HOSPITAL CARE IN WHO EASTERN MEDITERRANEAN REGION: AN AGENDA FOR CHANGE

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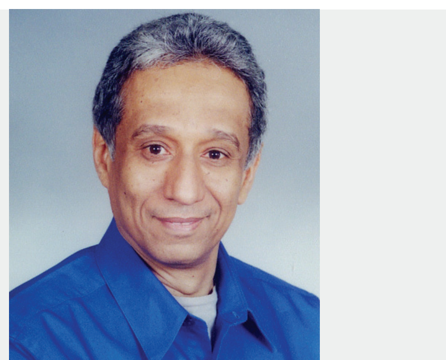
Abstract

THE EASTERN MEDITERRANEAN REGION (EMRO) COVERS A LARGE AREA AND IS HOME TO 500 MILLION PEOPLE. THE GREAT DIVERSITY WITHIN HOSPITAL SERVICES AND HEALTHCARE BUDGETS IN THE REGION, AND EVEN WITHIN THE INDIVIDUAL COUNTRIES, MAKES THE DEVELOPMENT AND IMPLEMENTATION OF AN APPROPRIATE AGENDA FOR CHANGE INTO A VAST TASK. IT IS A NECESSARY TASK, HOWEVER, BECAUSE THE FUNCTIONS OF HOSPITALS NEED TO ADAPT TO MEET THE MANY CHANGING AND CHALLENGING SCENARIOS OF THE 21ST CENTURY.



WHO/EMRO consists of 22 Members covering the geographical block (except Algeria) extending from Morocco in the west to Pakistan in the east, and has a population of 500 million. The diversity of the countries of the Region in terms of political, economic, demographic, epidemiological and environmental situation explains the variety and degree of magnitude of change and challenge, and their impact on health systems in the Region.

With more than 90% of the population of the Eastern Mediterranean Region living in low-income and middle-income countries, economic constraints are reflected in the rising levels of poverty and social deprivation in many countries.

Most countries within EMRO have “mixed systems of healthcare” which have various providers – public, private and governmental. In EMRO these providers operate usually with one sector dominating – either the public sector as in most countries or the private sector such as in Lebanon. In such mixed health systems, hospitals have emerged as a dominant institution for healthcare delivery. The main achievement in provision of care has been the improved coverage by primary healthcare. For example, accessibility in countries of the Region has improved substantially, to reach 84% in 2000. The wide primary healthcare infrastructure increased the need for referral care.

Challenging environment

The rapid changes taking place in the social, demographic, technological, epidemiological and economic spheres, both in the world in general and in the Eastern Mediterranean Region in particular, call for a review of the present status of policies for hospital health system infrastructure development; the resources available; the roles and functions of hospitals; technology in use and the mechanisms for maintaining that technology. This is needed in order to ensure the provision of equitable and quality hospital care to people.

Hospitals in the Eastern Mediterranean Region have evolved since early times and their status and role were identified in the teachings of Arab and Muslim Scholars of Medicine. Nowadays, national hospital systems are coming under increasing scrutiny with a view to cost containment and quality improvement, often as a direct or indirect result of initiatives for health system reform.

There is great diversity within hospital services in the Region, often even within the same country. Prominent public and private medical centres exist in the Region that are comparable to the most advanced in any other region. However, in many other hospitals there are services that do not meet a minimum level of quality. Hospital performance, generally speaking, is characterized by low bed-occupancy rates varying from more than 80% in most Gulf Cooperation Council (GCC) countries to around 45% on average in other low- to middle-income countries of the Region. Country reports for 2004 show the range for the number of physicians per 10,000 population – varying from 0.4 in Somalia to 28.1 in Lebanon, whereas the average for the Region is 9.1 physicians per 10,000. The range for the number of beds per 10,000 population ranges from 3.9 in Afghanistan to 39.0 in Libya.

In general, the distribution of hospital beds, skilled personnel and costly health technology in many countries is skewed in favour of urban areas, illustrating a striking difference and inefficiency in the use of resources. The private sector so far has confined its investment to urban areas, adding to the inequity of access to hospital care.

Ministries of health spend more than half their budget on hospital-based curative services, yet many hospitals operate at very low occupancy rates, employ excess staff and use their resources inefficiently.

Gaps in service delivery and efficient use of resources are multifactorial. The main causes are lack of coordination between the two main providers of

hospital care, namely the government on the one hand and private sector on the other; under-funded healthcare systems, and escalating costs of healthcare. The overall trend in healthcare financing in the Region shows a clear shift of the burden from government to households, even in oil-producing countries and those that provide social welfare. Direct out-of-pocket spending by households accounts for a major portion of private spending in most countries. In some countries working conditions of health workers are unsatisfactory, with low salaries, poor living conditions especially in remote needy areas and inadequate career structures. Multiple employment is a common feature among the health workforce in some countries and this will continue if privatization is not regulated and monitored. Leadership development and management capabilities are lacking. Governments face a potentially confusing array of policy tensions and choices of types of healthcare delivery, especially in respect to decentralization of authority and hospital autonomy; the unsettled issue of provision of care versus financing of care is still a major concern of many national health authorities and planners. Weak management has also caused poor organization and delivery of health services at all levels including ineffective referral systems. The weakness of health information systems at central and peripheral levels has resulted in difficulties in collecting and using information to measure performance of health facilities.

Agenda for change and the way forward for credible hospital care

Hospitals now have to face the changing environment created by globalization, advances in health technology, ageing and urbanization patterns, as well as the burden of disease. Pressures are intensifying to make hospitals more accountable to national health policies. WHO/EMRO has promoted accreditation as a way to re-engineer hospital care and to ensure that hospitals contribute to national health systems as set by health planners. Hospital treatment patterns are shifting due to changing technology and demands. Hospitals are being 're-engineered' to cope with challenges of high cost and increase demand.

> There is a need to widely adopt management protocols in order to curb the cost of services and to improve the quality and accessibility of care

Reorientation of healthcare institutions and provision of care

In conjunction with the development of the network and infrastructure, efforts were made in some countries (Egypt, Jordan and the member countries of the GCC) to develop family practice as a strategy for effective coverage through gatekeeping and screening of users of services. The Declaration of Al Manama (Bahrain), where PHC and family practice specialists convened in 2003, emphasized the role of the family physician in healthcare delivery.

Some of the Region's low-income countries (Afghanistan, Sudan and Yemen) and middle-income countries (Egypt, Lebanon and Iran) have developed "core packages", which define health interventions that should be available at the district hospital level. In the early 1980s quality assurance and improvement (QA/I) in healthcare occupied an important position in the agenda of most countries in the Region. Almost all EMRO countries have developed training programmes and QA/I plans. Several countries (Jordan, Pakistan, Saudi Arabia, Sudan and Syrian Arab Republic) conducted a quality assessment, either nationally or in pilot areas.

Developing accreditation systems for hospitals: A number of government, semi-private and private health institutions in the Region are currently seeking recognized accreditation systems in order to cope with heightened demands for quality in healthcare service delivery. Many countries, including Egypt, Iran, Jordan, Kuwait, Lebanon, Morocco, Oman and Saudi Arabia, have established national committees to study requirements for accreditation and are piloting national accreditation programmes.

Involvement of and incentives to healthcare providers: Contracting physicians to provide a core package of care is being tried in Egypt, Iran and Pakistan to improve the quality of care and to provide incentives to workers in district hospitals.

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Improving efficiency and effectiveness of hospital care services

New methods of payment for services are being designed in order to introduce efficiencies in the provision of hospital care services. Examples are initiatives to provide services to patients in less costly settings (Bahrain, Iran, Oman), such as through ambulatory care and community-based approaches, e.g. home-based care and long-term care. Different Health Insurance Schemes are also introduced as risk-sharing in Lebanon, Tunisia, Morocco, Iran and Egypt. In addition to the various efficiency measures which need to be introduced, there is a great need to make physicians and teams accountable, not only for their patients' health, but also for the wider resource implications of any treatments involved, including referrals from primary care into secondary and tertiary care. There is a need to widely adopt management protocols in order to curb the cost of services and to improve the quality and accessibility of care. Efficiency gains could also be achieved through appropriate selection of biomedical technology. However, this technology is still limited and in its early phase.

Organization, management and reorientation of healthcare service provision: Hospital care requires a new organizational culture which should prevail at all levels and sites. Actions taken so far have included: changing the existing organizational structure within the Ministry of Health (Bahrain, Egypt,

Iran, Qatar, Sudan) to support a general management or business management style; introducing multidisciplinary management teams working within each service and department; collaboration and joint planning between private and public sectors to ensure mutual benefits (Jordan, Saudi Arabia, Lebanon, Oman, Tunis, UAE).

Strengthening management and strategic planning for health workforce development: New leadership modalities are necessary to establish the role of ministries of health to exercise effective oversight. Efforts are being made in many countries of the Region to train managers at various levels and to introduce innovative approaches for training focused on leadership, problem-solving techniques, continuous quality improvement, evidence based practices and community involvement.

Enhancing decentralization through district health systems development: The district health system in all EMRO countries has received special attention through the convergence of resources at the operational level to foster hospital autonomy and referral system support. These efforts are not fully operational at this stage.

Investing in collaboration with nongovernmental organizations (NGOs) and the private sector: In Afghanistan, Lebanon and Sudan, NGOs are major providers of health services. Contractual agreements are in progress with NGOs to secure hospital care at the district level. Contractual agreements with private sector hospitals are a common practice in many other EMRO countries, particularly Saudi Arabia, Lebanon and Jordan.

Conclusions

In striving to cope with prevailing changes and challenges, the agenda in front of hospitals is substantial. Hospitals have to prove efficient, through better use of their resources by opting for alternative ways of providing care such as using ambulatory care; enhancing adherence and compliance of providers and users to the standards of care and evidence-based practices; effectively reducing avoidable hospitalization and average length of stay (ALOs), and increasing bed-occupancy rates (BOR); using the Gatekeeper principle to ensure screening and better referral care, classification systems of patients according to severity, comorbidity and socioeconomic vulnerability status. Hospitals also should improve quality by reducing substantially medical errors and adverse events rates of hospital patients, enforcing licensing and re-licensing, and making operational the accreditation systems. The societal role of hospitals can be effected through a shift from sick care to comprehensive healthcare approaches which include health promotion. The appropriate skill mix of staff and reward system for them cannot be over-emphasized. ❑

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