Providing health care is not synonymous to subsidies in Lebanon

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We Lebanese used to hail our health care system as one of the crown jewels of our local industries. Quality indicators rubber-stamped this claim. Similarly, many Lebanese expats and patients from neighboring countries (particularly Iraq) believed in this and lived by it.

In reality, the influx of revenue from both local and foreign patients only managed to conceal chronic ailments in the system. Unfortunately, the same ailments are now contributing to depletion of our foreign currency reserves. After all, to finance a broken system is the actualization of the concept of escalation of commitment. For those unfamiliar of the latter, this concept is at the root of addiction psychology! Simply put, this is why a gambling addict keeps coming back hoping that he may retrieve his losses. Only by admitting the presence of these ailments can we find the solutions. One way to do that is to see them through health care's control knobs.

Five control knobs in health care determine the course of progress this industry and the industry's stakeholders follow. These stakeholders are the government, insurance providers (work-related or private), hospitals, nurses and physicians, and patients. The input these stakeholders provide to the following questions/knobs sets the path: How do we finance our health care system? How do we pay for the service providers? What are the regulations set to achieve our desired goals? How are health care stakeholders organizing their work to address the above three questions? How are the stakeholders behaving in this system?

Historically, health care system financing used to be from one of three categories: 1. from taxes for the Public Health Ministry (21 percent), or 2. from contributions of workers (23 percent), or 3. out of pocket for self-payers and private insurance coverage (33 percent and 19 percent respectively). Now the country is broke, massive layoffs are occurring, and most of local self-payers are under strenuous financial conditions due to the economic conditions. Thus, it is reasonable to assume that the total amount of financing has dropped, and to aggravate the situation there has been a shift from the last two categories into Category 1 i.e. the government as an insurer of last resort! Furthermore, based on reports from the airport that travel activity is now at 30 percent what it was last year thus indicating foreign influx is also low. Yet despite all of the above, our resigned government elected to use our reserves to subsidize health care with no new regulations to drop expenditures whatsoever and with no monitoring and evaluation arms in place and no plan on how to taper the subsidy system. To add insult to injury, Riad Salameh, governor of the Central Bank, announced that the subsidy system will be terminated by December 2020, without a plan, wreaking havoc in the health care sector. This contributed to a panic situation among patients with hoarding of already missing medications. Vital medications such as tamoxifen for breast cancer patients are now missing. The estimate of the damage inflicted by those in charge of these decisions, and lack of, relative to the damage inflicted by their predecessors is a subject worth studying and highlighting per se at some point of time.

Only a hypocrite denies that incentives drive behaviors and a key incentive is money paid for health care service. Of the several internationally known forms of paying for health care services, by far most of the money paid flows in the Lebanese health care system in the form of a fee for service. This form is well-known to not only put all risk on the payer, i.e. the patient or insurance provider, and none whatsoever on the hospitals and physicians, but also promotes providing more services – warranted or not, so providers are paid more. This is key in understanding why fraud is so prevalent in Lebanese health care system: Everybody is incentivized and tempted, and some succumb to the temptation! And although yes preauthorization requirements by some insurance providers do limit expenditure, what is there to protect the self-payer?

The other extreme in payments forms, referred to as capitation, shifts the risk entirely onto the shoulders of service providers. Under the capitation system, the financing agent informs the hospital for example of how much they intend to pay for providing care for a certain patient and then it is up to the hospital to work under that budget. The capitation financing systems incentivizes hospitals to try their best to limit cost and therefore negatively affect quality of care while trying to remain profitable. Adopting that form is therefore neither realistic nor achievable. Here again, our government and stakeholders fail to have a meaningful discourse to attend to this fundamental question despite many international good models to learn from.

Having answered the first two questions, and stated the near absence of regulations needed for improvement of our system we can now better appreciate how Lebanese health care providers organize and what are the behaviors we would expect from the stakeholders. Simply put our health care bill is destined to continue to grow with no leashes attached. This cycle, is driven by at the extreme: 1. patients who want all tests to be done regardless of the indication because they have insurance; 2. insurance providers that will continue to increase the premiums on annual basis partly because of the latter behavior; and 3. hospitals and physicians who profit from the above and at the same time increase the burden on the self-payer who has nobody to negotiate on his behalf to reduce health care cost!

We must stop this vicious cycle instead of subsidizing it! And as is the case with all subsidized sectors, an honest, nonpopulist, realistic and humane plan that permits accessibility to health care ought to be laid out to taper the subsidy system.

Naturally, this cannot happen overnight, similar to how Riad Salameh proposed, but instead in a gradual manner ensuring there is a safety net present for those who need it and takes into consideration the macro-economic recovery parameters of the country. More importantly, the voice of the patients i.e. the consumer, must be included while forming this plan. Such are the plans we need to listen to from the Public Health Ministry and all other stakeholders.

What we are witnessing now from some of these players is the opposite, and in fact evidence of short sightedness with reliance on policing and media games. Although it is wise to adhere to the common Lebanese saying "there is no benefit from beating a dead horse," perhaps this piece serves as an alert for the coming government and team.

Big problems in complex systems such as health care deserve a vision for remedies - particularly when a new social deal is in the making that is promoting decentralization. We deserve better and we deserve to know what decentralization in health care means?

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