The PSO work-programme

PSO projects

October 2018

INTRODUCTION

THE ROLE OF THE PSO

The Lebanese health sector has shown remarkable resilience and progress, despite an adverse geo-political context. To a large extent this has been made possible by the performance of the MoPH in its capacity of steward of the health sector.

A review of achievements and the critical role of MoPH governance has shown that the MoPH has gained considerable authority and respect in the sector: in terms of policy making, of sector regulation, and of brokerage between multiple stakeholders. It has developed an original and homegrown collaborative governance style, that mobilises two essential assets. First, strategic intelligence: a combination of scientific evidence, operational information, and an understanding of the geography of stakeholder interests. Second, social consensus: through systematic, open and transparent collaboration with stakeholder networks and sensitivity to the expectations of the public. MoPH's governance track record has been, given circumstances, remarkable.

Nevertheless, the system remains vulnerable to Lebanon's human and pollical geography, in a context of clientelism and politicisation. Whereas MoPH has thus far managed to avoid direct confrontation with vested commercial interests, these remain present, with important stakes. The regional geopolitical context remains volatile: the health sector has thus far shown remarkable resilience, but likely future shocks need to be anticipated. The presence of large numbers of refugees on the territory presents an additional strain on the MoPH. MoPH has the ultimate responsibility for governing health care for the entire resident population in Lebanon, giving priority to the uninsured and vulnerable. It has to balance the ambition to leave no one behind with the realities of limited resources and rising demand.

The MoPH has shown its adaptability and resilience in recent years: its capacity to absorb internal and r external shocks while sustaining and improving access to health care services in difficult circumstances. At the same time, it has to face the challenge of modernising to prepare for the challenges of the future. Its approach to collaborative governance must be consolidated and expanded, in two dimensions: a 'technical' one of institutionalising the reliance on evidence, information and alliance-building that has characterised MoPH work over the last two decades; and a 'political' one of building the social consensus and support for the collaborative efforts to rationalise the health sector.

Integrated but not incorporated within the MoPH, the PSO aims at supporting structured analytical and decision capacity, in line with MoPH needs and taking full advantage of the various data sources that are being developed by MoPH and of its relations of collaboration with academia. It supports MoPH's various collaborative networks which are instruments for implementation of shared policy objectives, and also, through the linkages with a wide range of constituencies, a powerful source of support and social consensus. Increased visibility of the technical work and achievements of the networks would not only enhance their stabilising influence, but also serve as a platform to facilitate adoption of benchmark practices and to market the innovations they represent for the Lebanese context.

The PSO supports and builds capacity for rational decision making, steering and regulation in the health sector, by Institutionalizing the reliance of MOPH and key health sector stakeholders on sound data, evidence and strategic intelligence that contextualizes technical evidence with

operational knowledge of the health sector and analysis of stakeholder expectations and interests. It promotes effective and resilient collaborative approaches to health sector governance and strives to enhance the social consensus around shared health sector priorities and policies that benefit the entire resident population in Lebanon.

THE PSO PROJECTS

In the run-up to the establishment of the PSO, issues where policy action is required and possible have been pre-identified and configured as "PSO Projects". Each "PSO Project" is a concrete and organized effort to take advantage of a perceived opportunity to deal with a circumscribed policy issue or challenge. Each PSO Project has a beginning and an end, is expected to produce direct deliverables and to contribute to improved capacity for health sector governance. PSO Projects are assigned to teams that include relevant MoPH staff and PSO. The configuration through which PSO runs a Project can vary as appropriate: PSO Core staff as such; PSO Core staff reinforced by external experts (contracted or rotated between academia and MoPH); or PSO managing a contract with an academic or civil society organisation that brings the necessary expertise and manpower.

In the selection of policy issues to be addressed through PSO Projects trade-offs had to be made:
- the policy issue that is addressed must be policy relevant and of strategic interest to the sector: it has to address a health sector issue or challenge where advances can be made that would contribute to improving health and health equity, moving towards universal coverage, and strengthen the institutional base for governing the health sector in the public interest.
- dealing with this issue in a Project format has to bring a potential for capacity building and creation of alliances with key sector stakeholders. This is key to ensure that the Project contributes to sustaining effective, collaborative, and information and evidence-based governance of the health sector.
- the policy issue has to be amenable to treatment in a project format and offer perspectives of translation into implementation within the country's context and resources. This means building on Lebanon's experience with incremental reform, where one moves forward where political and technical opportunities for doing so exist, and does not waste energy on issues where political or resource constraints make change an illusion.

There are consequences to these trade-offs. First, it means the selected Projects do not constitute a comprehensive reform plan (though most would no doubt be included in such a plan): this is because the selection of Projects had to balance the needs for change with the capacity and opportunities to move forward. Second, it means the list of PSO Projects that make up the Work Programme has to be seen as dynamic: it may change as new challenges and opportunities arise or avenues for change are closed. It behoves the PSO Guiding Committee, with its representation of MoPH, WHO and AUB to monitor the need to adapt the Work Programme over time.

The PSO Projects are grouped in four broad categories, according to the manner in which they are to support decision making and facilitate sector governance and organisation processes. These four broad categories are:
 I: Building MoPH & PSO readiness (2 PSO Projects);
 II: Modernising health care provision for Universal Health Coverage with People-centred care (11 PSO Projects);
 III: Generating strategic intelligence to guide sector governance (5 PSO Projects); and
 IV: Organising the policy dialogue on the health sector and its future (5 PSO Projects).

The short and long titles of the pre-identified tentative PSO Projects are in the table below:

4 | P a g e   1 4 / 1 0 / 2 0 1 8

SHORT AND LONG TITLES OF THE PSO PROJECTS

I: ESTABLISHING PSO AND BUILDING MoPH READINESS

1. OPERATIONALISING PSO: *Establishing flexible mechanisms for policy support and for capacity building*

2. MoPH READINESS: *Modernising MoPH capacities for knowledge management*

II: MODERNISING HEALTH CARE PROVISION FOR UNIVERSAL HEALTH COVERAGE WITH PEOPLE-CENTRED CARE

3. EXPANDING UNIVERSAL COVERAGE SCHEMES: FILLING COVERAGE GAPS IN CARE FOR THE UNINSURED AND VULNERABLE

4. EHR: GENERALISING THE USE OF STATE-OF-THE-ART ELECTRONIC HEALTH RECORDS

5. PEOPLE-CENTRED CARE: ALIGNING ORGANISATION AND INCENTIVES TO THE NEED FOR BETTER COORDINATION AND CONTINUITY OF CARE

6. SCALING UP ACCREDITATION

7. OVERMEDICALISATION: REDUCING EXCESSIVE RELIANCE ON HI-TECH INTERVENTIONS, SPURIOUS PROCEDURES, AND FUTILE TREATMENT

8. PALLIATIVE AND ONCOLOGICAL CARE: AN ENTRY POINT FOR HUMANISING HOSPITAL CARE

9. EMS: AN UPDATED MASTER PLAN FOR CONSOLIDATION OF EMERGENCY MEDICAL SERVICES

10. HOSPITAL NETWORK MASTER PLANNING: LONG TERM SCENARIOS TO GUIDE CONSOLIDATION, SPECIALISATION AND COMPLEMENTARITY IN LEBANON'S HOSPITAL NETWORK

11. EBP & HTA: HEALTH TECHNOLOGY ASSESSMENT AND PRODUCTION OF QUALITY-ASSURED CLINICAL GUIDELINES FOR EVIDENCE-BASED-PRACTICE

12. HIS MASTER PLAN: MASTER PLAN AND KPIS FOR A COMPREHENSIVE HEALTH SECTOR PERFORMANCE INFORMATION SYSTEM

13. PHARMACEUTICAL REGULATION

III: GENERATING STRATEGIC INTELLIGENCE TO GUIDE SECTOR GOVERNANCE

14. BENEFICIARY ANALYSIS: *Assessing targeting of public purchasing of hospitalisation and high-cost treatments*

15. PROVIDER PRACTICE PROFILES SURVEY

16. HEALTH & HEALTHCARE UTILISATION SURVEYS: *Inventory, perspectives and priority setting for household health, healthcare and health expenditure surveys*

17. PILOTING PROMS AND PREMS: *Patient-reported outcome measurements, patient-experience measurements, and user expectations*

18. NETWORKS SURVEY: *Survey of core characteristics and added value of networks for collaborative governance*

IV: ORGANISING THE POLICY DIALOGUE ON THE HEALTH SECTOR AND ITS FUTURE

19. NGO PROFILE DATABASE: *Establishing an analytical database of profiles of NFP-NGOs and CSOs active in the health sector*

20. STAKEHOLDER MAPPING AND MANAGEMENT: *Mapping and managing societal expectations, interests and positionings*

21. THE NATIONAL HEALTH FORUM: *Preparation of the 2019 National Health Forum/conference by the permanent secretariat*

22. COMMUNITIES OF PRACTICE: *Preparatory work for setting up a platform of communities of practice*

23. ROADMAP FOR VISION 2030: *Building consensus on a vision for 2030 in preparation of the next health sector strategic plan*

For each PSO Project a number of work-packages have been identified. Not all can be implemented, or even started at the same moment: human and financial resources are limited and the workload would be unmanageable. During the starting phase in 2018-19, the PSO will start working on a number of work-packages from the different Projects. These are specified in the table below:

WORK PACKAGES SCHEDULED TO START IMPLEMENTATION IN 2018-19 (PROVISIONAL)

PSO-01 Operationalising PSO	All WPs
PSO-02 MoPH Readiness	All WPs
PSO-03 Expanding Universal Coverage	WP1, WP2, WP4
PSO-04 Electronic Medical Records	WP1; WP2a; WP2b
PSO-05 People-centred care	WP1
PSO-06 Accreditation	WP1
PSO-07 Overmedicalisation	WP1,WP2
PSO-08 Palliative and oncological care	WP1, WP4, WP5
PSO-09 EMS	To start later
PSO-10 Hosp Master Plan	To start later
PSO-11 EBP & HTA	WP1, WP2
PSO-12 HIS Master Plan	To start later
PSO-13 Pharmaceutical Regulation	WPs 1-3
PSO-14 Beneficiary analysis	All WPs
PSO-15Provider Practice Profile	All WPs
PSO-16 H&HC Utilisation surveys	WP1; WP2
PSO 17: Pilot PROMs PREMs	To start later
PSO-18 Networks survey	WP1-6
PSO-19 NGO Profile database	WP1-5
PSO-20 Stakeholder mapping	WP1-2
PSO-21 National Health Forum	WP1-3

I: Establishing PSO and building MoPH Readiness

1. OPERATIONALISING PSO
ESTABLISHING FLEXIBLE MECHANISMS
FOR POLICY SUPPORT AND FOR CAPACITY BUILDING

Background and scope:
PSO is intended as an instrument for integrated, but not incorporated, support to MoPH-led collaborative health sector governance. The key modus operandi of the PSO is structured as a set of "PSO Projects", through which expertise is mobilised to tackle specific policy issues or questions. Such expertise may be internal or external to MoPH, but it always operates in close collaboration with MoPH, a collaboration that can take various formats, in function of the specificities of each project). As a result, each Project both provides a policy-formation support service to MoPH, as well as direct expertise and capacity building support to the MoPH units. This mandate puts the onus on PSO to develop clear and transparent operating principles, mechanisms and procedures that ensure effective support of MoPH and its technical units, as well as transparent financing and management of each PSO Project.

The *Operationalising PSO project* Establishes the flexible mechanisms for this purpose (staff recruitment, equipment, arrangements for MoPH↔AUB staff rotation, collaboration with MoPH units, transparency)

Expected impact in terms of policy support[1]:
Avail MoPH decision makers with an effective and transparent instrument to implement the PSO mission of building MoPH capacity for collaborative governance of the health sector.

Work-packages:
1. Staff and equip the PSO core team (profiles, responsibilities, TORs, accountability, admin status, selection, contracting) and formulate Operating Procedures for project implementation and capacity building support;
2. Manage day to day PSO activities and report to the PSO Guiding Committee
3. Assist the PSO Guiding Committee in identifying and prioritising policy issues to be addressed as discrete PSO Projects, with their MoPH capacity building implications;
4. Establish a small *Executive Group* to:
   a. formulate budgeted TORs for prioritised PSO Projects,
   b. identify potential entities eligible as implementers,
   c. Identify funding sources,
   d. award contracts;
5. Establish, for each Project, a *tripartite Project Management Teams,* consisting of (i) the PSO staff in-charge, (ii) the entity implementing the project (ie the entity that has the implementation contract), and (iii) the MoPH staff directly concerned by the Project's topic.
6. Follow-up, manage and quality assure contracted projects, including their direct expert capacity building support to MoPH structures.

---

[1] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Instruments for modernised sector management in place"

2. MoPH Readiness:

MODERNISING MoPH'S CAPACITY FOR MANAGING KNOWLEDGE

Background and scope:

Informing health policy formation and implementation with sound data, evidence and strategic intelligence that contextualizes technical evidence with operational knowledge of the health sector is constrained by recurrent challenges:

(i) Data sets in MoPH are fragmented, patchy, and compartmentalised, with problems of completeness, reliability and access;

(ii) Staff is ill-prepared, technically and in terms of work culture, for generating, sharing and using information and knowledge;

(iii) The current equipment in terms of information and communication technology does not allow for smooth access to and sharing of information and knowledge;

(iv) The internal organisation of MoPH (structure, responsibilities as currently defined, organisational and career incentives) are not conducive to operation as the proactive knowledge management organisation required by Lebanon's health sector context; of knowledge

At a broader level a critical limitation of MoPH's capacity to inform policy formation and implementation derives from its current focus on data on what is directly under control of the MoPH. Proper sector management requires a sector wide system of looking at data and information. Tackling this broader issue is the object of *PSO Project 12 (HIS Master Plan)*.

In the meantime the *MoPH Readiness Project* focuses specifically on MoPH's capacities and internal processes, as a basis for its transformation into a knowledge management organisation. The *MoPH Readiness Project* will foster a culture of using and sharing knowledge and information within MoPH by eliminating bottlenecks: in the architecture and management of data sets; staff capacities and capabilities; organisational structure and incentives; and equipment. This will optimise the use of information on what is of immediate concern to MoPH, whilst readying it for a more comprehensive, sector wide role that covers both the public and private realm.

Expected impact in terms of policy support[2]:

MoPH decision-makers can rely on consistent and easily accessible information, managed and formatted for decision making, in an organisation that evolves from an administrative structure into a knowledge management organisation. MoPH can produce timely, consistent and reliable synthetic reports and transparent access to key data and information.

Work-packages:

1. Map readiness
   a. Data sets and platforms within MoPH, including issues with interoperability and consistency, access and sharing, actual and potential linking with decision making;
   b. Mapping individual level capacities and capacity gaps for knowledge management;
   c. Equipment constraints (hardware, software, services, maintenance, supplies);
   d. MoPH structure: formal responsibilities and incentives for generating, sharing and using information.
2. Streamline information flows
   a. Harmonisation and integration of data sets;
   b. Training, coaching and (re)deployment of staff to bridge capacity gaps;
   c. Upgrading of equipment;
   d. Define responsibilities and organisational incentives for information sharing.

---

[2] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Instruments for modernised sector management in place"

3. Propose options for the functions and structures of a knowledge-based MoPH that focuses on setting the policy and regulatory agenda.

II: Modernising health care provision: Universal Health Coverage with People-centred care

The common denominator in this group of PSO Projects is that they address different aspects of health care delivery operations where improvements appear both necessary and possible. They cover a range of service challenges, with a particular accent on improving access and quality of care.

3. EXPANDING UC SCHEMES

FILLING COVERAGE GAPS IN CARE FOR THE UNINSURED AND VULNERABLE

Background and scope:
The MoPH has made much progress in extending health coverage to its priority target population: the uninsured and vulnerable. It does so by purchasing in-hospital care, by arranging for affordable medicines, and by working with the National Network of PHC to give the targeted population access to ambulatory care, both primary and specialist. On current knowledge the uptake of both ambulatory and hospital care by the priority target population does not indicate exclusion of major subgroups within that target population. While this remains an area of some concern, MoPH would now assess ways of broadening the range of affordable services covered for the priority target population. This is intended to (i) result in added health benefits; and (ii) result in extra reduction of OOP payments by the households in the target population, as it would reduce the need to rely on commercial services. The range of packages (with specification of technical acts) currently envisaged covers: wellness benefits, diabetes, hypertension, prenatal, geriatrics, CAD and depression. Consideration is also given to the establishment of Patient Pathways, emergency services, palliative care (cfr PSO Projects 2, 6 & 7). Full implementation is constrained by: (i) the possibility of funding the expected take-up of services; (ii) the need to identify ways of paying providers for these services with the right kind of incentives; and (iii) the need to build up the capacities of the providers in implementing these packages effectively.
The *Expanding UC schemes* project will identify options to address these three constraints. It will be informed by *Project 14, Beneficiary Analysis*. The *Beneficiary Analysis* will allow to quantify the relative proportions of false positives and false negatives among beneficiaries, as compared to the intended target population. This has obvious implications for estimating the funding gap and the potiential for package expansion for the targeted population.

Expected impact in terms of policy support:[3]
The project will assist MoPH in meeting one of its core objectives and responsibilities: moving towards universal coverage, giving priority to meet the needs of the uninsured and vulnerable.

Work packages:
1. Quantify the expected funding gap, by modelling expected demand, uptake and cost of the proposed clinical packages (wellness benefits, diabetes, hypertension, prenatal, geriatrics, CAD and depression, patient pathways, emergency services, palliative care);

---

[3] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

2. Develop costed scenarios for provider payment formulas with their expected incentive impact on provider performance;
3. Develop scenarios for mobilising sustainable funding to meet the funding gap;
4. Accelerate implementation of the Family Medicine and Community Nursing training schemes; complement with guidelines and workshops for other medical staff practicing in Health Centres.
5. Incorporate the full range of activities in the EHRs.
6. Organise a communication programme to inform the public on their positive rights to uptake of the expanded range of services

4. EHR
GENERALISING THE USE OF STATE-OF-THE-ART ELECTRONIC HEALTH RECORDS

Background and scope:

The deployment of state-of-the-art EHRs is *the* key transformative intervention to obtain a visible jump in quality of care. To be transformative, state-of-the-art EHRs have to be designed to:

1. Benefit quality of care for patients and professionals and help professionals / institutions organise their work (facilitate continuity -over life course and between levels-, coordination and affordability, package definition, gatekeeping, rational e-prescription and between-provider communication):
   a. Improve the quality, safety, and efficiency of care while reducing disparities
   b. Engage patients and families in their care
   c. Promote public and population health
   d. Improve care coordination
   e. Promote the privacy and security of EHR's
2. Demonstrate achievement of "meaningful use" objectives as key to qualifying providers for incentives;
3. Generate the KPIs for the Health Sector Performance Information system, i.e. provide information useful (i) for managing public purchasing of health care and (ii) for informing sector stewards and the public on trends, progress, critical issues in the whole system.

The *EHR* project aims at launching the generalisation of state-of-the-art EHRs as an instrument to transform quality of care and system intelligence.

Expected impact in terms of policy support[4]:

MoPH decision-makers and key stakeholders are provided with the technical and institutional elements to decide on an appropriate strategy for rolling out EHRs across the health sector.

Work-packages:

1. Review of (i) international experience and (ii) status quo in Lebanon (inventory of systems in use or development within private and public services): Literature review; expert seminar; study tour focusing on both systems and deployment strategies in complex contexts (It? Pt? Dk? Be?), EU and US regulation.
2. Preparation of strategic choices for deployment:
   a. Propose Meaningful Use Criteria set for decision on a national normative framework that certified systems need to respond to;
   b. Propose regulatory frame for digital authentication processes and alignment with international interoperability frameworks (eHealth European Interoperability Framework eEIF) that certified systems need to respond to;
   c. Propose costed deployment strategy:
      i. For public facilities and National Primary Health Care Network: availability of open source EHR and conditions for customisation and certification;
      ii. For private hospitals with accreditation/contractual arrangements and systems in place: certification of compliance with Meaningful Use Criteria, generation of required KPIs and interoperability; For private hospitals with accreditation/contractual arrangements but without systems in place: alignment to best practices;
      iii. For private clinics: NSSF/MoPH incentives for registration of patients with certified instruments.
   d. Policy mapping of stakeholders regarding the deployment strategy options.

---

[4] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

5. PEOPLE-CENTRED CARE

ALIGNING ORGANISATION AND INCENTIVES TO THE NEED

FOR BETTER COORDINATION AND CONTINUITY OF CARE

Background and scope:
This project addresses the fragmentation within current health care delivery (particularly between inpatient and ambulatory care). It aims to develop conditions and incentives for better integration, continuity and coordination of care across care levels. This should improve effectiveness, efficiency, and patient-experience, as well as health care providers' job satisfaction. On the basis of a review of the current status the *People-Centred Care* project will formulate a menu of macro, meso and micro interventions and incentives and organise pilot patient pathway collaborations for selected conditions.

Expected impact in terms of policy support:[5]
MoPH and NSSF are provided with a menu of concrete options and measures to establish contractual incentives and performance payment models for care coordination, including access to and follow-up of complementary examinations, specialist outpatient care, home care.

Work-packages:
1. Review (Inter-health centre peer reviews, observation, staff interviews, patient experience (telephone interviews, focus groups, Online patient & carer stories, Discharge interviews)) of the current status of:
    a. Problems with continuity, coordination and patient experience under current arrangements and organisation of patient pathways (theoretical and actual): guidelines, financial arrangements, incentives, malfunctions, duplications, delays.
        i. users of the National PHC network
        ii. users of public hospitals (out- and inpatients)
        iii. users of contracted hospitals (out- and inpatients)
    b. Offer and uptake of complementary examinations (guidelines, cost and price benchmarking, affordability, alignment of incentives for rational prescription, communication, quality control): see also *Project 4: Overmedicalisation*
    c. Home care, day care, palliative care (administrative constraints, incentives and disincentives, implications for contracts, mapping of positions and interests of professional and institutional stakeholders, communication with public and professionals)
    d. Integration of chronic disease and mental health care programmes (incentives, guidelines, implications for contracts, mapping of positions and interests of professional and institutional stakeholders, communication with public and professionals, ...).
2. Menu of macro, meso and micro interventions and incentives for improving continuity and coordination of care, overall and/or for selected tracer conditions
    a. Organise hearings and/or a community of practice to develop a Menu of Desirable Interventions and Incentives (including feasibility of appointing care coordinators at primary and/or hospital level);
    b. Establish MoPH working group to translate the Menu into administrative measures.
3. Rationalisation of patient pathways
    a. Roadmap for developing formal patient pathways (in cooperation with the European Pathway Association) and choice of priorities (eg diabetes, CVD, Ca, geriatrics);

---

[5] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

b. Feasibility study and pilot for an Oncology Care Pathways Network with production of a "Template of Multidisciplinary Care Quality Manual";
c. Feasibility study and pilot for a Cardiac Care Pathways Network with production of a "Template of Multidisciplinary Care Quality Manual".

6. SCALING UP ACCREDITATION

Background and scope:

The MOPH introduced hospital accreditation in 2000. When hospitalization reimbursement tariffs were linked to accreditation results it became possible to revise contracts so as to incentivize continuous quality improvement. Perceived as transparent, fair and objective the hospital accreditation programme has been well accepted and institutionalised.

Currently accreditation does not cover hospital outpatient care; moreover, for non-hospital health care attempts at mainstreaming accreditation are limited to a subset of the National PHC network health centres, with disappointingly slow expansion.

Nevertheless, the success and institutionalisation of accreditation approaches in inpatient care shows there is capacity for applying the approach to the rationalisation of ambulatory care, and particularly for primary care.

The *Scaling Up Accreditation* project will
- (i) review and streamline the governance of the PHC accreditation so as to speed up the uptake of accreditation within the National PHC network;
- (ii) ensure the accreditation criteria used for primary and specialist ambulatory care take into consideration the organisational innovations for improving coordination and continuity of care (EHR, pathways, …);
- (iii) use the 6th accreditation round to include ambulatory outpatient care in the accreditation criteria of the hospitals.

Expected impact in terms of policy support:[6]

Improved capacity for governance and regulation of ambulatory care through:
- Extension of PHC accreditation to the whole National PHC network;
- Inclusion of outpatient ambulatory care in the 6th round of accreditation for public and private hospitals;
- Exploration of the potential for accreditation in the private ambulatory sector.

Work packages:

1. Specify possible options for accreditation within the private ambulatory sector
2. Include outpatient care in the accreditation process for hospitals
3. Identify incentives for National PHC Network health centres to accelerate and expand accreditation
4. Negotiate with NFSS the possibilities for linking outpatient care reimbursement (hospitals, clinics) to accreditation, as a precondition for developing a system of accreditation of private clinics
5. Identify a strategy for boosting accreditation capacities

---

[6] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

7. OVERMEDICALISATION
REDUCING EXCESSIVE RELIANCE ON HI-TECH INTERVENTIONS, SPURIOUS PROCEDURES, AND FUTILE TREATMENT

Background and scope:
Given the perverse incentives in the way hospitalisations are billed in Lebanese hospitals, overmedicalisation has become a public health problem: multiplication of non-validated medical practices, with no clear benefits, unjustified hospitalisations, spurious procedures, overreliance on lucrative hi-tech interventions and futile treatment: these represent an iatrogenic health risk and a needless expenditure for individual patients and the public purse. The current system of TPAs seems to have contributed to a downward trend in two conditions that are considered significant causes of unjustified hospitalisation: diarrhoea-gastroenteritis and abdominal/pelvic pain. This confirms that there is potential for improving the protection of health care consumers and the efficiency of public purchasing.
The *Overmedicalisation* project will provide information on the extent of the problem and explore mitigation options.

Expected impact in terms of policy support:[7]
This project is to provide health authorities with:
- Baseline measurement for monitoring the extent of problem (profiles, trends, benchmarking, and identification of outliers) and its consequences (iatrogenesis, financial impact; perverse incentives);
- Information for a review of: admission criteria used by the TPAs; gatekeeping; case-mix contract incentives specification; insurance coverage;
- Input in the development of KPIs;
- A menu of options for containing excessive/irrational diagnostic and therapeutic interventionism.

Work-packages:
1. In-hospital care:
   a. Develop STATA scripts to monitor long term trends for admissions for tracer indications and procedures and identify tracer events suitable for audits.
   b. Adapt maternal death audit methodology to organise hospital-level audit/analysis of a sample of patient files with tracer events to
      i. assess the importance of unjustified admission, duration, procedures, discharge medication, and adverse events;
      ii. validate the use of potential tracers (eg Diarrhoea/gastroenteritis, Abdominal/pelvic pain, Diabetes, Dehydration, Urinary tract infection, Bacterial pneumonia …) to monitor trends.
   c. Assess the potential of TPAs to monitor unjustified hospitalisations and procedures
2. Benchmarking and market analysis for diagnostic procedures:
   a. Map providers of laboratory, imaging and other selected diagnostic procedures: profile of services (volume, pricing, payers and sources of revenue, quality assurance) and users (self-referrals and referrals)
   b. Establish pricing benchmarks (national and international), identify outliers, model potential impact of changes to price structure in terms of savings to users, social insurance, MoPH
3. Review of national and international experience with mitigation strategies and potential feasibility in the Lebanese context:

---

[7] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

a. Guidelines, EMR-steered guidelines, audits, peer reviews, feedback strategies
b. Nudge strategies
c. Cost education
d. Rationing (Dr volume-cost caps, prescription cost caps, smart rationing…)
e. Structural measures (economies of scale, investment in equipment and quality, licensing and accreditation, merging and consolidation, specialisation)

8. PALLIATIVE AND ONCOLOGICAL CARE:
AN ENTRY POINT FOR HUMANISING HOSPITAL CARE

End-for-life care as currently organised is often characterised by overmedicalisation, interventionist eagerness, therapeutic excesses and futile treatment. This leads to adverse patient experience, and avoidable cost to patient and system, with little or negative health benefits in terms of survival or quality of life. The same goes for oncological care, and more generally for what happens with patients in hospitals.

The traditional culture and organisation of hospitals and the hospital network has contributed to these distortions: hospitals in Lebanon are still essentially organised around clinical directorates and their financial and technical interests rather than around the patient's interests and wellbeing. This calls for a reform of both the internal organisation and design of the network of hospitals (see *Hospital Network Master Planning* project). While such reforms take place over the medium term, immediate attention can be given to tackling direct determinants of distortions in the way palliative and oncological care is provided:

(i)   Eliminating the perverse financial incentives that push providers to overmedicalisation;
(ii)   Promoting technical and behavioural standards in the interests of patients
(iii)   Provide funded alternatives for in-hospital hi-tech care (ambulatory-, home- and hospice-care);
(iv)   Give more voice to patients and their families.

The *Palliative and Oncological Care project* will complement *Project 7 Overmedicalisation*, as an entry point to humanise hospital care, making palliative and oncological care more patient-centred and less overmedicalised.

Expected impact in terms of policy support:[8]

MoPH has the factual elements, and accumulates knowledge, experience and alliances from pilots, to rationalise cost and quality of palliative and oncological care.

Work-packages:

1. Review current financial incentives (volume, destination, hospital- and specialist-dependency, market share) from public sources to palliative and oncological care; Produce scenarios for funding of alternative/complementary strategies (HC, Home, hospice).
2. Map current supply of palliative and oncological care and pain clinics and make available to the public.
3. Pilot advance care planning and the appointment of care coordinators/patient advocates in selected hospitals.
4. Pilot HC and home palliative and oncological care.
5. Review, adapt and disseminate relevant NICE guidelines, with inclusion in accreditation mechanisms and training packages.
6. Collaborate with patient and professional organisations to develop a code of conduct and instruments for ethical management of end-of-life care

---

[8] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

9. EMS

AN UPDATED MASTER PLAN FOR CONSOLIDATION
OF EMERGENCY MEDICAL SERVICES

Background:

Timely emergency medical services (EMS) for life-threatening situations constitute a high-profile challenge in all countries: delays in access to EMS are perceived as a matter of 'life or death' and undermine trust in health authorities. At the same time rising numbers of unnecessary emergency department attendances are a source of inefficiency, professional frustration and user in-satisfaction. EMS thus function as a sentinel for barriers to access and inadequate follow-up of chronic conditions. Although the evidence base from international comparative research on emergency medical services remains scanty, most mitigation strategies fall under three headings:

- For the pre-hospital phase: rapid response and consolidation of EMS, striving for a balance between the "load & go" model for complex trauma care and the "stay & stabilise" model for medical emergencies such as heart attack or stroke.
- For the in-hospital phase: optimising emergency department equipment and procedures, with concentration and structured provision of specialised hospital services.
- Easing the pressure on emergency departments by diverting patients to primary care (patient pathways, financial incentives, out-of-office-hours services, telephone triage, etc).

Current EMS in Lebanon have been influenced by the 1999 EMS master plan (a three-level system including a call reception and control centre, a dedicated emergency number, a network of twelve medicalized intervention centres and a network of first aid centres), and the 2007 MoPH plan for a Road EMS. Currently MoPH bears the cost of emergency evacuation if it is followed by hospital admission. MoPH has contracted the Lebanese Red Cross for a "load and go" pre-hospital phase of response; private companies also have a market share. The facilities of the in-hospital phase vary from sophisticated trauma centres to very basic services. There are currently no standards for either pre-hospital or the in-hospital emergency care, for the qualification of first responders, nor for the equipment that should be available in ambulances.

The *EMS* project will produce an updated master plan for EMS in Lebanon that considers the distribution of needs, contractual and technical constraints, and contemporary medical and communication technologies.

Expected impact in terms of policy support:[9]

MoPH has the factual elements to negotiate a revision of how EMS are provided and funded in the country and is better equipped to contract such services.

Work-packages:

1. Review the status quo, including
   a. Pre-hospital phase ambulance and dispatch EMS (structure, productivity and adequacy of equipment to needs, distribution, financing, performance, typology and geo-temporal distribution of demand, sample audit of evacuation failures),
   b. In-hospital phase EMS (WHO Emergency Care System Assessment Tool; availability of the essential package of EMS care; stratification of hospitals in function of capacities for triage, ability to cope with complex cases, and 24/7 availability; financial arrangements)
   c. Excessive reliance on Out-of-hours access to primary care
2. Propose and build consensus on
   a. Adaptation of the DCP3 essential package of EMS to the Lebanese context

---

[9] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place"

b. Standards and key performance indicators to monitor EMS and guide licensing, accreditation and contracting of EMS
   c. Experimentation with lean pathway approaches to Emergency Department triage and orientation of patients, starting with the hospitals with the busiest EDs
3. Provide MoPH with an updated and costed EMS Master Plan for
   a. pre-hospital ambulance and dispatch services (balancing "load & go" and "treat & stabilise"),
   b. the in-hospital phase of 24/7 emergency medical care (with consolidation and stratification of emergency departments), and
   c. the arrangements for out-of-hours primary care
4. Formulate guidance for MoPH staff for the follow up performance of contracted EMS

10. HOSPITAL NETWORK MASTER PLANNING
LONG TERM SCENARIOS TO GUIDE CONSOLIDATION, SPECIALISATION AND COMPLEMENTARITY IN LEBANON'S HOSPITAL NETWORK

Background and scope:

In the 2000s the expansion of Lebanon's hospital infrastructure has slowed down. The new public hospital infrastructure now accounts for 14% of the hospital beds. While the larger private hospitals increased in size, some of the smaller ones closed down. From the early 2000s onwards, the public hospital infrastructure that had been planned in the immediate post-war years, became operational. The ratio of hospital beds per inhabitant is now at the lower extreme of the OECD distribution, while admissions are slightly below the OECD median. The purchase of admissions by MoPH accounts for a substantial part – 30.0% – of the number of admissions in the private sector. If one adds in the hospitalisations covered by the National Social Security Fund (a volume comparable to that covered by the MoPH), those covered by UNRWA for Palestinians refugees, and, more recently, those purchased for Syrian refugees with donor funds, this highlights the dependence of the private hospitals on pooled, albeit fragmented, public funding mechanisms. Accreditation, TPAs and increasingly sophisticated performance-linked public purchasing has introduced a degree of rationalisation and allows for good accessibility.

At the level of individual hospitals current trends in high-income countries concentrate around three pillars:
   o   progressive patient care (pooling patients inf function of acuity and patient dependency),
   o   patient-centred approach (organising work around patient pathways, as opposed to an approach in which patients must go and seek the services they need in specific physical and organisational locations, and enhancement of positive relationships between care providers and patients by promoting daily routines that are tailored to their life experiences, abilities and preferences); and
   o   the lean approach (active management of bottlenecks and reduction of waste).

At the level of the hospital network technological change, the relation with primary care and ambulatory specialised care, and the push for day-care and homecare will be important drivers. The hospital network will, in the long run, have to reorganise and evolve towards stratification by levels of complexity, with a degree of inter-hospital specialisation and complementarity, and possibly consolidation.

The *hospital network master planning* project can assist in moving in the right direction by organising the policy dialogue about the necessary rationalisation of Lebanon's fragmented network of hospitals.

Expected impact in terms of policy support:[10]

- MoPH has basic information and capacity to build scenarios to guide consolidation, specialisation and complementarity in Lebanon's hospital network.
- MoPH animates a policy debate about the future of Lebanon's hospital network.

Work-packages:

1. Familiarise (study tour: Tuscany, Denmark) opinion leaders in the hospital network with shifting from structures based on speciality-driven directorates to progressive patient care;
2. Quantify progressive patient care scenarios on the basis of an analysis of a sample of discharge summaries (discharge database);
3. Determine (case-mix corrected) volume and outcome of activity per hospital for tracer interventions and disease grouping for whch the information can be abstracted from the

---

[10] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Instruments for modernised sector management in place"

discharge databases. Determine threshold volumes to guide accreditation and contracting decisions, and implications for consolidation and specialisation scenarios

4. Update the information on availability, utilisation and distribution of complex technology
5. Analyse hospital market share trends and dynamics (national and regional dimensions); Triple stratification by specialisation/disciplines; by patient profiles (distribution over chronic, protocolled, uncertain, highly complex, critical); by services offered (intensive care, classic beds, day care, home care, telemedicine);
6. Map the insertion of the hospitals in ambulatory and emergency care networks.
7. Map inter-hospital collaborations / sharing / outsourcing of non-medico-technical activities
8. Conduct scenario building exercise (Drivers for change, critical uncertainties, options and trends) for the future of the hospital network

Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output:
"Instruments for modernised sector management in place"

11. EBP & HTA

HEALTH TECHNOLOGY ASSESSMENT AND PRODUCTION OF

QUALITY-ASSURED CLINICAL GUIDELINES FOR EVIDENCE-BASED-PRACTICE

Background and scope:

A systematic approach to structuring, coordinating, financing and follow-up of providing all caregivers with access to up-to-date, validated and evidence-based guidance on care practice and health technology can contribute to improving quality of care. The MoPH has established a structure and framework for Health Technology Assessment and regulation. It recognises the need to promote evidence-based-practice across the health sector, and so do a number of individuals and organisations in academia and professional organisations.

Yet, current attempts to prioritise and establish guidelines and regulations for quality assurance and for rational supply-side investment (and disinvestment in obsolete or low-added value technologies) remain unsystematic, particularly in the private sector. The recommendations for validated quality assurance for guidelines development increasingly used in high-income countries (eg AGREE II Appraisal of Guidelines, REsearch and Evaluation, version two criteria, ADAPTE methodology, EPOC Cochrane Effective Practice and Organisation of Care) can help rationalise these efforts.

The *EBP&HTA* project will propose the structures and processes to improve the coherence and quality of current production and dissemination of clinical guidelines and HTA.

Expected impact in terms of policy support:[11]

MoPH and relevant stakeholders reach a consensus on the framework, structures, and processes adopted in health technology assessment and in the production, dissemination, and adoption of clinical guidelines to promote evidence-based practice follows best practice approaches and methods that guarantee the quality of guidelines and regulatory measures.

Work-packages:

1. Inventory of clinical guidelines currently in use in Lebanon: topics, summary recommendations, end-users, sources. Identification of guidelines requiring updating.
2. Inventory of technologies considered for disinvestment obsolete as obsolete or low-added value and of those under consideration for investment by major stakeholders.
3. Critical review of the 5 implicit steps in current practice and institutional/technical capacity for EBP & HTA, with a review framework covering:
    o Priority setting: Implicit and explicit criteria have led to selecting the topics of the existing guidelines. Role of MoPH, NSSF, academia, the public, international collaboration in ranking priorities. Options for improvement.
    o Generation of EBP guidance: How, with what technical criteria and by whom the guidelines and summary recommendations have been developed. Potential of AGREE II and ADAPTE to improve quality.
    o Independent pre-publication validation of methodological soundness and bias, and of the feasibility of the recommendations: current arrangements and options for improvement.
    o Diffusion and dissemination: Compare current practice compare to EPOC. Feasibility of and conditions for a unique platform or clearinghouse for guidelines in Lebanon.
    o Adoption, implementation and evaluation: Role of opinion makers and knowledge transfer teams. Options for monitoring adoption, implementation, and practice change.

---

[11] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Processes and tools to reorient service delivery in place".

4. Formulate a national EBP development framework and strategy, with a consensus on institutional responsibilities and collaborations informed by policy mapping, policy dialogue, and a financing feasibility study.
5. Establish the international networks of collaboration with HTA and EBP institutions (meetings, working groups, communities of practice), particularly in the European Region.

Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output:
"Processes and tools to reorient service delivery in place".

12. HIS MASTER PLAN

MASTER PLAN AND KPIS FOR A COMPREHENSIVE INFORMATION SYSTEM ON HEALTH SECTOR PERFORMANCE

Background:

Better understanding of how the care system is performing overall is key to assist health authorities and operators to use their resources effectively to drive up performance, ie to ensure patients receive the best possible clinical outcomes, with a more balanced consideration of patient safety, effective care, and a positive patient experience.

Currently such information is fragmentary, of inconsistent quality, and expensive to obtain. This constrains accountability and efforts to steer the system (particularly beyond the realm of services purchased by MoPH). Better assessment of performance measurement can improve the quality of decisions made by all actors within the health system.

The *HIS Master Plan* project will develop a master plan for ongoing health sector performance assessment that brings coherence to the current fragmented information sources.

Expected impact in terms of policy support:[12]

MoPH has the basis for the progressive establishment of a factual and transparent performance assessment system covering the entire health sector, public and private, that can:

- improve performance by highlighting inefficiencies and possibilities of improvement; and
- improve governance effectiveness, by providing authorities with the relevant information to leverage, steer and negotiate.

The process of selecting KPIs relevant to systemic policy objectives and streamlining the architecture of the ongoing production of information on health sector performance is expected to result in gains in capacity and knowledge of MoPH as well as a broader range of stakeholders.

Work-packages:

1. Make arrangements for mobilisation and steering
    a. Identify key stakeholders
    b. Mobilise stakeholders in a steering network or community of practice;
    c. Formulate scope of the project.
2. Review and determine options for upgrading coverage, quality, granularity and timeliness of production of information through Vital Statistics and Epidemiological Surveillance mechanisms
3. Determine KPIs, Benchmarks, and Potential Sources.
    a. Review of status quo, international experience, alignment in Mediterranean region. Propose specification, sources and accompanying issues for the KPIs that are designed to show whether services are being delivered successfully and how resources are deployed and spent. Document how the proposed KPIs supersede existing measures and information routinely available.
    b. Benchmarks: build catalogue of KPI benchmarks in other countries; build catalogue of KPI's as currently observed in Lebanese facilities; establish consensus benchmarks
    c. Identify Potential Sources: map databases and data sources, with special attention for EMRs as source of data.
4. Design and negotiate architecture of performance assessment
    a. Formulate scenarios for processes by which data will be collected, including timing, financial implications, responsibilities, arrangements for transparency. Architecture to be structured around KPIs generated by EMR systems.
    b. Organise stakeholder consensus; prepare the decisions on resource allocation
5. Establish the administrative and operational apparatus

---

[12] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Instruments for modernised sector management in place"

13.   PHARMACEUTICAL REGULATION

Background and scope:

Over the past years the MoPH efforts to reduce the cost and improve fair access to pharmaceuticals has been central in its move towards universal coverage and protection of the vulnerable unsured. Lowering out-of-pocket spending on pharmaceuticals came about in two distinct phases: before 2000 the MoPH focused on managing discretionary subsidies; and after 2000 it undertook to lower OOPs for medicines As of 2000, MoPH began focusing systematically on OOP spending on pharmaceuticals, in an explicit attempt to prevent impoverishment through spending on health. The Ministry was a relatively small purchaser of pharmaceuticals (5.5% according to the 2005 NHA), but it has influenced things in three ways: by improving access to affordable drugs, and specifically drugs for chronic diseases, through publicly subsidised schemes targeted at the poor and the uninsured; by improving practices in the pharmaceutical sector, rendering it more efficient and transparent; and by revising the price structure of medicines so as to make pharmaceuticals generally more affordable.

The *Pharmaceutical Regulation* project will assist MoPH in further strengthening its impact on the whole pharmaceutical sector in Lebanon.

It will

Expected impact in terms of policy support:[13]

MoPH has better strategic information and an enriched arsenal of instruments to regulate a sector that is key to the proper functioning of the health system, and without effective regulation would threaten efforts to move towards universal coverage.

Work-packages:

1. Improved monitoring of the pharmaceutical market
    a. Generalisation of bar coding of pharmaceuticals as basis for mapping utilisation
    b. Quantification of imported pharmaceuticals
2. Update and implement the strategy for promotion of generics
3. Establish critical instruments for regulating the pharmaceutical market
    a. Pharmacovigilance
    b. Upgrade Good Manufacturing Practices and align to EU regulations
    c. Code of ethics for drug marketing:
    d. Clinical Trials Registry with inclusion of medical devices

---

[13] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Instruments for modernised sector management in place"

III: Generating strategic intelligence to guide sector governance

The five projects in this group have as common feature that they generate intelligence and information on issues of strategic important to the sector: the appropriateness of the targeting of public funds to the poor and vulnerable; the health care providers; the health and health status of the population; the expectations and experience of the populations; and the functioning of the networks that are the basis of the MoPH-led collaborative governance.

14. BENEFICIARY ANALYSIS

TARGETING OF PUBLIC PURCHASING OF HOSPITALISATION AND HIGH-COST TREATMENTS

Background and scope:
MoPH has given priority to direct its purchasing and subsidising of care towards the needs of the most vulnerable uninsured, behaving as an 'insurer of last resort'. This is of particular importance for two important budgetary posts: purchasing of inpatient hospital care; and provision of expensive drugs.

There is some uncertainty about the relative proportions, among the beneficiaries, of true positives (vulnerable uninsured benefiting from support) and false positives (non-vulnerable-uninsured benefiting from support), and about the financial implications this has. A high proportion of TP and low proportion of FPs among beneficiaries would confirm that the MoPH has been effective in implementing its strategic choice. On the other hand, a low proportion of TP and high proportion of FPs among beneficiaries would signal a need for a refinement of the administrative apparatus for targeting. The existence of large numbers of false negatives (vulnerable uninsured not benefiting) is unlikely but would be a matter of major concern.

The *Beneficiary Analysis* project will quantify TP, FP and FN, and estimate their financial implications. The project depends on availability of the database being updated with World Bank support, in a format that allows for cross-matching with the databases of the MoPH beneficiaries. This has not been ascertained as yet.

Expected impact in terms of policy support:[14]
The Beneficiary Analysis will supply MoPH with key information to decide on continuation or revision of current targeting practices in its pursuit of UHC.

Work packages:
1. Obtain the relevant databases (lists of poor & very poor, lists of beneficiaries).
2. Crossmatch the databases, calculate TP & FP with various thresholds.
3. Assess FN by comparing TP/population utilisation ratios with benchmark ratios.

---

[14] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

15. PROVIDER PRACTICE PROFILES SURVEY

Background and scope:

Knowledge about actual conditions of health care practice, particularly in the private sector, is fragmentary and largely anecdotal. This is the case for the working conditions and practice environment, for professional expectations, career intentions and burnout, but also for what services are actually being provided, with what technologies. The (limited) survey information that is available is some 10 years old.

Not all aspects of relevance can be included in a single survey round, and some topics (eg income and financial hardship) may be more delicate than others. Priorities (to be defined) may include: ambulatory care practice patterns, range of services offered, electronic and other types of medical record keeping, use of IT and web-based sources of information on medical decision making, profile of clientele, specialities, professional satisfaction, aspirations, burnout, and career perspectives.

On basis of past experience, it appears feasible to implement a Practice Profile Survey. Databases that can be used for sample framing include the order of physicians of Beirut directory for physicians, updated for 2017 (available on CD at a cost of Databases for sample frame include the order of physicians of Beirut 2017 directory for physicians (available on CD at a cost of 100$), and the directory of registered nurses of the Order of nurses (which, however, appears to be confidential). Previous surveys with sample sizes 500-800 (sufficient for a margin of error of ±3-4%) have yielded surprisingly high response rates (up to 88% for Aki et al in 2007; 60.5% for Alameddine et al in a survey of Health Centre Doctors).

The *Provider Practice Profiles* project will provide hard information on the way ambulatory health care is currently being provided.

Expected impact in terms of policy support:[15]

MoPH leadership provided with strategic intelligence relevant to:

- Reinforcing dialogue with professional associations and major stakeholders on the future and the transformation of medical and paramedical professions (including development of family medicine primary care career pathways, incentives, and roles of different professional categories)
- Developing realistic packages and pathways of care that start from the existing reality
- Identifying opportunities for quality assurance in ambulatory care
- Managing stakeholder expectations in the political process of modernisation/reform of primary care and the sector.

Work-packages:

1. Survey strategy (sampling frame; choice between self-, telephone-, interview strategies)
2. Choice of implementing agency
3. Questionnaire development, plan of analysis and reporting format
4. Implementation
5. Reporting (MoPH, professional associations, Forum)

---

[15] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Critical mass of reprofiled PC teams operational"

16. HEALTH & HEALTHCARE UTILISATION SURVEYS

INVENTORY, PERSPECTIVES AND PRIORITY SETTING FOR HOUSEHOLD HEALTH, HEALTHCARE AND HEALTH EXPENDITURE SURVEYS

Background and scope:

Historically household health, healthcare utilisation and health expenditure surveys have played a key role in shaping health policy in Lebanon. They have identified the importance of out-of-pocket spending for ambulatory care and medicines. Importantly, they made it possible to demonstrate the effect of policies aimed at reducing OOP expenditure, thereby comforting the health authorities they were on the right path towards UHC.

The most recent reasonably reliable surveys of this kind are by now outdated, though, importantly, in combination with a new assessment they would make it possible to appreciate evolution and trends. It has been suggested repeatedly that it would be timely to conduct a new such survey (upgraded on the basis of current evolution in survey methodology, particularly in terms of health status measurement), if only to ascertain whether, as hoped, the reduction in OOP expenditure continues.

At the same time there appears to be a multitude of population-based surveys organised by various agencies, measuring different aspects with varying methodologies, with little coordination, delays, and an amount of duplication. This creates a rather confused environment in which the gathering of otherwise vital information risks being discredited.

The *Health & Healthcare Utilisation Surveys* project will produce an inventory of ongoing and planned surveys, with an overview of lessons learnt, limitations, information gaps, and recent international methodological developments.

Expected impact in terms of policy support:[16]

The inventory of ongoing and planned surveys will provide the MoPH with:

- the elements to make an informed decision on the desirability and feasibility to complement information currently available or being produced with an investment in a national representative household surveys on health health care utilisation and health expenditure.
- up-to-date global information on progress in knowledge about survey techniques and approaches
- possible options for implementation arrangements (National Bureau of Statistics, Health Metrics Institute, …) and funding

Work packages

1. Inventory of past, ongoing and planned surveys since the late 1990s, with a critical synthesis of trends, uncertainties and scenarios for a rationalised survey programme for Lebanon
2. Exploration with National Bureau of Statistics, Health Metrics Institute, WHO of (i) new developments at international level and (ii) options for implementation of a priority survey programme.

---

[16] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

17. PILOTING PROMS AND PREMS
PATIENT-REPORTED OUTCOME MEASUREMENTS, PATIENT-EXPERIENCE MEASUREMENTS, AND USER EXPECTATIONS

Background and scope:

Patient Reported Outcome Measurements (*PROMs*, which can be generic or disease-specific) and Patient Reported Experience Measurements (*PREMs*, of which patient satisfaction is a subset) are key to understand user expectations and experience. Increasingly used in OECD countries, they are helpful at different levels:

- on the micro or individual patient level: to improve patient-centred quality of care by informing care planning and management and shared decision making between the patient and healthcare provider;
- on the service or institutional level: to identify what works well and areas for improvement, drive healthcare quality improvement initiatives, assess and compare the performance of providers, and facilitate informed patient choice;
- on the macro level, PROMs can be used for population health monitoring and reimbursement decision-making and PREMs for macro-level healthcare performance measurement; thy help to prioritise, design and assess public health activities, measure health disparities, and evaluate interventions.

Beyond these uses of the measurements, the piloting of Proms and Prems can have an additional positive effect: drawing up questionnaires, discussing and testing them among staff and patients helps improve the existing situation; availability of PROMs and PREMs can help structure the policy dialogue on balancing needs, resources and expectations.

The *Piloting PROMs and PREMs* project will develop instruments to measure PROMs and PREMs, pilot them in selected health care units, and organise a stakeholder debate on the implications of the results and the desirability of institutionalising their utilisation.

Expected impact in terms of policy support:[17]

MoPH provided with

- Information for benchmarking PROMs and PREMs in healthcare institutions and stimulating quality improvement initiatives at institutional level;
- Capacity and instruments to stimulate quality improvement initiatives at institutional level and possible use for pay-for-performance purposes;
- Elements for public reporting of institutional quality of care;
- A factual input in the Forum's policy dialogue on finding a balance between needs, resources and expectations.

Work packages:

1. review experience of UK and the Netherlands (countries with substantial experience); France for proms and prems for hospital care. Review of OECD guidance[18]:
2. Decide on purpose, objectives, strategy, instruments (survey formats, tentative individual questions).
3. Identify and mobilise selected hospitals, clinics, HCs interested in Piloting Proms and Prems.
4. Planning and Implementation of the pilots[19]:
5. Policy dialogue on: (i) the measurement results; (ii) the performance of the instruments; and (iii) on the effect of conducting the pilot (drawing up questionnaires, discussing and testing them among staff and patients) on improving the existing situation.

---

[17] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

[18] www.oecd.org/els/health-systems/health-care-quality-indicators.htm

[19] See the Dutch "Zorginstituut Nederland" toolbox www.zorginzicht.nl/kennisbank/Paginas/prom-toolbox.aspx

18. NETWORKS SURVEY

SURVEY OF CORE CHARACTERISTICS AND ADDED VALUE

OF NETWORKS FOR COLLABORATIVE GOVERNANCE

Background and scope:

The collaborative governance championed by MoPH critically relies on a set of overlapping networks of varying degree of sophistication and formalisation. These networks include: the network of NGO-operated PHC centres; the network of hospital managers; the network of mental health stakeholders; the network of professional organisations involved in HRH; pharma; health experts – academia; the emergency network; the palliative care network. A better understanding and monitoring of the way these networks operate (e.g. the degree of centrality of MoPH and other significant players) can assist MoPH in steering and detecting vulnerabilities. It would also provide empirical documentation about governance and stewardship, a domain rich in opinions and poor in systematic documentation.

The *Networks Survey* project will provide empirical documentation of the sector governance through a description of the operation of selected current collaborative networks. It will:

- Describe network member profiles and features (purpose; key people, institutions and organizations; type of linkage between network members, info sharing mechanisms, financial transactions)
- establish a timeline of milestones in the evolution of the selected networks
- produce an empirical quantitative description of core network performance metrics (density, centrality, and multiplexity of nodes and linkages)
- assess perceived benefits and drawbacks.

Ultimately the Networks Survey may comprise three rounds (2018,2019, 2020), each round including 5 components (Description of network features, nodes, and linkages; network achievements; network performance metrics; perceived benefits and drawbacks of network membership; Social network mapping using e.g. UCINET software). This will make it possible to monitor the evolution of the networks and make a more robust assessment of their contribution to collaborative governance. The first round will be limited to 2 of the MoPH's networks. After the first round an interim evaluation will assess the desirability of including other networks and conducting the subsequent rounds.

Expected impact in terms of policy support:[20]

Provide MoPH with strategic intelligence to detect vulnerabilities in the networks, to improve their functioning and to strengthen the resilience of its approach to collaborative governance.

Work-packages

1) Decide on the choice of networks to be analysed (two among eg National PHC Network; Mental health network; Palliative care network; …).
2) Draft, test and finalise the survey instruments (3 parts: linkages; benefits, drawbacks).
3) Identify and procure the software to be used for the network mapping.
4) Identify 1-2 key informants per network member (for networks of institutions), or a sample of members (for networks of individuals).
5) Survey and report to Forum.
6) Decision on future rounds and/or extension to other networks.

---

[20] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

IV: Organising the policy dialogue on the health sector and its future

The organisation of a societal policy dialogue on the future of the health sector is key to ensuring further development, sustainability and resilience of Lebanon's collaborative governance of the health sector. Project 19 (NGO database) and 20 (Stakeholder mapping and managing) are constitute the basis to set up a comprehensive dialogue. The core of the support to the policy dialogue itself is constituted by Projects 21 (The National Health Forum), and 22 (Communities of Practice), that together constitute a platform for the policy dialogue. Project 23 (Roadmap for Vision 2030) prepares the translation of the policy dialogue into a shared vision and plan.

19. NGO PROFILE DATABASE

ESTABLISHING AN ANALYTICAL DATABASE OF PROFILES OF NFP-NGOS AND CSOS ACTIVE IN THE HEALTH SECTOR

Background and scope:
MoPH works in various networks with a multitude of civil society organisations. These collaborations are critical for its collaborative governance. Yet information on how these partners operate are surprisingly patchy. There is a directory (administrative rather than analytical) of the NGOs that participate in the PHC Network. There is no directory that crossmatches this PHC list with the NGOs involved with other programs of the ministry. A directory of Civil Society Organisations that has been compiled by UNDP but it seems to be outdated and only gives very superficial info on health sector-relevant activities.

There are three main groups of NFP-NGOs and CSOs where improved information would be useful.

A first group of relevance to the MoPH is that of the NGOs (and municipalities) that run over 900 health centres and dispensaries. MoPH has federated the 200+ most important ones in a formal National PHC Network and supports 700+ with medicines for chronic diseases and/or vaccines. The Network provides the bulk of non-hospital ambulatory care for the lower-income members of their constituencies and has been playing a key role in the response to the refugee crisis resulting from the war in Syria.

A second group are NGOs and CSOs that collaborate with the various MoPH departments on specific topics, projects or activities.

A third group are NGOs and CSOs that have an activity in the health sector but without relations with MoPH. Many of these collaborations run in parallel, with little communication. This results in fragmentation, incoherence, duplications and missed opportunities.

The *NGO Profile Database* will contain analytical profiles of all NFP-NGOs and CSOs in these three groups that are active in the health sector.

Expected impact in terms of policy support:[21]
- MoPH provided with a unified database with analytical profiles of NFP-NGOs and CSOs active in the health sector, whether or not in collaboration with MoPH, so as to:
  - gain a better understanding of the potential and constraints of its partners in the National PHC Network and other programmatic collaborations;

---

[21] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

         o   inform MoPH programmes with a better view of with whom and on what each programme collaborates, allowing them to identify synergies;

- PSO provided with necessary intelligence to prepare the Forum

Work packages:

1. Identify the NFP-NGOs and CSOs to be included.
2. Identify what elements to be included in the profile.
3. Survey the NGOs currently in the Network, as well as others not in the Network but with health care activities.
4. Constitute a searchable database.
5. Produce a publication of the NGO profiles.

20. STAKEHOLDER MAPPING AND MANAGING
MAPPING AND MANAGING SOCIETAL EXPECTATIONS, INTERESTS AND POSITIONINGS

Background and scope:

MoPH has adopted a collaborative approach to health sector governance. Critical in this approach is the understanding of the expectations of citizens and stakeholders, of their positioning and of their interests towards policy or regulatory initiatives (interests related to the policy, position for or against the policy, potential alliances with other stakeholders, ability to affect the policy process through power and/or leadership). This is particularly important with regard to service users and citizens, the private sector, the NGOs and CSOs, and international agencies active in the health sector; perhaps the most pressing is better understanding and management of expectations, interests and positions of political and parliamentary actors.

Understanding stakeholder expectations, positions and interests can benefit from systematic stakeholder mapping and instruments of deliberative democracy such as citizen's juries. MoPH already has some formal experience with some of these techniques this field. As the regulatory work in the health sector becomes more complex, it is important to mainstream stakeholder analysis competencies among its key staff to ensure they rely on useful and accurate information about those persons and organizations that have an interest in specific policies. Along with stakeholder mapping, and monitoring of PROMs and PREMs, experimentation with instruments of deliberative democracy (citizens' juries, focus groups, opinion surveys and related techniques) can help identify ways of finding an acceptable balance between expectations and resource constraints.

Better understanding of stakeholders can then be used to increase support for public policy options and guide a participatory, consensus-building collaborative governance process, if policy makers also have the *capacity to negotiate* the formulation of policy options and adherence or compliance with their implementation. Many negotiations fail because they are position-based rather than interest-based, not properly focused and not dealing with their differences in a rational, effective manner. This is in part a question of technique that can be learned, through coaching and mentoring (as is currently the practice within MoPH), but also through more formal learning exercises.

The *Stakeholder Mapping and Managing* project aims at reinforcing the MoPH's collaborative governance by building up the capacities of its key staff and their familiarity with mapping stakeholder expectations, interests, and positions; with engaging in dialogue with citizens; and with negotiating policy options.

Expected impact in terms of policy support:[22]

- Increased MoPH capacity for policy legitimization and constituency building by:
  - Improved capacity to use systematic stakeholder mapping
  - Experimentation with deliberative democracy techniques to gauge citizen reactions to policy initiatives
  - Training in informed and rational negotiation techniques
- PSO provided with necessary intelligence to prepare the Forum

Work packages:

1. Identify themes
2. Involve targeted key MoPH staff in a real-life formal Policy Mapping Exercise on one or more themes of relevance to MoPH
3. Organise pilot deliberative consultations on selected themes within the Forum and evaluate the formats tried
4. Train targeted key MoPH staff in negotiation techniques

---

[22] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

21. THE NATIONAL HEALTH FORUM
PREPARATION OF THE 2019 NATIONAL HEALTH FORUM/CONFERENCE BY THE PERMANENT SECRETARIAT

Background and scope:
A core task of the PSO is to provide the permanent secretariat for the organisation of National Health Conference events involving a wide range of stakeholders (field actors, organisations, academia, users, media, policy makers, WHO…) in ongoing participative debates on key health sector issues. The PSO assists the Organising Committee of the Conference to achieve, through the preparation, implementation and follow-up of these events, objectives of:

- Increased visibility of the technical work, achievements and innovations produced by health sector actors;
- Heightened awareness among stakeholders about competing priorities and emerging problems;
- Receptivity of public opinion to rational policies.

The National Forum Organising Committee is composed of invited personalities with expertise and authority in the health sector. It is presided by the Minister of Health with the DG of the MOH as vice-president. It includes representation of the WHO. The NF Organising Committee orients the agenda, mobilises resources, and ensures visibility and mobilisation around the policy dialogue event(s) and the communities of practice. The Permanent Secretariat of the National Forum participates in and contributes to the meeting of the Organising Committee.

The Organising Committee ensures a follow-up meeting after the national event leads to the formulation of recommendations on next steps.

The Policy Support Observatory functions as Permanent Secretariat for the National Forum. The Permanent Secretariat supports the preparation and follow up of the national policy dialogue event(s), and moderates the communities of practice. It assists the Organising Committee in preparing the agenda of the policy dialogue events and the launching of the communities of practice, and in supporting the effective preparation of the participants for a successful policy dialogue.

It is envisaged to organise a first National Health Forum/Conference in 2019 centred around "the place of primary care in moving towards universal coverage" (organisational and technical innovations, implications for public policy, implications for professional action, EMR, …). This choice is provisional and needs to be confirmed by the Advisory Board.

The NHF 2019 Project constitutes the PSO's preparatory work for the 2019 NHF, in its capacity as Permanent Secretariat.

Expected impact in terms of policy support:[23]
Enable MoPH to involve a wide range of stakeholders in ongoing participative policy dialogue policy dialogue that will contribute to the sustainability and continuity of effective collaborative health sector governance backed up by a large social consensus, by:
- Institutionalising the reliance of MOH and key health sector stakeholders on sound evidence and strategic intelligence (contextualising technical evidence with operational knowledge of the health sector and analysis of stakeholder expectations and interests);
- Promoting effective and resilient collaborative approaches to health sector governance; and
- Enhancing the social consensus around shared health sector policies.

---

[23] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

Work-packages:

1. Advisory board discussion and consensus: thematic, format, participants and timeline for the 2019 Forum.
2. Mapping of the NGOs that operate health centres (see Project 8 NGO Profile database) and other potential participating constituencies
3. Presentation of a roadmap to the Advisory Board for the preparation of the conference
    a. Mobilisation of sector participants
    b. Technical and resource support (model presentations, assistance with analysis, coaching, …) to sector actors for preparing contributions to the conference, including provision of flexible seed funding to selected partners (particularly the HC-NGOs) for the preparation of the forum;
    c. Tentative programme;
    d. Logistics; communication,
    e. Funding.
4. Creation of the Organising Committee

22. COMMUNITIES OF PRACTICE
PREPARATORY WORK FOR SETTING UP A PLATFORM OF COMMUNITIES OF PRACTICE

Background and scope:

A core task of the PSO is to moderate a Platform of Communities of Practice, as an instrument for sector-wide policy dialogue and health system resilience. A platform of Communities of Practice is expected to:

- enhance exchange of experience and harness innovation;
- accelerate dissemination of organisational innovations and benchmark practices by contagion and diffusion;
- identify challenges, weaknesses and opportunities requiring further analysis or research;
- enhanced consensus around, involvement in and ownership of health sector reform initiatives and collaborative governance championed by MoPH.

The *Communities of Practice* project prepares setting up the Platform, up to the stage of presenting a business case for launching two pilot communities of practice.

Expected impact in terms of policy support:[24]

Provide MoPH with a basis for deciding on the launch of a platform of communities of practice.

Work-packages:

1. Identify problems/practice-areas of interest for the launch of a community of practice (EMR? Contracts? Proms & Prems? CVD network?).
2. Identify potential champions/focal points, and potential members.
3. Prepare the business case and budget. Present the business case to the Advisory Board

---

[24] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"

23. ROADMAP FOR VISION 2030

BUILDING CONSENSUS ON A VISION FOR 2030 IN PREPARATION OF THE NEXT HEALTH SECTOR STRATEGIC PLAN

Background and scope:

The current health sector strategic plan expires in 2020. A volatile geopolitical context, the rapid transition of demand and technological innovation, the multitude of diverse initiatives and competing interests in the sector result in a health-care landscape that is prone to disruptions and ad hoc policy changes.

In order to maintain continuity of the efforts to move towards UHC, it is important that sector stakeholders build a consensus on a vision for a sustainable future for the health system. This vision – and stakeholder engagement behind this vision – needs to balance need and demand, expectations and resource constraints. It needs to be fed by robust information and evidence (supported through the PSO work-programme) and an open policy dialogue (through the Forum and the communities of practice).

Through the *Roadmap for Vision 2030* project The PSO will assist the formulation of such a vision, in preparation of the next National Strategic Plan.

Expected impact in terms of policy support:[25]

Policy makers and sector stakeholders share a vision that serves as a reference point for the long-term steering of the sector, and in particular for the formulation of the next Health Sector Strategic Plan.

Work-packages:

Present a roadmap to the Advisory Board for the development of a "Vision 2030 statement" document to orient the next National Strategic Plan for the Health Sector. The roadmap has to include:

1. a review of the literature on scenario building in the health sector;
2. the organisation of the contribution of the Forum to the Vision;
3. the organisation of scenario building seminars;
4. the production of a reference "Vision 2030 statement" document; and
5. public consultation hearings.

---

[25] Corresponding MoPH-EU-WHO HEALTH SYSTEM RESILIENCE PROJECT output: "Vision 2030 based on robust strategic intelligence and inclusive policy dialogue"