, les soins dentaires...). Ces soins ambulatoires ne sont que partiellement et irrégulièrement couverts par le ministère de la Santé publique, les ménages en supportent le fardeau le plus important.

Si on considère uniquement les soins hospitaliers, on trouve que les dépenses publiques sont de loin les plus importantes et ceci malgré le fait que ces soins sont fournis à 90% par les hôpitaux privés.

Selon l'analyse des données agrégées, environ deux tiers des revenus des hôpitaux proviennent du ministère de la Santé publique et des assurances publiques.

Pratiquement la moitié des dépenses de santé – dons exclus – est ainsi consacrée aux soins hospitaliers. Le secteur public y contribue à raison de 12 $ EU par personne et par an pour la population (aisée) avec une assurance privée, 50 à 60 $ EU par personne et par an pour la population avec une assurance publique (employés et militaires ainsi que leurs dépendants), et 55 $ EU par personne et par an pour la population non assurée. Au total, les assu-

TABLEAU VIII
DEPENSES DES ORGANISMES PUBLICS EN 1997*
(1000 LL)

AGENCE	*Soins hospitaliers*	*Services extra-hospitaliers*	*Total des dépenses pour les soins curatifs*
MSP	192 409 259	28 187 606	220 596 850
CNSS	99 805 000	77 605 000	177 410 000
CF	21 500 000	18 563 000	40 063 000
Armée	47 528 000	9 600 000	57 128 000
Sécurité intérieure	47 000 000	10 843 000	57 843 000
Sûreté générale	2 680 000	2 920 000	5 600 000
Sûreté de l'Etat	1 409 746	878 500	2 288 246
Total	**412 332 000**	**148 597 106**	**560 929 100**

**Sources : Chaque information, l'agence concernée. 1 $ EU = 1527 LL.*

TABLEAU IX
CAISSES MUTUELLES FINANCEES
TOTALEMENT OU EN PARTIE PAR LE BUDGET DE L'ETAT*

Caisse / Budget	*Coopérative des fonctionnaires de l'Etat*	*CM[a] des députés*	*CM des fonctionnaires du Parlement*	*CM des juges*	*CM des professeurs de l'Université libanaise*	*Total à l'exclusion de la CF*
Budget 1997 (1000 LL)	81 000 000	8 500 000	1 622 000	11 193 840	9 000 000	30 315 840
Budget 1998 (1000 LL)	81 000 000	9 100 000	1 820 000	6 550 000[b]	13 000 000	

**Source : Ministère des Finances ; ces chiffres correspondent au total du budget dont la moitié seulement concerne la santé.*
a : Caisse mutuelle.
b : Exemptés d'impôts.

TABLEAU X
DEPENSES GLOBALES POUR LA SANTE PAR ORGANISME DE FINANCEMENT PUBLIC ET PRIVE ET DEPENSES DIRECTES DES MENAGES*

Source de financement	Dépenses globales pour la santé (1000 LL)	Commentaires
MSP	250 773 235	Le total des dépenses y compris les salaires, les dépenses des hôpitaux publics, les programmes de prévention et le remboursement du privé. *Source : MSP.*
CNSS	200 410 000	La CNSS attribue 23 milliards de frais administratifs à sa caisse maladie et maternité, ce qui représente 13% des dépenses de cette caisse.
CF	41 563 000	Les frais administratifs de la CF s'élèvent à 2.5 milliards dont la moitié est attribuée à la couverture des soins soit 3% de celle-ci.
FSI	60 735 000	Pour les autres (FSI, SG, SE) les chiffres n'étant pas disponibles, on a majoré leurs dépenses de 5% pour inclure les frais administratifs.
SG	5 880 000	
SE	2 402 000	*Sources : CNSS, CF.*
Armée	82 345 000	Remboursement des hôpitaux privés : 38 200 000 Remboursement des soins ambulants : 19 597 000 Budget de l'hôpital militaire : 10 404 000 Budget de la brigade médicale : 14 144 000 *Source: La brigade médicale de l'armée.*
Assurances privées	359 621 100 (683 000 000)	*Sources : Al Bayan # 316, Association des assurances privées.* Les primes pour couverture médicale des assurances privées faisant partie du réseau Med Net = 33 020 000 $. = Net premium 21 756 000 + brokery 15% + Overheads 2% + profit 10% + Med Net charges 10% + premium taxes 11%. A cette somme il faut ajouter le montant relatif aux soins ambulatoires estimé à 20 000 000 $. *Source : Med Net.* ( ) extrapolation à partir de l'enquête "Conditions de vie de vie des ménages 1977" : (228.15 x 100/33.4)
Caisses mutuelles financées par l'Etat	15 158 000	Ces caisses ont un régime de couverture et des compensations assez semblables à la Coopérative des fonctionnaires : on a estimé que la moitié de leurs revenus est consacrée à la santé.
Caisses mutuelles autofinancées par contributions des adhérents	12 539 220	*Source : Ministère de l'Habitat et des Coopératives*
Dépenses des ménages	1 198 903 000	Soins hospitaliers : 282 885 000 services extra-hospitaliers : 916 019 000 *Source : "Conditions de vie des ménages 1997"*

**Sources : voir commentaires.*

TABLEAU XI
REDISTRIBUTION
PAR SOURCE DE FINANCEMENT

Source de financement	*Agence de financement*	*Dépenses 1997 en 1 000 LL*	*Total (1000 LL) 2 230 329 555*	*%*
Taxes	MSP	250 773 235	513 856 235	23
	CF	41 563 000		
	Armée	82 345 000		
	Forces de Sécurité	69 017 000		
	Caisses mutuelles	15 158 000		
	CNSS	55 000 000		
Contributions	CNSS	145 410 000	517 570 320	23,2
	Assurances privées	359 621 100		
	Mutuelles	12 539 220		
Out of Pocket	Ménages	1 198 903 000	1 198 903 000	53,8

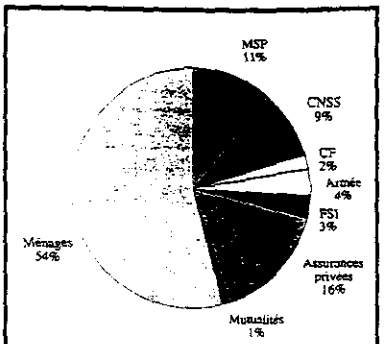


Figure 8

rances publiques et le ministère de la Santé publique ont déboursé environ 80 millions $ EU pour les soins hospitaliers fournis dans les hôpitaux privés en 1992, et environ le double en 1995. Le reste provient des assurances privées et directement des usagers [18-19].

Ces chiffres se présentent en 1997 de la façon suivante : La population couverte uniquement par le MSP (les non assurés) incombe à l'Etat un coût de 74,2 dollars EU par tête. Les services, préventifs et curatifs, généralisés du MSP* dont bénéficient tous les citoyens, y compris les assurés, représentent pour l'Etat un coût de 12,6 dollars EU par tête d'habitant. Le coût moyen d'une couverture publique est de 127 dollars EU par bénéficiaire, celui d'une assurance privée varie entre 750 et 1 000 dollars EU. Ces chiffres qui sont obtenus en considérant la population libanaise de 4 005 000 habitants [7] ne doivent pas être comparés avec l'étude susmentionnée, qui considérait un nombre d'habitants de 3 111 828 [20].

Maîtriser les dépenses hospitalières est un objectif primordial du ministère de la Santé publique afin qu'il puisse réorienter les allocations budgétaires vers la promotion de la santé et les programmes de prévention.

Les dépenses pour les médicaments, estimées à 25% des dépenses totales, méritent une attention particulière. Il existe au Liban 130 distributeurs de produits pharmaceutiques et 1 267 pharmacies. Le nombre de médicaments enregistrés au MSP dépasse les 4 500 préparations pharmaceutiques dont 2 500 sont importées régulièrement et disponibles sur le marché. Plus de 85% de celles-ci sont produits par 380 firmes et importées de 21 pays d'origine.

*Les services généralisés sont : les médicaments distribués par le bureau du ministre et la pharmacie centrale, les programmes de prévention, les contributions et soutiens aux ONG pour exécuter des programmes de santé et 15% du reste du budget du MSP.

La séparation du financement et de la production des soins de santé d'un côté, la fragmentation et le chevauchement des sources de financement d'un autre côté, entravent le contrôle du coût et de la qualité des prestations. Les organismes financeurs ont échoué à assumer leurs responsabilités dans ce domaine, bien que les hôpitaux privés soient largement tributaires des fonds publics qui assurent plus de 50% de leurs revenus [21].

Le MSP, en couvrant les frais d'hospitalisation de tout citoyen ne bénéficiant pas d'une couverture sociale, a pu résoudre en grande partie les problèmes d'accessibilité et d'équité. En effet, des enquêtes récentes confirment l'inexistence de problèmes majeurs d'accessibilité aux services de soins au Liban [22], ainsi que l'absence de barrières financières empêchant les pauvres de profiter des soins appropriés voire de bonne qualité. Cependant, il y a un problème évident d'efficience du secteur tertiaire, un problème de coût/efficacité du système de santé, et surtout un problème de pérennité du système de couverture sociale.

Le ministère de la Santé publique, étant un financeur majeur des soins hospitaliers, peut avoir une grande influence sur le secteur hospitalier à travers les contrats conclus avec les hôpitaux privés. Ces contrats représentent un puissant outil de régulation du secteur tertiaire. Le MSP devrait utiliser aussi bien ses prérogatives que sa position importante comme financeur principal du secteur, pour promouvoir la réforme.

REFERENCES

1. Ammar W. Basic Social Services Delivery : Government-NGO Cooperation. Paper prepared for the UNDP and presented in the seminar on Entry Points for Sustainable Human Development in Lebanon. Beirut, 1997.
2. Daher M, Husseini H, Kasparian R, Kasparian C. La démographie médicale au Liban, pléthore, féminisation et rajeunissement. J Méd Lib 1998 ; 46 (1) : 43-6.
3. Akatcharian R, Mansour A. Analyse de situation du per-

sonnel paramédical au Liban. 1994.
4. Ammar W. Health Sector Reform : Reorienting Public Services. Paper prepared for the World Bank and presented in the regional seminar on the Improvement of Public Services Delivery. Ecole Supérieure des Affaires. Beirut, 1998.
5. Van Lerberghe W, Ammar W, Mechbal A. De l'impasse à la réforme : La crise du secteur de santé au Liban. Studies in Health Services Organization and Policy. 1997 (2).
6. Centre d'études hospitalières (CEH). Carte sanitaire. 1997 (A paraître).
7. Administration centrale de la Statistique. Conditions de vie des ménages en 1997.
8. UNDP. Seminar on Entry Points for Sustainable Human Development Report, 1997.
9. Zakhour E. Aksat Al Taamin Al Mouhakaka Al'Am 1997. Al Bayan 1998 March ; 316 : 68-9.
10. Zakhour J. Kitabat Fi Taamin Wa l'adat Al Taamin. 1998.
11. Décret no. 9812. Le Journal officiel libanais 13/5/1968 : 39 : 652.
12. Bitar E. Qadiyat Al Sohat Fi Loubnan. Beirut : Dar Al Nahar Publications, 1973.
13. Jurjus A. Hospital and Heavy Medical Technology Utilization in Lebanon. 1995.
14. Décret no. 2195. Le Journal officiel libanais 6/2/1992 ; 6 : 118.
15. Décret no. 3686. Le Journal officiel libanais 24/6/1992 ; 25 : 3.
16. Ammar W. Health Care Market in Lebanon : Government-NGO Cooperation. Paper prepared for the WHO and presented in the seminar on New Partnerships for Health Development in Developing Countries : The Contractual Approach, a policy tool. Geneva, 1998.
17. Loi du budget prévisionnel. Ministère des Finances, 1998.
18. Ammar W. Health Sector Reform in Lebanon, the changing role of government. Paper prepared for the World Bank and presented in the regional seminar on Health Sector Development in the MENA Region. Cairo, 1997.
19. Van Lerberghe W, Ammar W, Rashidi R, Sales A, Mechbal A. Reform Follows Failure : I. Unregulated private care in Lebanon. Health Policy and Planning 1997 ; 12 (4).
20. Housing and Population Database. Ministry of Social Affairs. 1996.
21. Van Lerberghe W, Ammar W, Rashidi R, Awar M, Sales A, Mechbal A. Reform follows failure : II. Pressure for Change in the Lebanese Health Sector. Health Policy and Planning 1997 ; 12 (4) : 312-19.
22. Baddoura R, Debiolley D, Jurjus A. Enquête sur les dépenses de 1200 ménages. 1995.

ABREVIATIONS

AUB	American University of Beirut
CF	Coopérative des fonctionnaires
CNSS	Caisse nationale de la sécurité sociale
S EU	Dollar des Etats-Unis
FSI	Forces de sécurité intérieure
GDP	Gross Domestic Product
LL	Livres libanaises
MF	Ministère des Finances
MSP	Ministère de la Santé publique
OCDE	Organisation de coopération et de développement économique
OMS	Organisation mondiale de la santé
ONG	Organisation non gouvernementale
PIB	Produit intérieur brut
SE	Sûreté de l'Etat
SG	Sûreté générale
SSP	Soins de santé primaire
UNICEF	United Nations Children's Fund
USJ	Université Saint Joseph
YMCA	Young Men's Christian Association

PUBLIC EXPENDITURE REVIEW
- HEALTH SECTOR

Major Findings and Recommendations

February 1999

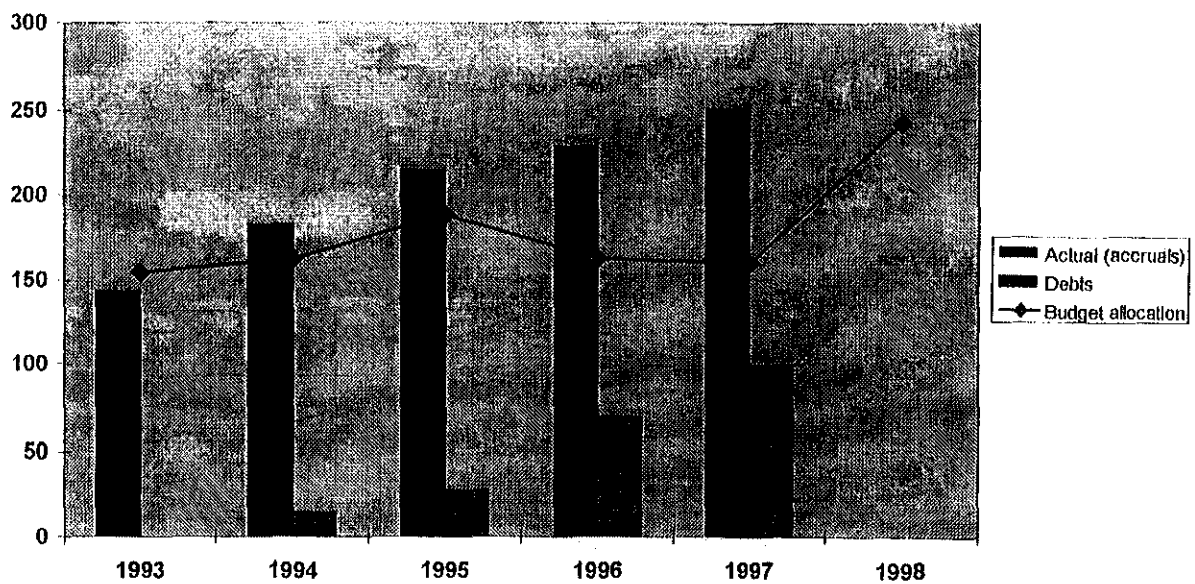
UNSUSTAINABLE HEALTH EXPENDITURE GROWTH

- 10-11.5% OF GDP
- SHARE OF GDP LIKELY TO BE GROWING:
  - MOH spending: 15% real a year 1993-1997
  - Mednet spending: 13% real a year per person
  - GDP growth: 5-6% real a year
  - Physician numbers: 9% a year 1993-1997
  - Hospital beds:5-6% a year 1996-2000
  - Population growth: 1.5-2% a year

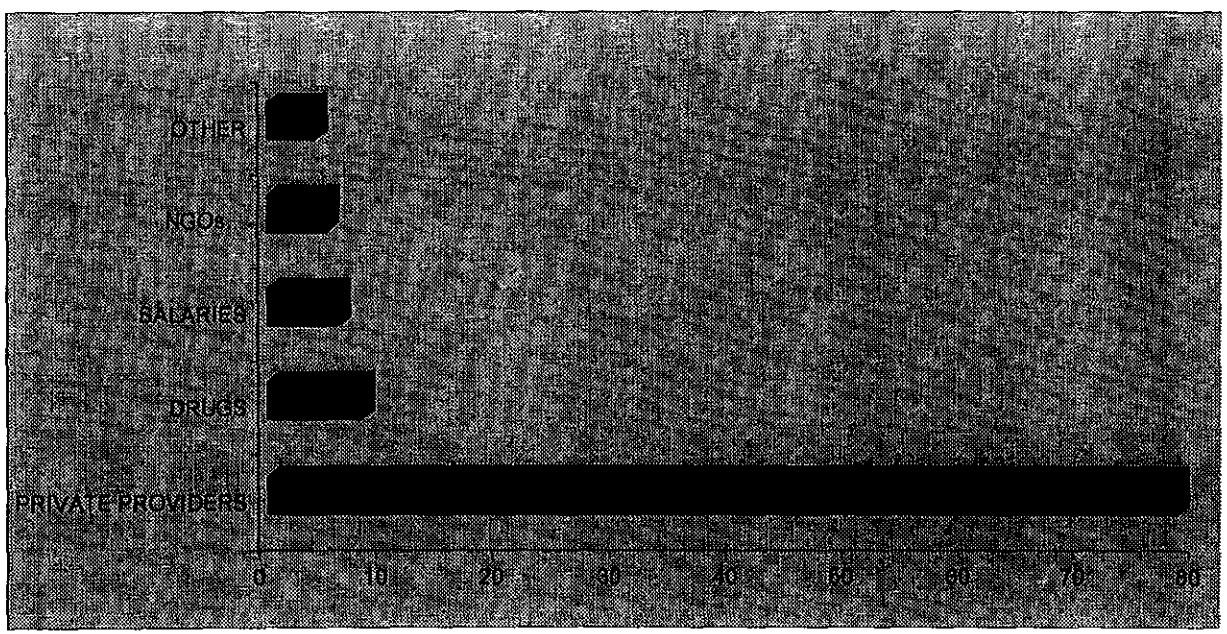
PUBLIC-PRIVATE EXPENDITURE MIX

SOURCES OF FINANCE

MINISTRY OF HEALTH EXPENDITURE 1997 LL bn



ALLOCATION OF MOH SPENDING (% 1997 spending)



PUBLIC SPENDING IS NOT COST-EFFECTIVE

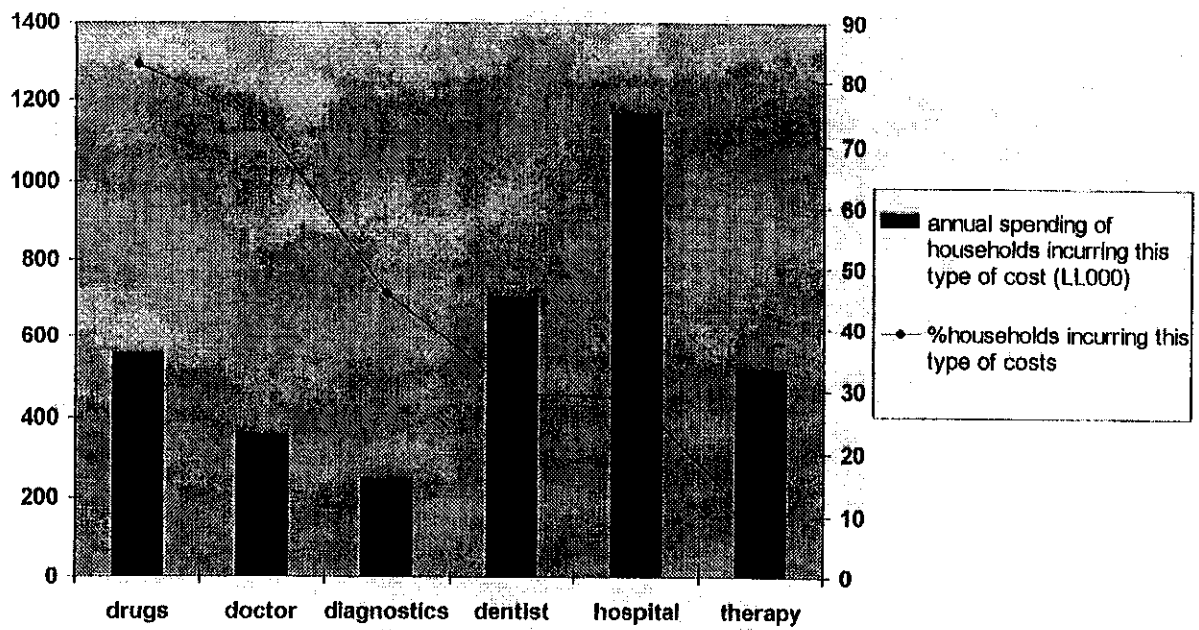
- PUBLIC HEALTH, PRIMARY CARE < 10%
- CURATIVE CARE > 80%
- 30% ON VERY HIGH COST CASES
  - end stage renal disease - dialysis, transplant
  - cancer treatment
  - open heart surgery
- POOR TARGETING
  - MOH pays for some insured and non-poor

INSURANCE COVERAGE

UNEQUAL ACCESS TO HEALTH CARE

- 2/3 poor households go without medical treatment due to financial problems
- public hospitals and health centers do not always provide a safety net for the poor
- uninsured pay 15% copayments & are not covered for ambulatory care in private sector
- uninsured more likely to be poor, elderly, and living outside greater Beirut

HIGH OUT-OF-POCKET SPENDING



POOR VALUE FOR MONEY IN PHARMACEUTICALS

- AROUND 25% OF HEALTH SPENDING
- HIGH MARGINS FOR DISTRIBUTORS
  - 10% wholesale margin (4-5% in UK)
  - 22.5% retail margin (15% in UK)
  - regulation prohibits retail price competition
- LARGE DISCOUNTS AVAILABLE
- LACK OF QUALITY GENERICS MARKET

EXCESS INVESTMENT IN HIGH TECHNOLOGY

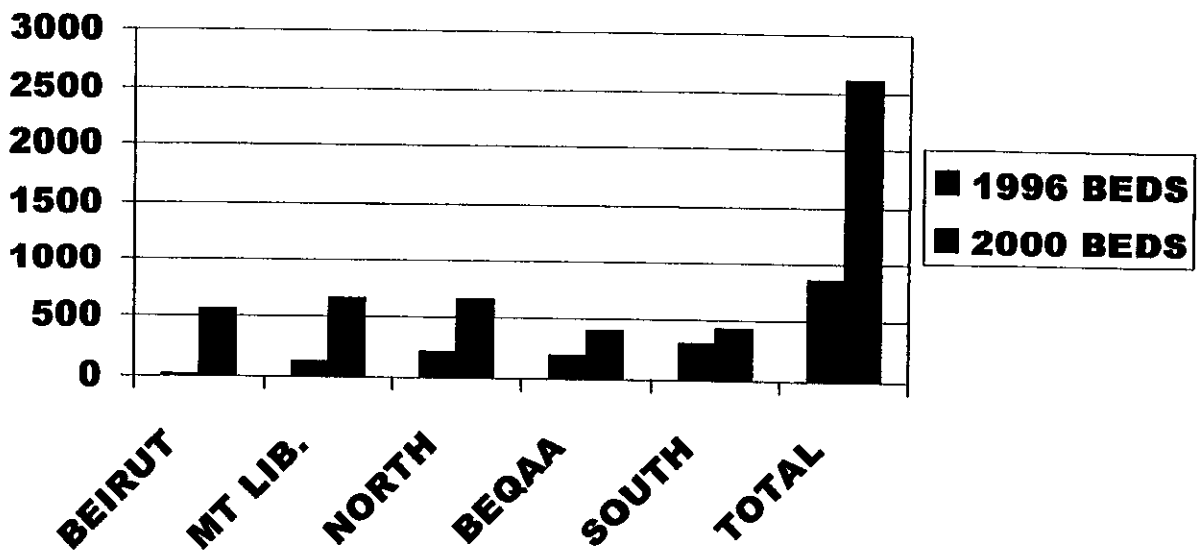
▮ LEBANON	▮ NEW ZEALAND
▮ 4 million people	▮ 3.8 million people
▮ low-middle income	▮ high income
▮ 12 open heart surgery	▮ 5 open heart surgery
▮ 12 MRI	▮ 6 MRI
▮ 27 lithotrypsy	▮ 4 lithotrypsy
▮ 39 renal dialysis	▮ 6 renal dialysis
▮ 12 in-vitro fertilization	▮ 4 in-vitro fertilization

EXCESS HOSPITAL BEDS RELATIVE TO DEMAND

- LEBANON
- 3-3.5 beds/1000 (plan)
- 80-100 admissions/1000
- 6.7% population >65
- 56% bed occupancy
- 4 days ALOS
- most investment is in public hospitals

- ENGLAND NHS
- 2.8 beds/1000
- 205 admissions/1000
- 16% population >65
- 85% bed occupancy
- 3.8 days ALOS
- investing in fewer, larger hospitals

PUBLIC HOSPITAL INVESTMENT PLANS



DOMINANCE OF SMALL HOSPITALS

EVIDENCE ON HOSPITAL COSTS AND QUALITY

- Costs rise in <150 or >700 bed hospitals
- Small acute hospitals cannot assure quality
- Specialized services should be concentrated
- Develop clinical referral/review networks
- To make significant savings you need to close whole buildings and hospitals

MAIN ISSUES IDENTIFIED

- COST CONTAINMENT
  - 2 fiscally incompatible strategies for hospitals
  - widespread fee-for-service payment
- COST-EFFECTIVE PRIORITIES
  - public health, primary care
- THE UNINSURED
- OUT-OF-POCKET COSTS FOR THE POOR

RECOMMENDATIONS FOR SHORT TERM ACTION

- CLARIFY MISSION OF PUBLIC HOSPITALS
  - safety net for poor, free or very low fees - OR
  - financial success, competing with private sector -OR
  - provision only where private sector won't invest
- RETHINK HOSPITAL INVESTMENT PLANS
- SET GLOBAL LIMITS ON MOH PAYMENTS TO PRIVATE HOSPITALS & STOP PAYING SUB-STANDARD HOSPITALS
- COMPARE DRUG PRICES WITH OTHER COUNTRIES

RECOMMENDATIONS FOR MEDIUM TERM ACTION

- FINANCE REFORM STRATEGY
- PRIMARY CARE STRATEGY

FINANCE REFORM STRATEGY

- CONSOLIDATE FRAGMENTED FUNDS
  - mergers - OR
  - contract out to third party administrators - OR
  - regulate payment methods and rates
- COMPULSORY INSURANCE FOR UNINSURED GROUPS
  - expand contributions base to cover pensioners, self-employed ...

PRIMARY CARE STRATEGY

- TRAINED FAMILY MEDICINE TEAMS
- PRIMARY-CARE BASED REFERRAL SYSTEM
- NEW PROVIDER PAYMENT SYSTEMS TO CONTROL COSTS IN PRIVATE SECTOR
- REDUCED OUT-OF-POCKET PAYMENT FOR THE POOR FOR PRIMARY CARE