



## Political Economy of Health in Conflict Workstream

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# The Political Economy of Health in Lebanon

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PHOTO BY: RAMY RIZK

## Lebanon - the failed state: how politics and policy shapes population health and wellbeing

*“In our age there is no such thing as 'keeping out of politics'. All issues are **political** issues, and **politics** itself is a mass of lies, evasions, folly, hatred and schizophrenia.”* (George Orwell, *All Art is Propaganda: Critical Essays*)

The massive explosion in Beirut, Lebanon on a sunny Tuesday afternoon in August laid bare how politics determines the health and wellbeing of Lebanese citizens. Years of state neglect and rent seeking political decisions led to more 300,000 people being left homeless, over 6,000 seriously injured and 190 dead.<sup>1</sup> The Beirut Blast arrived on top of a COVID-19 induced public health crisis, a protracted humanitarian disaster, years of environmental degradation, currency devaluation and an economic meltdown. All of this has impoverished millions of Lebanese as well as 1.2 million Syrian refugees who sought sanctuary in the country. One million Lebanese now live below the World Bank poverty line, half the country has no health insurance and a third of the nation have lost their jobs due to decades of economic mismanagement and corruption within government and public services.<sup>2</sup>

Since the end of the Civil War, Lebanon has been portrayed by the media, academics, Lebanese politicians and international diplomats as a modern and progressive country, where the food is world class, different religions live in harmony and whose citizens are resilient to episodes of protracted political trauma – *it's the Paris of the Middle East; the branch that always bends but never breaks!* The academic narrative of countries like Lebanon is of security, sectarianism and terrorism. What many academics, journalists, and politicians overlook is how public services and social policies – and contestation over them - have shaped people's lives in Lebanon. There is little understanding about the policy making process and the endemic socio-economic problems such as income and health inequalities that years of state corruption and policy neglect have created. Lebanon is emblematic of where government and market failure have made a nation sick and unhealthy.

The past year has been turbulent even by Lebanese standards. Formal parliamentary politics effectively ground-to-a halt in autumn 2019 in the face of widespread protests at worsening economic and social conditions. The present incumbent, Mustapha Adib, is the third prime minister the country has had since October last year. The arrival of COVID-19 further exposed the depth of the country's economic and social malaise, as well as long-standing problems arising from the chronically underfunded, under-staffed and overburdened public health

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<sup>1</sup> Olivia Giovetti, “Tragedy in Beirut: What Lies Ahead, *Concern International*, August 11, 2020, Retrieved at: <https://www.concernusa.org/story/beirut-explosion-humanitarian-impact/>

<sup>2</sup> Aljazeera, “COVID-19: Almost half of Lebanon now lives below poverty line”, *Aljazeera*, April 1, 2020, Retrieved at: <https://www.aljazeera.com/news/2020/04/covid-19-lebanon-lives-poverty-line-200401124827120.html>

system. As of 17<sup>th</sup> September there had been just over 26,000 confirmed cases of COVID-19 and 259 deaths had been reported by Lebanon's Ministry of Public Health.<sup>3</sup>

Our report<sup>4</sup> does not address the impact of COVID-19 in detail because much of our primary research had already been completed by the time lockdown measures were imposed, and properly grounded political economy work should take a longer-term view of relationships between political economy exposures and health outcomes. It is clear that COVID-19 has disrupted the health system, services – and all aspects of life in Lebanon. This grave situation has now been compounded by the explosion in Beirut – as a result of which public health practitioners are anticipating a spike in cases among the health and rescue workers involved in the response. The World Health Organization (WHO) reported that three Beirut hospitals were “non-functional” and an additional two suffered “substantial damage”.<sup>5</sup> Additionally, WHO reported that 55 healthcare facilities evaluated by the agency were “non-functional,”<sup>6</sup> and that 17 containers with essential medical supplies, as well as delivered shipment of personal protective equipment to tackle COVID-19 were destroyed as a result of the explosion.<sup>7</sup> <sup>8</sup> It is hard to see how an effective response to a public health crisis like COVID-19 can be mounted in such difficult circumstances.<sup>9</sup>

Taking a longer view, the state of Lebanon's health is even bleaker when it is considered that the country spends between 8-10% of its GDP on health care and treatment which is comparable to many European countries. However, this high health expenditure does not translate into better care, services and improved health for the Lebanese or refugees, even for those able to pay. A major problem is that this expenditure is concentrated in many high-tech-high-cost interventions used by small number of patients suffering from chronic or serious illnesses. It is said that Lebanon possesses more state-of-the-art health care

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<sup>3</sup> Lebanon Ministry of Public Health Epidemiological Surveillance Program, “Coronavirus COVID-19 Lebanon Cases September 17, 2020, Retrieved at: <https://www.moph.gov.lb/maps/covid19.php>

<sup>4</sup> Please see our other articles for a discussion of the Covid-19 situation in Lebanon: Diab JL, Fouad FM. The Politics and Economics of COVID-19 Relief in Times of Conflict and Vulnerability in the MENA Region. *jhsn* [Internet]. 2020Jul.19 [cited 2020Jul.21];5(7):01-0. Available from:

<https://ijrdo.org/index.php/hsn/article/view/3752>; Diab JL, Fouad FM. Navigating Access to Healthcare in Lebanon: The Political Economy of Health across Conflict, Revolution and Applicability. <https://www.e-ir.info/2020/03/20/navigating-access-to-healthcare-in-lebanon-the-political-economy-of-health-across-conflict-revolution-and-applicability/>

<sup>5</sup> Reuters, “U.N. agencies scramble to help Beirut warehouse blast victims”, *Reuters*, August 7, 2020, Retrieved at: <https://www.reuters.com/article/us-lebanon-security-blast-un/u-n-agencies-scramble-to-help-beirut-warehouse-blast-victims-idUSKCN25319K>

<sup>6</sup> CGTN, “Two weeks of Beirut blast: A crisis on top of a crisis”, *CGTN*, August 19, 2020, Retrieved at: <https://news.cgtn.com/news/2020-08-19/Two-weeks-of-Beirut-blast-A-crisis-on-top-of-a-crisis-T3DBUdtsBO/index.html>

<sup>7</sup> Ibid

<sup>8</sup> Ibid

<sup>9</sup> Miriam Berger, “After Beirut blast, the race to save lives outweighs coronavirus safety”, *The Washington Post*, August 6, 2020, Retrieved at: <https://www.washingtonpost.com/world/2020/08/06/after-beirut-blasts-race-save-lives-outweighs-coronavirus-safety/>

technologies than Germany and Sweden yet lacks the basic primary and preventive health services. In addition, a cartel of medical suppliers who import pharmaceuticals have made millions over the past twenty years. Health and social welfare policy in Lebanon are one of profit and cure rather than access and prevention. Thousands of poor Lebanese and Syrian refugees have died as a result.

In this report we show how the health and wellbeing of a nation cut across religious and political boundaries. They are highly sensitive political issues and as we show, the policy and political structures of the Lebanese health and social welfare system have clearly had a negative effect on the health of a nation. For example, over half the Lebanese population are not formally covered by any health insurance, whether public or private. In a country where 85% of the health sector is private, it costs money to be healthy and recover from illness. Over two million Lebanese cannot realistically afford to go the doctor. Refugees fair even worse. This is a staggering figure which has severe social and economic consequences for establishing a stable state. Multiple attempts have been made by the World Bank, United Nations and European Union to strengthen and reform the Lebanese public health care system but have been met by sclerotic political management keen to bolster the private health care industry from which many politicians have benefited financially.

This report is intended as a *living document* which will be continually updated given the dynamic on-the-ground events in Lebanon. The report provides academics, journalists and policy makers with evidence and background knowledge on a key public service and public good which has been overlooked but which forms the foundation of any international aid attempts at reforming the Lebanese state and more importantly building a stable, healthy and just society.

We welcome comments and advice on further iterations of this report.

**The political economy of health research team.**



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## Executive summary

- This living document summarises the results of a political economy analysis (PEA) of the health sector in Lebanon. It is based on a literature review of multiple source types and findings from key informant interviews with stakeholders in Lebanon. It will be updated on a rolling basis as R4HC proceeds.
- The health sector in Lebanon has been profoundly influenced by conflict, varying in intensity and geographical scope, but nevertheless an almost continuous feature of the Lebanese landscape since the mid-1970s. The disruptive effects of the 1975-90 Civil War on the health sector were particularly profound, re-shaping power relations and the financing model for health in ways that continue to influence activities today. The present crisis in Syria presents the health sector with a new challenge: as of September 2020, there are some 1.2 million displaced Syrians in country; many live in informal or semi-formal settlements, geographically concentrated in outlying areas that have historically suffered from poor public services.

### *Governance*

- Successive crises in Lebanon have given rise to a health sector which displays a dualism, at almost every level from high-level decision-making down to service delivery at local level, between what might be considered the “mainstream” health system (run by and for Lebanese residents) and what is referred to as the “humanitarian health response system” (which has evolved primarily to serve the needs of multiple waves of refugees). This reflects a well-recognised normative and institutional divide between development and humanitarian agendas at the global level, but more particularly a persistent policy by successive generations of Lebanese decision-makers of designating responsibility for refugee needs primarily to international agencies and NGOs.
- The mainstream public health sector comprises a patchwork of actors and services. The MOPH is the lead government Ministry but has long-standing human resource issues and is challenged by an unwieldy remit that spans the complete spectrum from technical support, regulatory and oversight functions, third-party financing through to direct service delivery. Its authority in the sector is also undermined by division of key sector roles and responsibilities (notably health financing) with other Ministries, and the presence of powerful parastatal organisations (notably the National Social Security Fund) with sometimes divergent priorities.

### *Financing*

- The financing system for health in Lebanon is notoriously complex - but out-of-pocket payments continue to be a major funding source. Public insurers such as the NSSF sit alongside private sector insurers but there remains a substantial proportion of the population who are not insured, and who rely on services funded by the MOPH. Refugee populations are excluded from this system and a wholly separate set of arrangements – subsidized partly by the MOPH, and by international organisations, but increasingly reliant on out-of-pocket spending especially for specialised care – has evolved to attempt to meet their needs. Effectively charting changes in the financing for health is challenging in the absence of routinely updated National Health Accounts for Lebanon.



### *Service provision*

- The provider landscape in the mainstream sector is mixed, with a dominant role for the private sector and for NGOs/not-for-profit organisations, including those with strong confessional and political affiliation, and separate service provider networks for the army and security services, and civil service. The emergence of overlapping confessional- or sectarian- and politically-affiliated providers in recent years has contributed to the growing use of health service provision as a political clientelist (electoral) bargaining chip in Lebanon, although the relationship between group membership and service access and provision is rather complicated. Importantly, provision across the sector continues to be skewed towards cost- and technologically-intensive secondary and tertiary care services at the expense of prevention and broad-based primary care.
- The humanitarian health response system is also fragmented, partly because it has evolved piecemeal in response to a succession of crises of differing natures and origins, but also because consent for international agencies such as UNHCR to operate in Lebanon has always been granted with significant constraints. Governance of the response to the Syria crisis is particularly fraught, with uncertainties over leadership roles between key international actors and opaque financing mechanisms contributing to coordination and service delivery problems.
- Service provision varies according to the refugee population concerned. Displaced Palestinians benefit from a well-established, and comprehensive provider network through UNRWA, albeit subject to the vagaries of international donor funding. While international actors have tried to meet escalating health needs arising from displacement from neighbouring Syria, a combination of the limited political space for action and heavy financial constraints mean that displaced Syrians suffer from chronic service access and affordability barriers. A burgeoning informal service provider system has evolved to help fill gaps in the service offer, but there are major questions about scope, regulation and quality assurance in this space.

### *Bargaining and decision-making in the health sector*

- Overall, the financing envelope for refugee health service provision is coming under considerable strain, and there are increasing signs that agencies are imposing tougher constraints on the costs of services they are prepared to cover - especially for complex care for chronic conditions (a major driver of the disease burden among displaced Syrians).
- Processes of bargaining and decision-making in the health sector vary according to the policy question concerned, but in general policymaking is a fairly closed, elite-driven process with limited opportunities for public consultation. Interviewees highlighted a strong tendency to maintain the sector status quo as a result of constrained economic conditions, the political system in Lebanon and the powerful influence of personal and other vested interests. Influence over policymaking, where exerted by external stakeholders, often operates through elite political intermediaries - partly explaining the powerful role played by major system actors such as the professional orders, and the Syndicate of Private Hospitals. This work found little evidence documenting processes of decision-making in the humanitarian health system.
- While there are established bodies generating evidence for policymakers in Lebanon (such as Knowledge to Policy (K2P) Centre and SPARK at the American University of Beirut), the ways in which evidence is procured and used in decision-making are not documented in a systematic way.

We found that evidence could exert powerful influence over decision-making under some conditions (e.g. providing political receptivity to changes in tobacco control policy, and the existence of established networks between academic researchers and civil society advocacy organisations), but very little under others (e.g. health financing reform, where opposition to change comes from powerful sector stakeholders). We found virtually no evidence on the role of public opinion or patient involvement in shaping health policy priorities or decision-making processes. We were also unable to identify data on the scale, source or distribution of research funding for health in Lebanon.

- We found no literature or evidence on the role of corruption and rent-seeking in the health sector (although the rise in confessional- and politically-affiliated providers is indicative of some recent trends in this regard), and particularly on policy *implementation*. The shortage of evidence on the former may reflect political sensitivities carrying out work on corruption and rent-seeking in relation to health in the Lebanese context. The shortage of evidence on the latter is harder to explain and suggests possible research avenues exist in exploring the implementation of flagship initiatives such as the National Mental Health Strategy, and Lebanon Crisis Response Plan.
- The report concludes with a series of suggested political economy research questions on cancer specifically, and more general questions for the operation of the sector as a whole, to inform onward research proposal development in the PEOH stream.

## Abbreviations

<i>Abbreviation</i>	<i>Full term</i>
DFID	UK Department for International Development
LCRP	Lebanon Crisis Response Plan
MOL	Lebanese Ministry of Labour
MOPH	Lebanese Ministry of Public Health
MOSA	Lebanese Ministry of Social Affairs
NCD	Non-communicable disease
NGO	Non-governmental organisation
NSSF	National Social Security Fund
PEA	Political Economy Analysis
PHC	Primary healthcare centre
UHC	Universal Health Coverage
UNDP	UN Development Program
UNHCR	UN High Commissioner for Refugees
UN OCHA	UN Office for the Coordination of Humanitarian Affairs
UNRC/HC	UN resident coordinator/humanitarian coordinator (Syria response)
USAID	US Agency for International Development
WHO	World Health Organisation

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Any remaining errors or omissions are those of the report authors.

# 1. Introduction

## 1.1 Background

Health systems in Jordan, Lebanon, Palestine and Turkey face significant and common challenges including a rising non-communicable disease (NCD) burden, and managing the near and long-term impacts of conflict (notably in neighbouring Syria). There are, however, important differences in the historical trajectory of health system development in each of these countries, in the capacity of system stakeholders to produce and use evidence in developing policy, and at a basic level, in the investment in both public health systems and health research in each country. Powerful actors with vested interests - governments, donors, NGOs and the private sector - shape national health agendas, including the formation of social protection systems across all four countries.

## 1.2 Purpose of the report

The purpose of the four country political economy analyses (PEAs) of which this report - focused on Lebanon - forms part is to provide a sector-specific analyses culminating in assessments of barriers and opportunities to change in health. Through this analysis we hope to bring to the fore distinctive aspects of the political economy of health in each of the participating countries, and key ways in which it has been influenced by conflict. A central aim is to map areas of strength and weakness in the evidence to inform an onward research agenda on political economy of health in conflict. Importantly, this report is intended as a living document, with an expectation that it will be updated over the course of the project as new research material that is pertinent to the questions below is assembled.

## 1.3 Conceptual aspects

### *Defining conflict*

Two operational definitions of conflict are pertinent to this work:

**Conflict:** "A social factual situation in which at least two parties (individuals, groups, states) are involved, and who: i) strive for goals which are incompatible to begin with or strive for the same goal, which, can only be reached by one party; and/or ii) want to employ incompatible means to achieve a certain goal" (1).

**Armed Conflict:** A dispute involving the use of armed force between two or more parties. The international humanitarian law distinguishes between international or non-international armed conflicts:

- International armed conflict: A war involving two or more States, regardless of whether a declaration of war has been made or whether the parties recognize that there is a state of war.
- Non-international armed conflict: A conflict in which government forces are fighting with armed insurgents, or armed groups are fighting amongst themselves (2).

In this report we define conflict according to the second of these two definitions, involving armed conflict. We have taken the view that the first definition - focused on social conflict of all varieties - is too expansive to be analytically useful. As will become clear later in the report, however, one of the challenges in Lebanon is recognising fluid boundaries between overt, armed conflict, internal disturbances or tensions, and sometimes prolonged periods of precursory political instability that

directly precipitate or predate active unrest. The conflict in Syria offers an example. The first waves of displacement from Syria into Lebanon in 2011-12 occurred as internal disturbances unfolded that nevertheless could not be categorised as having reached the level of non-international armed conflict (3).

We also draw on operational definitions for crises related to conflict as follows (although it is notable that there is currently no universally agreed definition of the foundational term, “humanitarian emergency”):

**Complex emergency:** a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict, which requires an international response that goes beyond the mandate or capacity of any single agency, and which has been assessed to require intensive and extensive political and management coordination (4).

**Protracted crisis:** instances where a significant proportion of the population is vulnerable to death, disease or disruption of their livelihoods over a long period of time (5).

### ***Health system focus***

The focus of this report is on the political economic aspects of health in Lebanon. From a health system perspective (consider the WHO’s six building blocks (6)), we focus principally on governance and leadership, financing and service delivery - areas in which the evidence base for Lebanon turns out to be strongest. In view of our broader interest in this workstream on the potential for achieving universal health coverage (UHC) in the R4HC partner countries, this report also considers how priorities for spending are set in Lebanon. The report considers human resource, supply chain and health information system questions to the extent to which they cast light on wider aspects of bargaining, decision making and evidence use in the health sector in Lebanon.

## **1.4 Guiding research questions**

The material presented in this report has been drawn together in response to the following guiding questions:

- What are the key contextual factors determining the direction and formulation of health policy in Lebanon? What role has conflict played in shaping this?
- What specific effects of different types of instability (armed internal conflict, armed international conflict, spill-over from neighbouring countries and chronic political instability) on the political economy of health can be discerned in Lebanon?
- Who are the key actors/stakeholders in the health sector in Lebanon? How has the stakeholder map changed under the pressure of conflict in neighbouring Syria?
- What are the characteristics of bargaining processes by which health policy in Lebanon are made? How inclusive/exclusive are these processes and what are the main currencies used for bargaining? How have new groups been included/excluded from bargaining since 2011?
- What key values/ideas underpin the identification of priority health policy issues/formulation of health policy?
- What main opportunities/incentives for health reform or change exist in each country, and what are the principal barriers to reform?

### **1.5 Structure of the document**

Section 2 describes the methodologies used in the report. Section 3 gives a meta-review of literature sources describing the kinds of material on political economy of health in Lebanon that are available and who produces them. Section 4 outlines some of the contextual features (political, macroeconomic, social and conflict-related in broad terms) that have shaped the evolution of the health sector in Lebanon, before providing a detailed assessment of the health sector picture today in Sections 5 and 6. This covers institutional forms and functions in the health sector, and current dynamics in the formulation and implementation of health policy - including ideological stances, power relations between key stakeholders. We also consider some of the key, long-range reform options in the health sector, and barriers and facilitators to their realisation. The report concludes by summarising key findings and then outlining a tentative forward research agenda on the political economy of health in Lebanon, focusing particularly on intersections with conflict.

A series of issue-based case-studies highlighting key political economy factors as they relate to specific policy issues (tobacco control laws, mental health policy and resource allocation for cancer care) are provided throughout the report.

## **2. Methodology**

### **2.1 Security and ethical considerations**

Ethical approval for the work described in this report was sought and received from both the University of Cambridge in the UK and American University in Beirut in Lebanon.

### **2.2 Approach to the literature review**

Full details of the approach for the literature review conducted for this report are given in appendix 1. In brief, we conducted systematic, keyword-based searches in English of a series of peer-reviewed publication databases (principally PubMed, SSRN and EconPAPERS). These searches were supplemented by complementary searches across grey literature databases such as OpenGrey, databases carrying material specifically relating to the humanitarian response in Lebanon (e.g. Reliefweb.int and Humanitarianresponse.info) and targeted searches of document archives for key agencies and organisations with a footprint in the health sector in Lebanon (including the World Bank, WHO EMRO, UNHCR and other UN agencies, along with major bilateral donor organisations such as USAID and DFID). We conducted an additional search in Google Books to ensure breadth of coverage across book-length sources (many of which were captured through database searches in any case). Further searches were carried out spanning Arabic and French-language sources to ensure coverage. Finally, given the exploratory nature of this work, we snowballed our search for relevant material using reference lists for included papers, articles and books.

For peer-reviewed literature searches, we used an expansive list of keywords to ensure broad literature coverage given the breadth of the topic and the range of evidence types potentially relevant to discussions of political economy (the full list and keyword combination structures used for the peer-reviewed literature searches are outlined in Appendix 2. We also took an expansive view on inclusion criteria, judging that all peer-reviewed article types with relevant content identified through searches should be reviewed. A similar approach was adopted for grey literature searches.

### **2.3 Interviews**

The list of interviewees by subject area and type of health sector stakeholder can be found in the appendices to this report. A total of 20 key informant interviews (KIIs) were performed with health sector stakeholders in Lebanon between June and August 2019. Participants were sampled purposively with a view to achieving broad representation across the range of relevant stakeholder organisations operating at national level in Lebanon, and with a selection of individuals with academic expertise in the political economy of service delivery in the country.

### **2.4 Data analysis and synthesis**

For the literature review, data extraction was carried out using a standardised template, developed for this study, to extract data from included studies. The template was based around themes derived from selected political economy analysis tools. Barriers and facilitators were identified and categorised by the study authors, with disagreements over categorisation and prioritisation resolved by consensus across the group (7).





Interviews were transcribed, translated, and thematically analysed to identify relevant themes and codes, with cross-mapping of these across interviewees and stakeholder groups.

### **3. The State of the literature on political economy and health in Lebanon: a brief overview**

There is an expanding body of literature addressing various topics in Lebanon under the broad banner of “political economy of health”, published in English, Arabic and French (indicative references are given in the discussion that follows). This includes some peer-reviewed, academic research work, predominantly published in English, and originating particularly from a cluster of researchers based at AUB, taking political economy perspectives on the development and implementation of specific health policy initiatives (8,9), attempted health policy reforms (10,11), and more limited discussion of the dynamics of “street-level” implementation (12,13).

In terms of “state of the sector” analyses (including the historical evolution of current arrangements), the range of sources is smaller, and comes predominantly from either long-term health sector insiders including current and former senior officials in the MOPH (14–16), or international agencies and donor organisations with their own institutional perspectives and evidentiary biases (17,18). There is an emerging body of academic material on the role of confessional factors in determining allocation of public resources across sectors in Lebanon, including for health, produced by both Lebanese and overseas researchers (19–22).

Three other features of the evidence base on the “mainstream” health sector in Lebanon are notable. First, few studies directly evaluate the impact of conflict on health policy formulation and implementation, although the effect of both current and past violence is a strong background theme. Much of what we report below about the Civil War and its legacy for the health sector, for example, comes from a cluster of sector overview articles (14,23,24).

Second, and importantly, existing work overwhelmingly presents elite perspectives on the policy process. Data on public attitudes towards health in Lebanon and how these have changed over time are few, and assessing the effect of either civil society pressure, media production or other modes for popular engagement on policymaking and implementation is difficult (10,25). This is linked to a broader observation about the theoretical orientation of published work on Lebanon, which mostly takes rationalist and institutionalist perspectives derived from policy analysis. We found no research approaching political economy questions from critical or radical perspectives.

Third, most of the evidence we have comes from qualitative work ranging from narrative literature reviews through to mixed-methods studies incorporating key informant interviews and survey work. Quantitative analyses are few and far between, with some of the most methodologically innovative work addressing the thorny topic of confessional and political affiliation determinants of resource allocation in the health sector using regression techniques.

There are particular challenges in accessing material on the humanitarian response in Lebanon. We rely on agency documents and reports, the vast majority of which are published in English. There is just a handful of relevant peer-reviewed studies published on health in recent years (for example 23), and others addressing specific questions such as the implications of registration status for service access rights for displaced Syrians in Lebanon (27–29). Studies of relations between different actors in the humanitarian response, and the effect of this on bargaining and decision-making in health, are limited to a few grey literature reports published in English (30).



This bias and gaps in empirical evidence has implications for what we can and cannot say on the political economy of health in Lebanon, and offers opportunities for future research. These questions are addressed in Section 7.

## 4. Contextual features in Lebanon

### 4.1 Periodising conflict and political instability in Lebanon

The recent history of Lebanon includes both lengthy periods of internecine conflict, and shorter episodes of cross-border conflict and skirmishes or localised fighting (Figure 1). It also encompasses conflicts of varying intensity. The formative recent experiences, however, have without question been the civil war of 1975-1990 (a conflict that rapidly regionalised and then internationalised, spanning a Syrian intervention in 1976 and an Israeli invasion beginning in 1978), the 2006 war with Israel, and spillover effects since 2011 from the conflict in neighbouring Syria. Each of these conflicts have had major influences on political and fiscal space for policymaking and implementation in the health sector.

It is important also to recognise, however, the profoundly disruptive influence of persistent, low-level conflict and political instability rooted in the country's postwar consociational power-sharing arrangement. The period since the assassination of former Prime Minister Rafik Hariri in 2005 has been particularly troubled in this respect. It was followed later that year by the withdrawal of a Syrian military presence in Lebanon that had numbered up to 40,000 personnel. There have also been periods of instability since 2005 arising from, on the one hand, efforts by the Lebanese state to enforce a monopoly on the use of force within the country's borders (which have led to within-border conflicts in 2007, 2008, 2013 and 2014 (see Figure 1)), and on the other, paralysis in the executive. This included a 17-month political crisis between 2006 and 2008 pitching the sitting government at the time, against a coalition of opposition groups – and which was resolved only by an internationally-brokered agreement signed in Qatar.

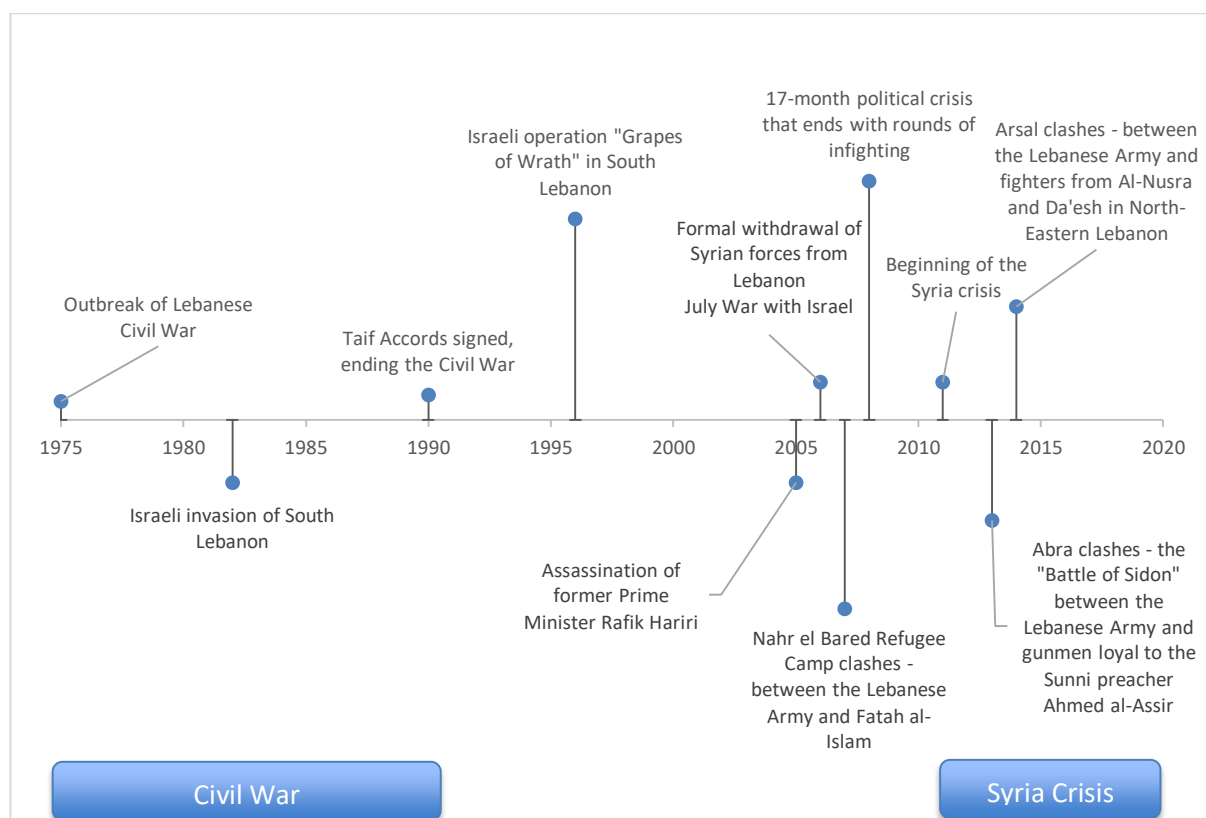


Figure 1. Timeline of key conflicts either within Lebanon or with major cross-border security implications, 1989-2018.

Any detailed assessment of the current impact of conflict on the political economy of health in Lebanon, must, however, begin by recognising the extraordinary implications of the current crisis in Syria even in the context of Lebanon's turbulent recent history. As of September 2020 there are estimated to be 880,400 registered Syrian refugees in Lebanon, with an untold additional number who are not registered – down from a peak of 1.18m in April 2015<sup>10</sup>. Many of those displaced are concentrated in the East (and particularly North East) of the country, in areas where services have historically been understaffed and under-resourced.

## **4.2 Historical legacies and evolution of the health sector in Lebanon**

A full, chronological history of the evolution of the health sector in Lebanon is beyond the scope of this report, but important themes emerge from the literature that are relevant to the political economy of health policymaking and implementation. The legacy of armed conflict has unquestionably been a powerful influence on the evolution of the health sector – in particular the Civil War.

First, managing health service provision for migrant and displaced populations is not a new phenomenon in Lebanon. Even before the start of the Syria crisis in 2011 for example, there were some 300,000 Syrian migrant workers in Lebanon, and Syrians accounted for 55% of all unskilled workers and 30% of skilled workers in the country (31,32). The country also hosts some 470,000 registered Palestinian refugees, many of whom have been living in Lebanon since 1948, and for which health services are provided directly by UNRWA among others through a network of 27 primary care facilities (33). There have also been regular episodes of internal displacement (following incursions into Southern Lebanon for example), and latterly large-scale inward movement from neighbouring Syria. Strikingly, however, the policy response to refugee and asylum questions has been marked by persistent (and latterly growing) hostility. Successive Lebanese governments have consistently ignored issues of service access and use for refugees, preferring to leave them to international agencies, the NGO/charity or informal sectors. There has also been a tendency towards exclusionary positions across a range of social policy issues including labour market integration (34).

A second feature is the changing power of the private and not-for-profit sectors over time. Before the beginning of the Civil War in 1975, the MOPH had provided free healthcare for the vulnerable in public hospitals, and covered the costs of private care only where relevant services were not available in the public sector. In 1975, this amounted to around 10% of the Ministry's budget, but by the late 1990s, the MOPH spent more than 80% of its budget on the care of beneficiaries in the private sector (14). A de-facto purchaser-provider split emerged in Lebanon during the Civil War as the state contracted out health care to private providers, partly as a result of widespread destruction of public health facilities, but also because of progressive governance fragmentation as the conflict progressed. The few public health programs that were able to continue operating at scale during the conflict - such as vaccinations and maternal and child health care were largely donor-supported and delivered by NGOs (either Lebanese or international) (35). There was also an explosion in supply of hospital services during this period at the expense of ambulatory care – which was to contribute to a funding crisis in the early to mid-1990s (24).

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<sup>10</sup> UNHCR – Syria Regional Refugee Response portal. Online at: <https://data2.unhcr.org/en/situations/syria/location/71> [accessed on 17.09.2020].

But it was not just the shift in the balance of power between public, private and not-for-profit actors during the Civil War that mattered – it was also the *nature* of the actors that emerged during this period that was significant. In particular, the Civil War saw a marked rise in the power of confessional- and politically-affiliated organisations in the health sector. Recent evidence suggests that up to 17% of medical centres and dispensaries are run by Christian charities, 11% by Muslim charities (Sunni and Shi'i parties respectively account for about 7% and 8% of basic healthcare institutions) (19). Sections 5.3 and 5.5 detail in more depth the implications of this change, which accompanied a broader confessionalisation and, in the postwar era, sectarianization of the political system in Lebanon (see section 4.3 below).

The skewing effect of rising donor activity also had an important influence on the shape of the health sector in Lebanon after the Civil War - in two ways. The first of these was discontinuity in funding streams: as international funding for what had been a wartime response dwindled after 1990, NGOs that had previously relied on these funding streams moved increasingly towards fee-for-service models, and doctors (many employed on part-time basis within this network) used centres increasingly as recruiting grounds for patients, leading to fragmentation in care provision (35). This transformation has proven remarkably resistant to reform, partly because incentives for health workers to change their practice are weak. The second was in implicitly encouraging irrational approaches to treatment. Programmes for diabetes and hypertension were heavily donor funded during and immediately after the Civil War, but often without associated guidelines to ensure cost containment (24).

Finally, the importance of political contingency (civil war, assassination of Prime Minister Rafik Hariri in 2005, public protests related to Syrian government presence in Lebanon, and others) in stymying policy change at various times over the decades from 1975 to 2011 also comes through in some of the research on reform, (see, for example, the case of tobacco reform illustrated in box 1).

### **4.3 Politics and the macroeconomic picture in Lebanon today**

Four features of the political and macroeconomic context in Lebanon today are noteworthy.

#### ***International and regional actors are influential players in Lebanon***

The first is that Lebanon is significantly influenced by regional and international political and economic actors– with important implications for the policy making process, who shapes policy priorities, design and implementation. This includes the enduring legacy of French colonial rule under a League of Nations mandate from the early 1920s through to independence in 1946 (and continuing European and particularly French influence over political and economic activities in Lebanon to this day) (36), the expansive role of the Syrian state (in the form of a physical, military presence until 2005, but also allied business and commercial interests both before and since that time) and related interests in Lebanon both now and in the recent past (37), and a complex relationship with neighbouring Israel (38).

International institutions also exert significant influence over Lebanon domestic affairs, partly because of the historical openness of the Lebanese economy (39). The World Bank and International Monetary Fund have historically been major players because of the country's reliance on external aid support, and shape domestic perceptions of policy priorities in important ways (17). The World Bank's current Country Partnership Framework for 2017-22, for example, covers support across a range of areas

spanning improved municipal service delivery (water, transport, environmental services and local economic development) and increased job opportunities (40). Importantly, health does not feature among the key priority areas for support identified in the Bank’s country diagnostic, although structural challenges in the health sector are recognised (17). In the health sector, the WHO has an important technical presence and multilateral bodies are exercising increasing influence especially in the context of the humanitarian response to conflict in neighbouring Syria (see below).

***The confessional orientation of the political system in Lebanon matters***

Second, Lebanon is a corporate consociational democracy where the dynamics of domestic policymaking are profoundly shaped by the confessional power-sharing arrangement, fear of the potential political implications of shifts in the country’s demographic and confessional balance, and a political economy in which clientelism is widespread (it has, as a result of this, been described as a “fragmented democracy” (41)). The top three offices of state are, by agreement, reserved for individuals from specific confessional groups (the Presidency falls to a Maronite Christian, the premiership to a member of the Sunni Muslim community, and the role of Speaker of Parliament to a Shia based on Lebanon’s National Pact).

This system is itself partly a legacy of conflict. The current predetermined sectarian quota of public posts is a direct result of the 1989 Taif Agreement that marked the key step in bringing an end to the Civil War (and, as we note below, has had significant implications for the political economy of public policymaking and implementation). Similarly, although the country is estimated to have a population of around six million, no formal population census has been conducted since 1932, partly because of political sensitivities relating to data on the changing demographic balance within the country’s borders. The census question is emblematic of broader challenges around the acquisition and use of population level data in Lebanon, where this information may be at risk of challenging the political status quo (42,43).

	2017	2018	2019e	2020f	2021f	2022f
Real GDP growth (at constant market prices)	0.9	-1.9	-5.6	-10.8	-6.3	-3.4
Real GDP growth (at constant factor prices)	0.9	-1.7	-2.6	-8.6	-6.3	-3.4
Inflation (consumer price index)	4.5	6.1	2.9	16.0	8.0	4.5
Current account balance (%age of GDP)	-22.8	-24.3	-12.5	-7.8	-7.3	-8.2
Fiscal balance (%age of GDP)	-6.7	-11.0	-10.6	-12.2	-12.7	-14.5
Debt (%age of GDP)	149.7	154.9	171.8	162.8	176.2	189.9

*Table 1 . Trends in a selection of key macroeconomic indicators for Lebanon, 2015-2020 (projected) – highlighting fiscal imbalance and the worsening debt:GDP ratio in recent years (e = estimate; f = forecast) (18)*

***The fragility of Lebanon’s macroeconomic position***

Third, the macroeconomic picture in Lebanon is parlous and fiscal space for increased public investment in public services including health is very limited (see Table 1 ). This situation has been strongly shaped by both the near-term and longer-term legacies of armed conflict, but also irresponsible fiscal and monetary policies. This includes periods of intensive government spending

under the guise of reconstruction following the 1975-1990 civil war, and more recent (2006) war with Israel. A key aspect of the macroeconomic picture in Lebanon is the government's reliance on heavy borrowing on local and international markets to meet reconstruction and other needs. In 1990, real GDP per capita in Lebanon was less than a third of what it had been in 1974 before the beginning of the civil war. That conflict also inflicted physical infrastructure losses estimated at US\$25 billion (44). These losses compound wider structural weaknesses in the Lebanese economy to create macroeconomic conditions - including sluggish GDP growth (17) - that have imposed profound constraints on fiscal space for investment in public health services. By the late 1990s, interest expenditure on the national debt was costing Lebanon over 60% of its revenues (41), and this picture of indebtedness continues in moderated form today (18). Although a number of stakeholders interviewed for this PEA cited the promise of untapped oil and natural gas reserves for improving the country's global macroeconomic position, the impact that new discoveries might have on resource allocation for health is unclear.

### ***Policy responses to refugee movement***

Fourthly, and perhaps most importantly in the current climate, the political and legal contours of the Lebanese government's response to successive waves of refugee movements has had profound implications for health policymaking and service delivery. The Syria crisis provides a case in point. Although Lebanon operated a *de facto* open-border policy towards Syrian refugees between 2011 and 2014, the government's positioning vis-à-vis the crisis has been complicated by concerns over potentially destabilising spillover effects from the conflict in Syria, embodied in the "Dissociation Policy" introduced in 2012 (45,46). This was intended to enforce a policy of neutrality by political actors in Lebanon towards the crisis to reduce the risk of violent spillover from Syria, but has had the effect of providing cover for limited recognition of rights for Syrians, who have no meaningful prospects of integration in Lebanon, and for whom – as an article of official government policy – no refugee camps can be established (46).

Since 2012, this has resulted in policy dualism towards the refugee question. On the one hand, the government has strengthened its domestic response to the crisis through the establishment of a multi-sector Crisis Response Plan (LCRP). On the other, it has adopted increasingly exclusionary rhetoric towards Syrian refugees, and in May 2015 formally requested that UNHCR stop registering new arrivals from Syria (28). Relations between the government and many of the major agencies involved in the response are strained (47).

For refugees themselves, rights of residency for displaced Syrians are severely restricted, as are meaningful opportunities for labour market and other forms of social and economic integration – especially for skilled workers. The latest Vulnerability Assessment of Syrian Refugees in Lebanon for 2019 reports labour market participation rates of 38% for Syrians in Lebanon, down from 43% for the previous year (and just 11% for Syrian women, down from 16% in 2018) (48,49). The Lebanese government also eschews the use of refugee camps: although UNRWA does operate camps for displaced Palestinians (a truly long-term refugee crisis), the million or more displaced Syrians currently living in the country are scattered across 2,100 formal and informal tented settlements, many of them in governorates such as Bekaa and Akkar bordering Syria where public service access and quality for host communities has historically been variable. Some 73% of the displaced Syrian population in Lebanon live below the poverty line (49).



#### 4.4 Broad features of the population health context in Lebanon

Along with many of its middle-income regional neighbours, Lebanon has experienced a partial epidemiological transition with a burden of disease today in which non-communicable diseases (NCDs) predominate. There has also been a marked improvement in average life expectancy at birth from around 70 in 1990 to around 79 in 2018 (the last year for which complete data are available)<sup>11</sup>. The health policy implications of rising life expectancy - in terms of both the design of care delivery models (spanning both health and social care) and the sustainability of financing for the health sector in Lebanon – are broadly recognised in the literature but policy responses to this changing picture are generally regarded to have been slow (50).

Major causes of both death and disability in Lebanon in 2017 (the latest year for which complete estimates are available) were cardiovascular diseases, diabetes, cancers, diabetes and chronic kidney disease<sup>12</sup>. The distribution of major sources of disability (in DALYs) have remained remarkably similar since 1990, although the impact of maternal and neonatal causes of disability today is markedly lower than at that time. Importantly, while there was a consistent downward trend in all-cause mortality and disability (DALY) rates in Lebanon throughout the 1990s, progress against these measures appears to have stalled since 2000. Factors contributing to this levelling off in health outcome performance are varied.

The disease distribution described above is also reflected in the risk factor profile for Lebanon, which in 2017 (again, the last year for which complete data are available) was very much that of a middle or higher income country: high body mass index (BMI), tobacco consumption, dietary risks and hypertension contributed the greatest share of DALYs lost to ill-health in Lebanon<sup>13</sup>.

The crisis in Syria has transformed the population health picture in Lebanon. Displaced Syrians are mainly young (53% are children) and poor, with low levels of prior educational attainment. Geographical distributional effects are an important factor in understanding the pressures shaping demand for health services, and policy responses, across the country – especially in the context of inward movement from Syria. Historically, specialist health service provision has been concentrated in major urban centres (especially Beirut), rather than in poorer, peri-urban and rural areas in the interior of the country where health needs are most concentrated. These areas have also seen some of the largest influxes of displaced Syrians, and most pronounced demand pressures on services at local level (48,51).

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<sup>11</sup> World Bank indicators, online at: <https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=LB> [accessed 17.09.2020]

<sup>12</sup> IHME Vizhub - GBD compare portal. Online at: <https://vizhub.healthdata.org/gbd-compare/> [accessed 17.09.2020]

<sup>13</sup> IHME Vizhub - GBD compare portal. Online at: <https://vizhub.healthdata.org/gbd-compare/> [accessed on 17.09.2020]

## 5. Current form and function in the health sector

### 5.1 Roles and responsibilities

<i>Category</i>	<i>Actor</i>	<i>Description and summary of role and responsibilities in the sector</i>
Professional orders and syndicates	Lebanese professional orders (physicians, pharmacists, nurses etc)	The orders are professional bodies that perform regulatory and accreditation functions but are also important lobbying voices in the health sector in their own right. Perhaps the most powerful of these is the Order of Physicians (LOP), the representative body for registered and accredited doctors in Lebanon, and has around 12,000 members. Its role includes regulatory and oversight responsibility for doctors working across the public, private and not-for-profit sectors. The LOP has taken an activist position on health policy questions that might affect the scope of practice or earning power of its members – principally health insurance reform, to which it has historically been strongly opposed.
	Syndicate of Hospitals	The Syndicate is the representative body for private hospital providers in Lebanon, which dominate the field of secondary and tertiary care in the country. Founded in 1965, its membership spans small, district-level facilities through to major teaching hospitals in Lebanon. It occupies a powerful lobbying position in the health sector on matters including bargaining over tariffs charged (primarily to public, third party payers – principally MOPH and the NSSF), reimbursement from the MOPH for services rendered to Lebanese citizens, accreditation issues and legislation with the potential to affect the scope of practice of its members.
Public policymaking and implementing bodies	MOF	The Ministry of Finance sets the broad budget settlement for the MOPH – and thereby both funding for public health services, and that available to private and not-for-profit contractors for service delivery. It also has an institutional relationship with the Regie, the state-run tobacco monopoly in Lebanon.
	MOL	The Ministry of Labour houses the National Social Security Fund (NSSF) – the largest and oldest compulsory insurance scheme in the country. There is some uncertainty as to whether the NSSF should be regarded as a formal arm of the MOL or a parastatal institution with its own institutional interests and bargaining power.
	MOPH	The central public administrative structure in the health sector, with a mix of norm-setting, regulatory, technical/advisory and financing functions. In contrast to Ministries of Health in some other settings, however, the MOPH is also a third-party payer for care for sections of the Lebanese population, and is a primary provider of ambulatory care (through the public PHC network).
	MOSA	The Ministry of Social Affairs is the main provider of social protection and assistance in Lebanon. Besides the importance of its work in addressing key social determinants of health, MOSA is also the nodal Ministry for oversight of the Lebanon Crisis Response Plan (LCRP) – which governs the official response to the Syria crisis (including health).
Monitoring agencies	Insurance Control	The ICC is a quasi-governmental institution under the Ministry of Economy and Trade in Lebanon, in charge of maintaining an efficient and stable

	Commission	insurance market.
Not for Profit Organisations	Amel	Amel (Amel Association International) was established in 1979 as a nominally non-confessional not-for-profit organisation providing health services. It now operates a network of hospitals, clinics and accessory support services focusing on disadvantaged populations, and is a key delivery partner for a number of international organisations operational in Lebanon, including UNHCR.
	Islamic Health Committee (Hezbollah)	The Islamic Health Committee is the health service delivery arm of Hezbollah's wider social service programme ( <i>Jihād al-Binā</i> ). The Committee operates a network of clinics, hospitals and other facilities providing health services, and has at times (e.g. in 2006) played a prominent humanitarian response role during conflict (52).
International organisations and agencies	European Union	Through its Regional Trust Fund in Response to the Syrian Crisis, the European Union is now the largest single donor to the health sector in Lebanon, providing EUR165million in funds since 2014.
	WHO	The Lebanon office of WHO has played an important role in supporting technical capacity building in the MOPH and indeed across the health sector since the end of the Civil War in 1990.
	World Bank	The World Bank has had a presence in Lebanon since the mid-1950s, and while its focus has historically been on support for long-range development work in the mainstream health sector, it has taken a proactive role in responding to the crisis in Syria, including establishing the Lebanon Syria Crisis Trust Fund (LSCTF) (a multi-donor trust fund designed to help mitigate the effects of the crisis). Health is one of four emergency project focuses for the LSCTF.
Academic institutions	Lebanese American University, AUB and others	Lebanese American University, St Joseph University, AUB, Sagesse University and Lebanese University form a quartet of the major academic institutions in Lebanon carrying out research work on the health sector in the country. AUB in particular has a track record of work with policymakers and has dedicated centres (K2P and SPARK) focused on questions around evidence generation, synthesis and uptake into policy, principally in health.

Table 2. Selection of key actors in the mainstream health sector in Lebanon and a description of their roles. Note that this list is not comprehensive (especially when considering not-for-profit service providers in Lebanon).

Table 2 above outlines the roles and responsibilities of key actors within the mainstream health system in Lebanon. Table 3 below performs an equivalent function for the humanitarian response space. A third table (appendix 3) maps specific functions in the health sector to these actors where relevant to give a sense of span of activities. An important overarching observation from this is that the MOPH has a very broad and diverse remit, spanning the full range of activities from norm-setting and guideline development, through regulatory and quality assurance, to financing and direct provision of services.

The humanitarian response space in Lebanon has developed in large measure in isolation from the wider health system, and other players come to the fore here (Table 3). This results partly from the historical evolution of the health sector – particularly the long-standing presence of multilateral

agencies responding to protracted refugee problems (e.g. UNRWA for the Palestinian refugee population), and institutional legacy effects from past conflicts (notably the 2006 war). But is also results from the Lebanese government’s calculated, and long-established, hostility on refugee and asylum matters. For much of the first three years of the Syria crisis, there was no official Lebanese government policy response and UNHCR was by default the lead agency, in coordination with OCHA and UNDP under the overall supervision of a UN resident coordinator/humanitarian coordinator (UNRC/HC). The first comprehensive government policy position was not issued until October 2014. The policy positions MOSA as the central government ministry overseeing the response, and while MOPH has a line ministry function in the LCRP it is subordinate to MOSA (30).

<b>Category</b>	<b>Actor</b>	<b>Description and summary of role and responsibilities in the sector</b>
Governance, oversight and coordination	Health sector working group	Health Clusters are normally formed as short-term institutional arrangements to help manage crisis responses. An important feature of the Lebanese context is that the kind of health sector response mechanism activated has varied across conflicts. A Lebanon Crisis Health Cluster was formed in 2006 as a response to the conflict in that year, but continued to operate into the late 2000s, to support responses to ongoing instability, including fighting in Nahr el-Bared camp in 2007. The response to the crisis in Syria has been different; Lebanon is not formally part of the Whole-of-Syria cluster, and the domestic response to the crisis is instead governed by a health sector working group under the LCRP.
	UN OCHA	OCHA’s mandate theoretically focuses on coordination (covering financing, policy and information management in humanitarian responses) but the scope of its role in Lebanon is vague and it sits outside the core governance structure for the LCRP. OCHA houses the Lebanon Humanitarian Fund, a Country Based Pooled Fund theoretically aligned with LCRP.
International organisations and agencies providing programs and services	UNDP	UNDP’s presence in Lebanon dates back to 1960 – and spans work during the Civil War from 1975-90. While it does not provide health services, UNDP programming directly influences broader social determinants of health in Lebanon, and as joint lead UN agency in the LCRP (with UNHCR), it helps to coordinate the humanitarian response to the Syria crisis in the country.
	UNHCR	Primary provider of services to registered refugees in Lebanon. UNHCR has had a field presence in Lebanon since 1963 but its work in-country was not formalised until 2003 when an official MOU with the Lebanese government was signed (which was notably light on commitments for the Lebanese government to uphold the 1951 Refugee Convention) (27). It operates with the permission of the Lebanese government and there have been ongoing challenges in defining its operating space in-country.
	UNRWA	The UN Relief and Works Agency was established to meet the needs of Palestinians displaced in 1948. There are around 450,000 Palestinian refugees registered in Lebanon with UNRWA, living across 12 camps. A distinctive feature of UNRWA’s mandate is that its activities span almost the complete spectrum from policy development and implementation through to service delivery, and it has long-established systems for health service provision in Lebanon and other countries in the MENA region. UNRWA has a dedicated health provider network for displaced Palestinians incorporating 28 primary

		healthcare facilities across the country. It also has reciprocal arrangements with the Palestinian Red Crescent Society to support access to secondary care in Lebanon.
Not-for-profit organisations involved in service delivery	Lebanese Red Cross	The Lebanese branch of the International Red Cross movement, based in Beirut, the LRC is active across both the mainstream (covering services such as blood donation and transfusion support, for example) and humanitarian response sectors. It also acts as an auxiliary service to the Lebanese Army.
	Multi Aid Programs (MAPs)	MAPs was established in 2013, and operates a series of public service programs including a health program targeted at meeting the needs of displaced Syrians in Lebanon and supporting training of Syrian health professionals. Its focus is on primary healthcare delivery.

Table 3. Selection of notable actors in the humanitarian health response system in Lebanon (aside from those listed in Table 2 in the mainstream health sector).

## 5.2 Ownership structure and financing

The distribution of ownership for health facilities in Lebanon varies according to the level of care. While health promotion and prevention activities generally fall under the umbrella of the MOPH, provision of health services at primary, secondary and tertiary level looks very different. Secondary and tertiary care provision in Lebanon is almost exclusively the preserve of the private sector. Primary care is provided through a network of primary healthcare centres (PHCs) administered with MOPH support but in which services are delivered by NGOs.

The health financing landscape in Lebanon is notoriously fragmented and difficult to navigate. In aggregate terms, the country had historically one of the highest levels of spending on health as a proportion of GDP in the MENA region, but this has reduced somewhat in the years since 2000, and now stands at 8% (as of 2016, the last year for which complete data are available). Importantly, financing sources are skewed heavily towards domestic private health expenditure – which contributed 49% of current health expenditure (CHE) in Lebanon in 2017 – and particularly out-of-pocket (OOP) spending. Although OOP spending has steadily declined as a proportion of CHE from 58% in 2000, in 2017 it still accounted for 33% of all funding for health service provision in the mainstream Lebanese health system<sup>14</sup>.

<sup>14</sup> WHO Global Expenditure Database. Online at: <https://apps.who.int/nha/database/Select/Indicators/en> [accessed on 18.04.2019].

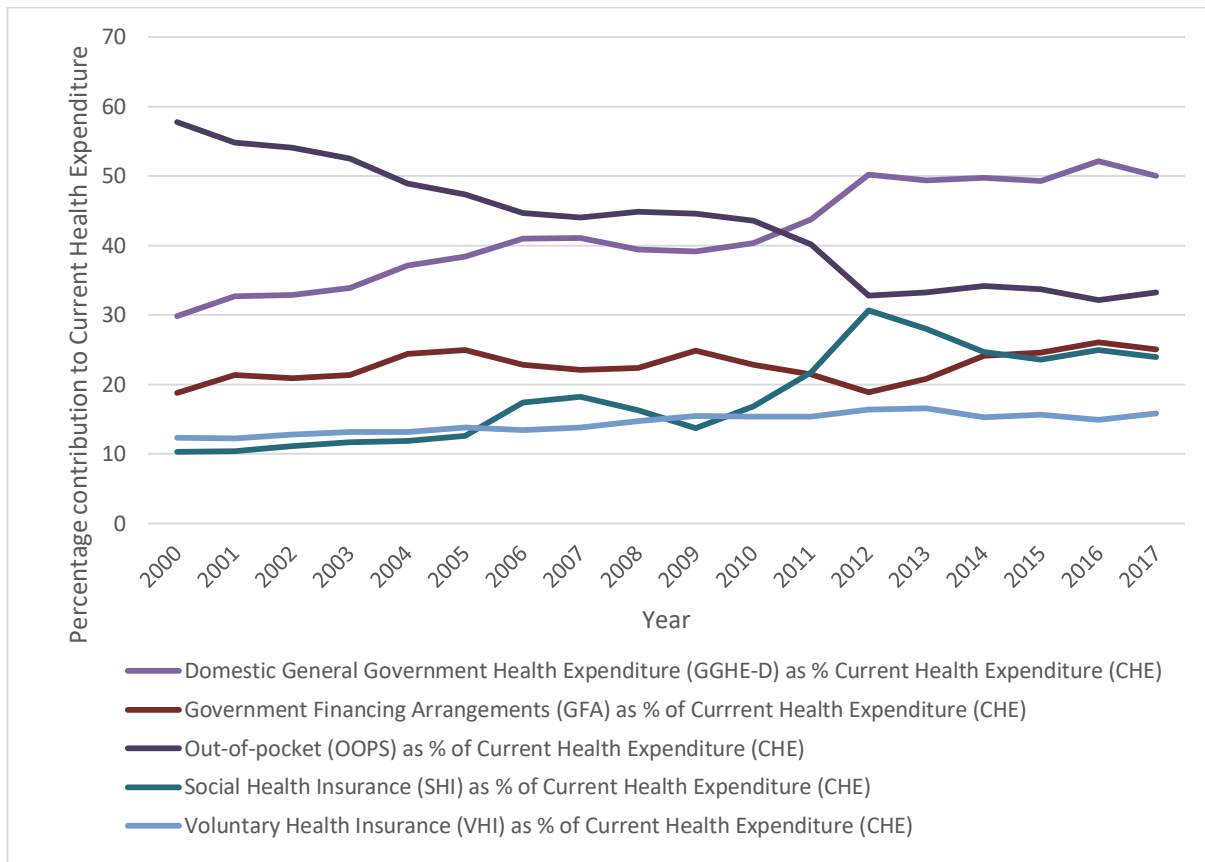


Figure 2. Trends in contributions of different financing arrangements to CHE in Lebanon, 2000-2017, the last year for which data are available (source: WHO Global Expenditure Database)

Turning to financing schemes, payment for services incorporates a number of financing intermediaries, principally six publicly managed, employment-based social insurance funds, which have different governance mechanisms (8). These funds are:

- The National Social Security Fund (NSSF) which covers those in formal employment in Lebanon, and is the oldest of the compulsory insurance schemes. The NSSF sits under the MOL;
- The Civil Servants Cooperative, which covers government employees, and sits under the Presidency of the Council of Ministers in Lebanon;
- Four military schemes for members of the armed forces and various domestic security agencies, and sitting variously under the Ministry of Defence or Interior

These compulsory schemes covered about 51% of the population in 2016, leaving 49% with voluntary (private) coverage or no formal coverage at all to enable them to meet catastrophic costs. Private insurers are regulated by a fourth ministry - the Ministry of Economy and Trade. For those individuals without any coverage at all, the MOPH covers the costs of essential services (medications, hospitalisations and so forth) (8). MOPH coverage reimburses around 80% of hospital costs for the uninsured depending on the nature of the service provided (53). Private insurance schemes naturally sit alongside all of those listed above - a proportion of the population are covered by both these and selected other schemes.

Besides the complexity of the insurance system and singular role of the MOPH as both a service provider and payer in Lebanon, perhaps the most striking feature of the financing environment is the high level of expenditure on pharmaceuticals. At 45% of total healthcare expenditure in Lebanon, spending is three times the global average (15%) and is driven by unusually high expenditure on patented medications (around 49% of the US\$1.6bn in pharmaceutical sales in the health sector in 2015) (54), partly because of failure to introduce pricing reforms, but particularly because of enduringly weak incentives for health practitioners to prescribe generic medicines despite the implementation of new policy in recent years to encourage drug substitution (12,55).

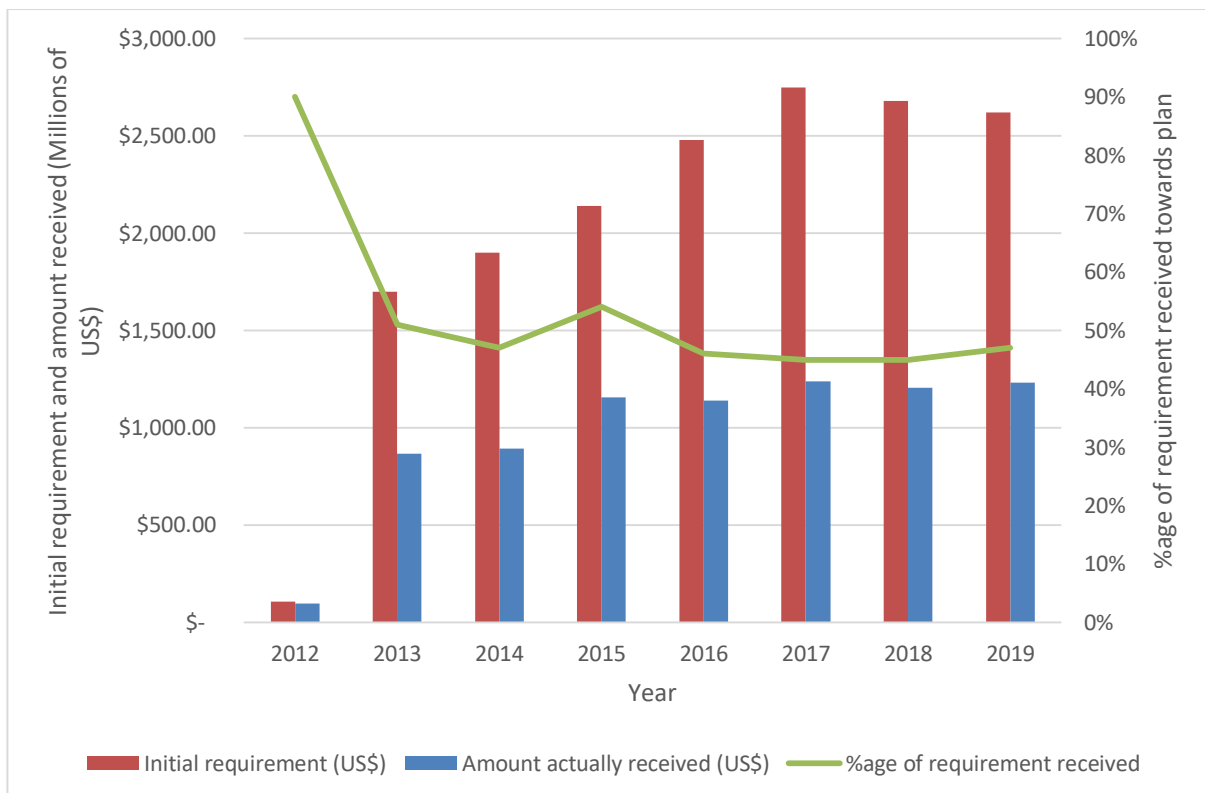


Figure 3. Trends in absolute funding receipts for humanitarian response activities in Lebanon (blue bars) mapped against requirements (red bars). The green line shows the trend over time in the proportion of funding requirements ultimately met by donors (source: LCRP Update 2018 (56)).

Data on both the volume and approaches to distribution of financing for the humanitarian response in Lebanon are sparse. We know that – as with many other humanitarian response efforts worldwide – the LCRP is chronically underfunded. For most years since inception, receipts to the LCRP have hovered a little under 50% of stated requirements (see Figure 3).

It is also clear, however, that there are important additional funding streams for the humanitarian response in Lebanon beyond those captured by official crisis response data sources – in particular financing from the Gulf States and Iran. Much of this money is allocated directly to partners in Lebanon or via other opaque channels rather than through the LCRP – and for this reason the scale and scope of this funding is almost impossible to independently verify (57). Evidence from the recent historical record in Lebanon is, however, clear on the importance of regional funding streams to both near-term

support and longer-term reconstruction efforts during and after the Civil War and the 2006 conflict (58–61). For example, the flash appeal for humanitarian response funding following the 2006 war requested US\$155m but the final allocation was some US\$520m, more than 25% of which came from donors outside the OECD’s Development Assistance Committee (DAC) – principally Saudi Arabia, the UAE, Kuwait and Turkey. The largest allocations to long-term reconstruction at a pledging conference later in 2006 also came from the Gulf States (61).

### **5.3 Power relations, bargaining and rent-seeking in the health sector**

The available literature shows there are significant power imbalances in the health sector, spanning both the mainstream health system and the humanitarian response architecture for refugees. A striking feature of some of the literature on the sector, and indeed on the political economy of public policymaking in Lebanon, is that the power-sharing arrangement put in place as a result of the Taif Accords at the end of the Civil War embedded clientelism in the public sector. This is particularly in entrenching a confessional and sectarian-based political economy that undermines the capacity and capability of public services in Lebanon to distribute public goods rationally (62,63).

#### ***Confessionalism and its influence on bargaining and rent-seeking in Lebanon’s health sector***

The redistribution of power enshrined by the Taif Accords ensured adjustments to quota arrangements for leading government and public administration posts (“first grade” positions equivalent to senior civil service and ministerial level) across confessional groups in Lebanon. In reality, the principle of parity in distribution of posts between groups was applied across the public sector as a whole after Taif, and has had significant implications for the speed and effectiveness of hiring to public posts. The implication of this change was that “recruitment to the public sector became part of a complex ensemble protecting the political, economic, and security prerogatives of the sectarian elite and their cronies” (63). This is seen directly in appointments to first grade positions in the health sector. Under Taif, the position of Director-General (DG) of the MOPH is allocated to the Druze community. Other DG-level positions with direct relevance to the health sector are allocated to members of other groups (DGs of the MOF and the High Council for Privatisation to Maronite Christians, DG of the NSSF to a Shia, DG of the Ministry of Labour to a Greek Orthodox, and DG for the Ministry of the Displaced to a Druze).

The ways in which these and other power imbalances manifest in bargaining within the health sector vary according to the actor concerned, and more particularly the policy question under consideration. The effect of the post-Taif system has been to allocate, by community, control over tenders for government contracts, access to resources, and to “confessionalise” the question of accountability for performance (62,63). The distorting influence of confessionalism over sector activities pervades all levels from policymaking through to ground-level service delivery (64,65) – but as we will see in section 5.5, the implications for service access are not always as straightforward as they might appear. Nevertheless, evidence suggests that confessional and sectarian affiliation has a direct effect on the allocation of public spending in Lebanon, which is often tenuously linked to actual service need (21,22).

#### ***The role of the MoPH***

In the government run health sector, the MOPH exercises a key technical, regulatory and quality assurance role but is also a third-party payer for primary, secondary and tertiary care, alongside public



providers of insurance and the various private insurance companies. However, its authority has not fully recovered from hollowing out during the 1975-90 Civil War during which much technical capacity was lost and public health service provision scaled back greatly. The Ministry can exert decisive influence over policymaking and implementation, as demonstrated during reforms to tobacco control laws in the mid-2000s (box 1) and more recently in the development and implementation of a National Mental Health Strategy for Lebanon. Policy change was successfully achieved in the former case despite the presence of powerful vested interests in this area – including both the international tobacco industry and the Regie, the national, parastatal state-run tobacco monopoly in Lebanon that is administered by the MOF and which provides key revenue streams for that ministry. This depended on a combination of global impetus towards change (the signing of the Framework Convention on Tobacco Control), strong technical support to the MOPH from the WHO, political commitment from leaders in Lebanon, and an activist academic and civil society lobby which effectively brought local research evidence to bear on the policy debate (see below). In the latter case, the extraordinary service pressures arising as a result of the crisis in Syria combined with the opening up of new, albeit insecure, funding lines and strong leadership appear to have created a favourable window of opportunity for change (66,67).

Reform of health financing, on the other hand, has been an area of persistent failure partly because power relations in this area have been skewed decisively towards a selection of actors – principally the Syndicate of Private Hospitals and the Lebanese Order of Physicians – who have a strong interest in maintaining the policy status quo. The MOPH – despite its status as a key third-party payer for services – has had limited success in pushing for reform of health financing arrangements (8).

#### ***The role of humanitarian actors in re-shaping power relations in the health sector***

At one level, literature sources make clear that there are tensions in relationships between multilateral agencies leading large parts of the response, and the Lebanese government – at the behest of which the UNRC/HC operates (27). But there have also been profound problems of coordination between these agencies themselves – including over leadership of different aspects of the response. Although UNHCR formally leads the humanitarian response to the Syria crisis in Lebanon (including provision of health services to Syrian refugees), recent reports including independent evaluations of the response have identified competition between UNHCR, UN OCHA and UNDP over leadership roles as a key factor in explaining ongoing weaknesses in coordination (30).

Evidence on the question of corruption and rent-seeking in the health sector – both mainstream and the humanitarian response space – is limited. While donor and agency reports make clear the scale of the corruption challenge in the wider economy in Lebanon (17,18), research explicitly addressing the scale and scope of rent-seeking in the health sector in the country was restricted to cluster of studies on the *confessionalisation* of health service provision (19,21).

#### **5.4 Ideology, norms and values**

An appreciation for stakeholder values and ideas (including political ideologies, religious and cultural beliefs) is central to any understanding of the political economy of the health sector. Four main themes are identifiable from the published literature and stakeholder interviews.

- An elite-level preference for *laissez-faire* approaches to economic management in Lebanon (39) emerges consistently from the academic literature, and combined with the destructive effects of the Civil War and support from international financial institutions (35), helped create the

conditions for private and not-for-profit sector expansion in health. But there are tensions in how this is practically manifested in the health sector, some of which are evident in the MOPH's current Strategic Plan for Health. This document puts health equity, universal health coverage and addressing key determinants of health (upstream from the health sector) upfront in its vision for the future of the sector. From a strategic and operational perspective, the document highlights strengthened *public* service provision as central to this aim, particularly through support for the public primary care and hospital sectors. However, it side-steps the question of financing reform as a means to improve coverage, and references to the refugee population in Lebanon are framed mainly in terms of emergency preparedness and response rather (68).

- A tendency among decision-makers towards political “abstention” (in the words of interviewees) – i.e. active decisions by key actors to maintain the *status quo* in the health sector because of a perception that this serves their own interests (personal, financial, mobilisation of voters) but also those of key allies in the sector.
- Elite and popular attitudes towards refugee populations in Lebanon and their civil rights. Section 4.3 highlighted the so-called “Dissociation Policy” as an important articulation of official policy towards the Syrian crisis with major implications for the health response for refugees, alongside a tacit desire by policymakers to avoid a repeat of the long-term settlement of Palestinian refugees in Lebanon. While displaced Syrians continue to be able to access primary healthcare through government-supported facilities, the uncertain status of those without formal registration acts as significant barrier to access. But there has also been a coarsening of political discourse in Lebanon towards Syrian refugees from some quarters over the past two years – especially so in the run-up to the 2018 parliamentary elections. Senior Lebanese politicians have publicly called for refugees to return to Syria, and efforts to realise this are now being pursued despite continuing insecurity over the border (69).
- The third key theme in the literature – raised in section 5.3 – concerns the role of identity politics in shaping health sector activity in Lebanon. Section 5.5 below details in depth how this manifests in service delivery.

## 5.5 Service delivery

The service delivery landscape in Lebanon is diverse – and characterised by pronounced market failures and inequities in access and quality (16,23,24,70,71). The privileging of secondary and even tertiary care services at the expense of prevention and broad-based primary care is a long-standing feature of the service delivery landscape in Lebanon, and again stems in part from the destabilising effects of the Civil War. Reviews published in the late 1980s and 1990s note an explosion in per capita provision during this period of what were then high-end medical technologies such as MRI and CT scanning facilities, and cardiac catheterisation laboratories – far beyond demonstrable health need – as fee-for-service provision proliferated (23,24,72). As Figure 4 illustrates, technology density in the health sector in Lebanon continues to outstrip regional neighbours today. And while the MOPH and Education Ministry do provide some preventive services, NGOs continue to be mainstay providers of vaccination, maternal and child health interventions and health education (35).

**Box 1: conflict and the progress of tobacco control legislative reform in Lebanon**

The key legislative instrument governing tobacco control and product regulation in Lebanon - law no 174 (which covers tobacco manufacturing, packaging and advertising, and regulates smoking in public places, workplaces and public transport) - was passed in 2011 as the culmination of a long and difficult process of raising tobacco control up the policy agenda from the 1970s onwards.

Conflict and its legacy have had important effects on efforts to reform tobacco control legislation in Lebanon. The most obvious effect has been disruptive: the outbreak of civil war in 1975 for example, drew a halt to national public information campaigns to curb tobacco use which were not revived until the late 1970s. Legislative efforts to strengthen tobacco control in the 2000s suffered from repeated cycles of political and economic instability, prompted partly by episodes of conflict (10). However, there was also an important *geopolitical* dimension to the tobacco question; a farming subsidy system evolved over time to support Lebanese leaf growers predominantly in the previously Israeli-occupied south of the country, to shore up territorial claims to this land.

Historically, the tobacco industry had also exerted a powerful influence over Lebanese policymakers, lobbying against marketing and advertising restrictions, and promoting voluntary codes of practice for producers instead of binding legal requirements (11). A key player had been the Regie, the state-run tobacco monopoly in Lebanon (falling under the Ministry of Finance). In 2004 a draft bill on a comprehensive tobacco advertising ban in Lebanon had been rejected partly because of Regie concerns about the macroeconomic impact of such a ban on employment and advertising revenue to the state.

How did circumstances change to bring about favourable conditions for reform? Although there was no specific prompt for change in 2011, literature evidence suggests that by 2009 a shift in the balance of bargaining power between stakeholders on tobacco control was underway. A good body of local and international evidence had emerged to support contextually-appropriate reform, and importantly the political climate was more stable than it had been for some years.

Incentives for change at elite level also altered in favour of reform, partly under pressure from powerful civil society lobbying. Specifically, in the mid-to-late 2000s there was a strengthening in the position of the MOPH's National Tobacco Control Programme (with technical support from WHO following the ratification of the Framework Convention on Tobacco Control in 2005) and the emergence of a powerful, advocacy coalition, including civil society organisations, parts of the media and importantly academics, who were able to use their position of credibility and trust to boost support for tightened tobacco control. Researchers at the AUB consistently highlighted spiralling tobacco use in Lebanon from 1999 onwards, and formed the Tobacco Control Research Group (TCRG), a multidisciplinary group of researchers committed to advancing evidence for prevention and control of tobacco use and its consequences, specifically to address it. Research by the TCRG provided the evidence-base for framing tobacco use as a major public health problem, and for the relevance and applicability of local solutions (10).

### Primary health care provision

For Lebanese residents, primary care is available through a nationwide network of PHCs (a majority of which are run by private or not-for-profit organisations, although the MOPH’s own network is gradually expanding) and pharmacies which provide a combination of curative and preventive services including vaccination. In practice, population coverage through the primary care network is limited – some studies indicate that as little as 20% of the Lebanese population have regular access to a family physician to cater to their health needs (14). By contrast, the post-Civil War period saw rapid expansion in the secondary and tertiary care sectors, which remain primarily the preserve of private providers although the number of beds in the public health sector has grown since the early 1990s (14,16).

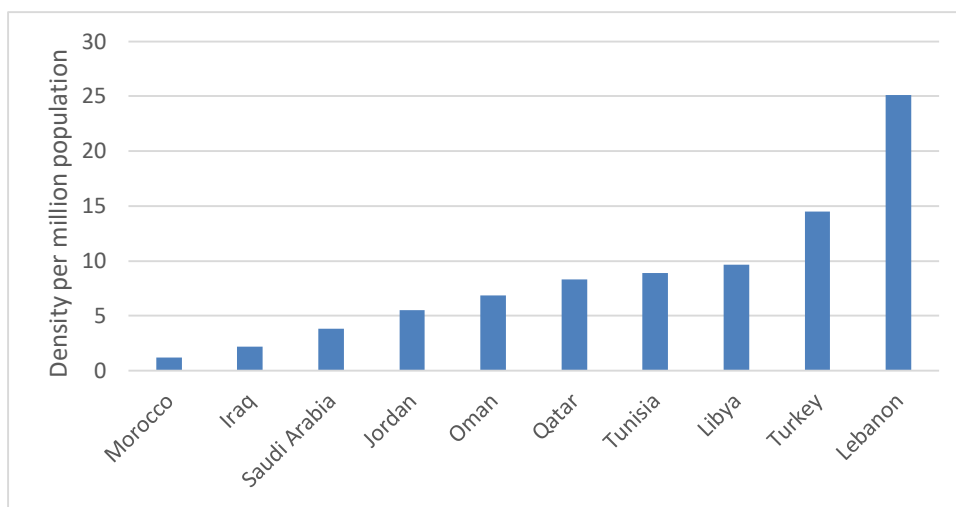


Figure 4. Density per million population of CT scanning units for Lebanon and a selection of other MENA countries in 2013 – the last year for which comprehensive data are available (source: WHO Global Health Observatory)

### Confessional providers

A key feature of the health service delivery landscape in recent years - with important implications in terms of bargaining processes within the sector as a whole - has been the emergence of confessionally-based providers. It is estimated that around 28% of medical centres and dispensaries are run by Christian and Muslim charities, and another 15 % of basic healthcare is provided by services affiliated to political parties in Lebanon (20). The relationship between the confessional and political turn in service provision and access across communities is complex. On one hand, the rise of this new class of providers has been important in expanding provision of key social services to vulnerable groups in society (including health services but also education and welfare support). There is evidence that confessionally- or politically-affiliated providers often open their doors to people from other communities (19,64). However, the extent to which different providers do so varies according to service pressures, the local politics of resource allocation for welfare services, and the potential for accrual of rents – especially given the relationship between electoral representation and targeting of service provision (17,65). This is linked to a wider pattern of instrumentalising institutions and service access for political and economics ends.

### ***Service provision for refugees***

As in other areas, a central fault-line in the service delivery landscape is between provision for Lebanese citizens and residents, and refugee populations. Access to services through the mainstream Lebanese health system is practically constrained by limitations on residency rights for displaced Syrians, and increasingly by the framing of health and welfare policy in Lebanon. This partly reflects the extraordinary pressure on services exerted by the influx from Syria. Data from December 2012, in the early phases of the crisis, show that some 40% of all recorded visits to MOPH-supported PHCs were by Syrian refugees (73).

Refugees can nevertheless access subsidized care through the MOPH's PHC network, and at some MOSA-affiliated clinics, and of course through the wider network of privately owned and operated PHCs which form the bulk of the primary care system in Lebanon (74). UNHCR is a key provider of services for Syrian refugees, doing so primarily through a network of UNHCR sponsored PHCs nationwide (direct support to around 30 such facilities, and partnerships with providers in another 100 where subsidised care for refugees is available, with collaborations with INGOs such as the International Medical Corps and Caritas, and Lebanese NGOs such as Amel (74)). UNHCR supports deliveries and life-saving emergency care by paying 75–90% of hospital fees depending on admission costs and an assessment of the socio-economic status of the recipient (75). For registered Palestinian refugees – many of whom have been in Lebanon for far longer than their Syrian counterparts – UNRWA's parallel system of 27 PHCs provides a key primary care access point, especially for the 50% of the displaced population living in the 12 UNRWA-run camps in Lebanon (15,76,77).

The picture in terms of access to specialised (or referral) services for refugees is different. MOPH-funded providers offer subsidized care although refugees have been obliged to meet an ever increasing proportion of the cost of services through co-payments. UNHCR covers 75% of the cost of emergency procedures, obstetric and neonatal care (74), but its ability to cover part or all of the costs of highly specialised care such as kidney dialysis or oncology services is increasingly constrained by limited budgets and pressure of demand (78). There is good evidence that this is having a deleterious effect on health service engagement especially by patients with chronic conditions for whom the cost of medications is a significant barrier to access (51,79).

### ***Informal health care provision***

A striking phenomenon since the start of the Syrian crisis has been the growth in *informal* service provision in Lebanon – especially in areas of the country where large concentrations of displaced Syrians are now living to help meet perceived shortfalls in the service offer for these populations. This includes emerging service provision by displaced Syrian health professionals, working without formal registration and regulatory oversight, primarily in primary care settings. These services offer a valuable, and low-cost alternative to the private sector for Syrian refugees, but there are obvious concerns both about service quality and protection for Syrian health workers working in settings which effectively operate in a governance vacuum. From a political economy perspective, the existence of informal providers depends on accommodations with local authorities (who turn a blind eye to these activities) and Lebanese health professionals (to whom onward referrals may be made) – both of which are insecure. Financing for these providers is opaque but appears to depend on a combination of charitable contributions and a willingness by many health workers to work on a voluntary basis, to support service fees that are much lower than those charged in the mainstream health system (80).

## 5.6 Decision-making in the sector, including procurement and use of evidence

### Processes of decision-making in the health sector in Lebanon

The section on power relations and bargaining in the sector (above) makes clear that power to influence decision-making processes in health is skewed, with some actors exercising considerably more power than others (although the exact balance varies by policy issue). In general terms, policymaking processes in health are fairly closed, driven primarily at Ministerial level (i.e. elite-driven) and with limited consultation with broader system stakeholders - *except* where these stakeholders have direct lines of influence over Lebanese politicians. There have been instances of policy change where civil society actors have shaped the policy agenda in more meaningful ways (tobacco control reform in the mid-2000s stands out as one example of this), but this is the exception rather than the rule.

### The political economy of evidence generation, synthesis and use

There are varying perspectives in the literature on the efficacy of evidence generation, synthesis and integration into health policymaking and implementation in Lebanon. Research indicates some consensus among decision-makers in the health sector in Lebanon that there are recognised sources and institutions in the country from which to seek health evidence (81,82). Productivity in research domains relevant to health policymakers in Lebanon continues, however, to be relatively weak, with low output of research types addressing policy-relevant questions (e.g. systematic reviews (83)) and germinal knowledge translation activities (84). **We were unable to identify data on the scale, source or distribution of research funding for health in Lebanon.**

The degree to which available evidence actually influences policymaking in health varies. On one hand, there is agreement across a number of studies on commitment at Ministry level to strengthening technical expertise and improving use of evidence in the post-Civil War period, partly as a result of what was perceived to be the irrational growth of health expenditure and poorly-evidenced practice between 1975 and 1990. One study points out that this was part of a deliberate strategy by the Lebanese MOPH, with WHO support, to restate its importance in policy development and implementation in the health sector after the end of the Civil War, by emphasising its role as a procurer and user of evidence (in a way that other actors in the sector could not). These efforts were underpinned by new research evidence commissioned from the WHO, academics in Lebanon and elsewhere (23).

It is also clear that evidence has been used effectively by various actors across the system in sometimes politically contentious areas to help bring about reform. Reform of tobacco control law in Lebanon provides a case in point (see box 1). On the other hand, studies of other reform efforts - notably recent attempts to reform public health insurance provision in Lebanon - suggest that research evidence often plays a limited role, or at least one subordinate to political (including confessional) and personal factors in decision-making. Some of these criticisms are linked to a wider critique of decision-making style in the health sector in Lebanon, which is described as closed and driven primarily by the interests of Ministers (8). This has hindered effective policy change in some areas, where studies note insufficient efforts to involve local stakeholders in policy design, and a

tendency to try to transplant international evidence into the health system without adequate consideration of contextual specificities in Lebanon (9).

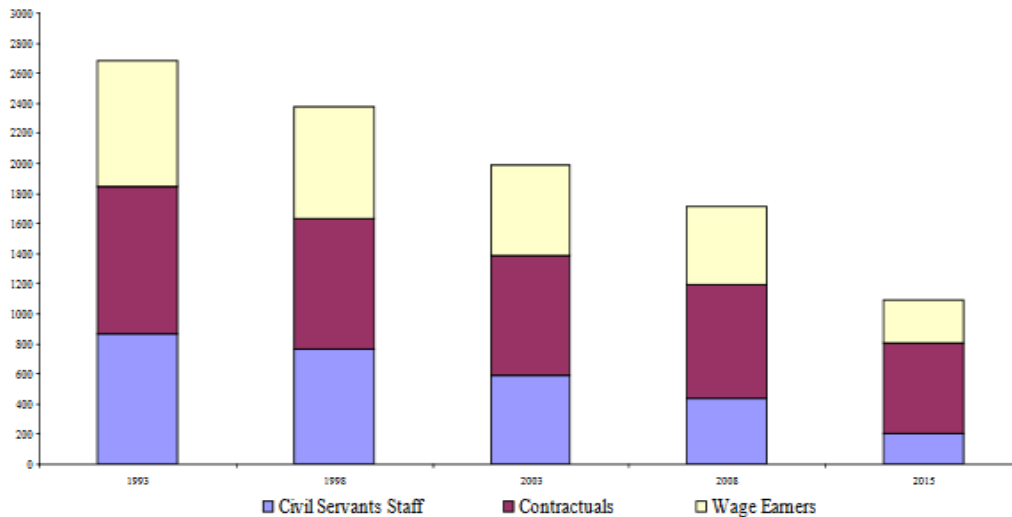


Figure 5. employee numbers by category for the Lebanese MOPH, 1993-2015 (76)

There is also consistent recognition in the literature on Lebanon that information asymmetries in the health sector are highly problematic. Technical capacity in the MOPH was badly hollowed out during the 1975-90 Civil War, and while there was a degree of recovery after that conflict, manpower in the Ministry has more than halved since the early 1990s - with significant implications in terms of the capacity of that institution to perform its regulatory, evidence-brokering and quality assurance functions.

Areas on which the research literature is silent include differences in approach to the procurement and use of different kinds of evidence. It is not possible to say, for example, how far health economic or political economy analysis evidence is integrated into policy development in the health sector.

**Box 2: the political economy of resource allocation for cancer care in Lebanon**

The allocation of resources for cancer care – and indeed the level of priority given to prevention and management of cancer more broadly – illustrates in microcosm many of the wider dynamics in the political economy of health in Lebanon, intercut by the effects of conflict. The degree of need is well-established: after a prolonged period of stable incidence rates for new cancers (85,86), there has been steady upward trend in reports from in line with broader demographic and epidemiological changes in the country (87). National cancer treatment guidelines – drawn up in partnership with the MOPH and other system stakeholders including UNDP – are available in Lebanon to help guide treatment and support cost-containment efforts (88), but cancer care remains prohibitively expensive.

Despite strong evidence of (1) rising incidence rates for cancers amenable to “lifestyle improvement” (for smoking and dietary risk), and (2) the availability of tried-and-tested screening approaches for breast and cervical cancers among others, action on prevention in Lebanon has been slow to take root. The trials of tobacco control in Lebanon are outlined in box 1; key dietary regulation measures are not in place (addressing food, salt and fat content, and restrictions in marketing to children) (89). Breast cancer screening is offered during limited campaigns, and uptake among vulnerable age groups is generally low (especially for re-uptake or follow-on screening) (90). A similar picture is seen for cervical cancer screening (91). These trends are linked partly to awareness issues but also to the centralisation of services in Beirut, and to the stated cost of screening (90,92).

The major focus in the health sector as a whole continues to be on curative care. Here, allocation of resources is, as one might expect given the labyrinthine nature of the financing system for the health sector, complex. Lebanese residents with health insurance can expect support for costs of treatment through their programmes, to varying degrees. For Lebanese residents without formal coverage, the MOPH has since 1999 been running a programme to cover costs of cancer medications and reduce catastrophic OOP expenditure. The sustainability of the drug cost-coverage scheme is in question; spending on medications was estimated at an average US\$6,475 per patient each year in 2013, up to around US\$31,000 for treatment-intensive conditions such as chronic myeloid leukaemia (93), but doubled over the five years to 2016 following the introduction of anti-TNF medications onto the domestic market (94). Cost pressures are accentuated by low uptake of generic medications in a sector where incentives for health professionals to prescribe generics remain weak (54).

The position for displaced populations is different and as elsewhere dependent on whether they are registered or undocumented displaced persons. For Palestinian refugees registered under UNRWA’s umbrella, the UN programme provides financial support through an initiative called CARE that covers 50% of the costs of cancer medications up to an annual ceiling of US\$8,000. UNRWA will also cover costs of radiotherapy sessions and provides limited funding to support hospital admission costs (a ceiling of US\$5,000 per year, given estimated annual admission costs of around US\$25,000 per patient) (95,96).

For Syrian refugees, access issues are acute. The degree of support offered by UNHCR to registered refugees in accessing secondary and tertiary care oncology services, and in covering the costs of medications is variable and for some populations (notably children, for whom treatment costs in Lebanon may range up to US\$200,000) thought to be virtually non-existent (97). In the context of the Syria response, eligibility is adjudicated by the UNHCR Exceptional Care Committee (78). This picture nevertheless describes registered refugees, which we know account for only a proportion of all



displaced Syrians in Lebanon. For those who are unregistered, access to care depends on personal or family resources to pay for private sector care, and ad hoc provision by charitable organisations.

## 5.7 Implementation of health policy

The focus of much of this report has been on health policy development. There is strikingly little evidence from Lebanon on factors influencing policy *implementation*. Much of what we do know comes from meso- or micro-level studies of regulatory change at the providers level (e.g. the implementation of hospital accreditation) (13,98). These studies provide a partial picture, but evidence is at least indicative that there are significant deficits in the capacity of the MOPH and other actors in the system to support implementation (12,13).

Studies addressing topics as diverse as improving care quality, the implementation of generic drug substitution policies and secondary care contracting reform all note common implementation challenges. They include: difficulties in cascading guidance on changes through the system (partly as a result of the fragmentation in financing and delivery noted above) resulting in poor adherence; misaligned incentives at different levels contributing to resistance to uptake of reformed or revised policies - including vested interests operating at micro-level; issues of trust between actors at the political centre and at the periphery in Lebanon; and the inability of authorities at the political centre to effectively monitor implementation and make incremental changes to policy in response to feedback (12,98). Use of participatory approaches to policy change has helped to improve engagement at both policy formulation and implementation stages (13).

## 6. Reform priorities and the potential for change

There is a high degree of consistency in the published literature, and among stakeholders interviewed for this report, on assessments of priorities for change in the health sector over time. Indeed, common reform priorities are identifiable across documents dating back over 20 years. This is partly because studies addressing reform questions originate from a small number of individuals who either currently, or have in the recent past, occupied leadership positions in the MOPH. Most studies identify fundamental challenges for the sector around:

- Cost-containment and financial sustainability across the sector
- Rationalising capacity especially in the secondary care sector where there is felt to be significant oversupply
- Shifting the focus of care from curative to preventive
- Ensuring equitable access and quality of care (14,16,23,24).

A striking feature of the literature on this topic is its tendency to describe reform options in *technical* terms, and discussion of politics is largely absent. There is in addition no clear sense from published work on Lebanon of public attitudes to reform in the sector or issues that are regarded as priorities for change. What little we know about public attitudes comes from a handful of public opinion surveys carried out in Lebanon, usually with small (if theoretically representative) population samples. The Arab Barometer Survey 2017, for example, showed generally low levels of satisfaction with the public health system, and low confidence in the government to improve the quality of basic health services (99). A similar survey among Syrian refugees in Lebanon also showed low levels of satisfaction with health service provision by comparison with refugee compatriots living in Jordan (99).

By contrast, interviewees spoke more openly about political space for reform and opportunities for change. Representatives from academia and civil society in particular noted the potential for armed conflict and/or political instability to create windows of opportunity for change through their disruptive effects on structures and incentives.

Arguably the key theme in the literature addressing the long-term potential for health sector reform in Lebanon is fragmentation. The health system reflects the broader economic and political situation of the country in that different health payers and providers (Ministry of Public Health, the NSSF, and the various specialty fund holders) fall under different ministries and have complex lines of accountability. This has historically undermined efforts at national, comprehensive health sector reform (17).

## 7. Concluding remarks

### 7.1 Headline findings from the PEA

The central findings from this report are, firstly, that political and economic space for change in the health sector is heavily circumscribed by barriers arising from:

- Lebanon’s critical fiscal, monetary and economic circumstances;
- Clientelism and the state’s institutional capabilities;
- The scale of the humanitarian crisis it faces;
- Long-standing power imbalances in the sector;
- Political instability, and
- Direct effects of conflict and political instability.

Although space for systemic reform appears limited given this combination of political economic and institutional constraints and challenges, the potential for change varies significantly according to the policy issue and the particular balance of power and interests between key stakeholders in that area (considering the contrast between tobacco control and health financing reform, for example).

The implication is that opportunities or proposals for policy change should – besides their technical merit – be carefully grounded by an assessment of what is likely to be politically and economically feasible, acceptable and realistic in the current social and political climate in Lebanon. Consideration of system constraints to implementation are also required. Above all, close engagement with relevant stakeholders, and the mobilization of public opinion, is likely to be essential to successful implementation in what is a highly pluralistic health sector.

### 7.2 Summary assessment of evidence and quality

The table below summarises, by domain, the extent and strength of currently available evidence on the political economy of health in Lebanon (focusing on the health sector). Material on roles and responsibilities, ownership and financing is fairly clear. There is generally less material on historical legacy factors, the dynamics of decision-making, and in particular evidence on approaches to priority-setting in the health sector in Lebanon, and downstream policy implementation. Published literature is largely absent on the effect of corruption on policymaking and implementation in the sector, although emerging work on confessional - and politically-affiliated providers gives an indication of rent-seeking constraints on equity, service efficiency and effectiveness.

<i>PEA domain</i>	<i>Evidence strength and clarity</i>	<i>(Some) enduring areas of uncertainty</i>
<b>Historical legacies</b>		Explaining the circumstances, incentives and funding conditions that precipitated growth in private and not-for-profit sector provision during the Civil War
<b>Roles and responsibilities</b>		Avenues for individual, community and civil societal voice in the policymaking process and whether/how space for contestation is modulated by conflict; the role of other actors including mass media organisations, multinational corporations and domestic business interests, and labour unions in influencing health policymaking and implementation.

<b>Ownership Structure and Financing</b>		Funding volume from international (particularly non-DAC) donors and the mechanisms used to channel these funds into the health sector, and modulating effect of conflict on these;
<b>Power Relations, bargaining and rent-seeking</b>		Relations between the MOPH and other government ministries (notably the Ministry of Finance) and the influence the MOPH has over the design and implementation of policies with the potential to affect health outcomes, and how relations have changed during conflict and in transition from conflict; the inclusion (or otherwise) of gender perspectives and marginalised voices in policymaking
<b>Ideologies and Values</b>		Public attitudes towards health service provision and financing, and prioritisation of health issues in the mainstream health sector, and with respect to refugee populations; differences in ideological orientation towards redistribution in the mainstream health sector and for refugees between political and confessional groups
<b>Service Delivery</b>		The effect of service delivery fragmentation on access for different population groups – in particular: gendering of service access; accessibility for older people (both settled and displaced)
<b>Decision-Making, including priority-setting</b>		Processes for prioritising health resource allocation in the MOPH and in the humanitarian sector: inclusivity of these processes, the role of evidence and criteria used to determine what to prioritise; the role of evidence in decision-making more generally
<b>Implementation Issues</b>		Relations between centre and periphery in Lebanon in both the mainstream health sector and humanitarian response; technical and administrative capacity to implement policy at local level; dynamics of political contestation, and the role of vested interests at local level in determining the success of implementation

Table 4. Overall assessment of evidence strength against key PEA domains for Lebanon, and a list of some areas of uncertainty (note this list is indicative rather than comprehensive, and based on literature assessment only)

## 7.2 Framing onward research questions

While researchers from Lebanon (including AUB) have made important contributions to the understanding of the political economy of policy change in the health sector, the focus on *conflict* in this literature is tangential and there is a large set of potential questions for research in the second phase of R4HC. One important overarching question given Lebanon’s recent experience, is whether there is a need to modify our definition of conflict. Specifically, can we construct a revised definition that accounts for the profoundly disruptive effects of political instability and recognises that it is not just the fact of conflict (but often the instability that precedes or post-dates it) that affects health policymaking and implementation?

Given R4HC-MENA’s focus on cancer and mental health, onward questions could include:

Mental health	<ul style="list-style-type: none"> <li>Given the historically low priority given to mental health services in Lebanon and the region as well as the dominance of specialist service delivery, how and why did incentives for action for different stakeholders change in 2012 to provide a window of opportunity for the development and implementation of the National Mental Health Strategy for Lebanon? What influence did donor and multilateral agency priorities and funding have on this? What role did domestic actors play in shaping the content of the ensuring Strategy? What lessons can be learnt for change in other areas?</li> <li>What challenges to implementation of the Mental Health Strategy have been experienced nationwide, and why? From a coordination perspective, what continuing practical incentives/disincentives to participation in implementation by the multitude of actors</li> </ul>
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	involved in the mainstream and humanitarian response sectors (and how can barriers be addressed)?
Cancer	<ul style="list-style-type: none"> <li>• What factors explain the historically low priority given to prevention of upstream determinants of cancer (including for example dietary risks and obesity) in Lebanon? How have vested interests shaped the political space for action on these upstream determinants?</li> <li>• What does the differential distribution of resources for diagnosis and management of cancers in specific vulnerable groups – notably children (across both settled and displaced populations) – tell us about the political economy of cancer care in conflict? What factors determine differential resource allocation?</li> <li>• What global and domestic factors explain exceptionally high expenditure on patented medications (including for cancer) in Lebanon? What are the key incentives/disincentives to change, and what do these imply for approaches to financial protection for cancer patients in Lebanon – across both settled and displaced populations?</li> <li>• How are decisions made by the UNHCR’s Exceptional Care Committee in Lebanon regarding eligibility for financial support for cancer care for registered refugees, and what factors influence these decision-making processes? Has the nature of decisions made by the ECC changed over time and if so in what way(s)?</li> </ul>

Table 5. Domain-focused research questions for mental health and cancer (indicative, not exhaustive)

There is, in addition, a broad set of political economy questions following on from this work that could merit further investigation either across the sector as a whole, or by focusing on specific case studies, including the following:

<b>Theme</b>	<b>Research need</b>	<b>Sample question(s)</b>
Historical legacies	Historical determinants of power relations in the health sector	<ul style="list-style-type: none"> <li>• Why did private and not-for-profit providers emerge as such powerful players in Lebanon during the Civil War? What funding sources facilitated this? How did they negotiate political space for action?</li> </ul>
Actors, roles and responsibilities	Understanding the role of domestic private and not-for-profit actors and associations in the sector	<ul style="list-style-type: none"> <li>• We know that private and not-for-profit providers have an important role in health service delivery in Lebanon, but exactly who are they and how has conflict shaped (or otherwise) the evolution of their service approaches?</li> <li>• What role, if any, has organised labour played in shaping health policy in Lebanon?</li> </ul>
	Understanding the role of mass media in shaping health policy formulation and implementation	<ul style="list-style-type: none"> <li>• How have the influence of mass media outlets, and new social media outlets, shaped prioritisation of health policy issues and influenced policy implementation in Lebanon?</li> <li>• How – if at all – have mass media and in particular social media outputs influenced the domestic humanitarian response to the Syria crisis?</li> </ul>
	Understanding the role of multinationals and corporate interests	<ul style="list-style-type: none"> <li>• What influence do corporate interests have in determining health policy and decision-making in Lebanon, for example in relation to dietary risks? Do periods of stability/conflict modulate (or even amplify) this influence?</li> </ul>

	Understanding the role of donors and other international actors	<ul style="list-style-type: none"> <li>• What role have regional actors (in particular the Gulf States and Iran) played as donors for humanitarian response and health sector reconstruction and recovery in Lebanon during and after conflict? Proportionately how much aid have they provided? What are the channels by which this has been distributed in Lebanon, and to whom?</li> <li>• What role have international financial institutions played in determining policy priorities in the health sector? How – if at all – has this changed in response to conflict?</li> </ul>
Power relations, bargaining, and rent-seeking	Determinants of the distribution of health spending	<ul style="list-style-type: none"> <li>• How are decisions in the Ministry of Finance made on the allocation of funds across public spending areas in Lebanon? What role does MoPH (and indeed other health actors) have in this process?</li> <li>• What approaches or considerations govern allocation of financial resources to local level in the health sector?</li> <li>• What is the relation between confessionalism and clientelism, and the allocation of financial resources to local level in the health sector?</li> </ul>
	Incentives and disincentives for policy change	<ul style="list-style-type: none"> <li>• How and why did incentives for key actors in mental health change to open a window for the development and implementation of the Mental Health Strategy in 2014/15?</li> <li>• How and why did incentives for key actors change to give rise to the LCRP? What factors explain the delay in developing an official response to the humanitarian crisis?</li> </ul>
	Voice and marginalisation	<ul style="list-style-type: none"> <li>• How do people in Lebanon perceive the health financing system and its role? Do attitudes differ between population groups (in particular among those displaced by conflict) and if so how?</li> <li>• What can we say about public perceptions of priorities for change in the health domain, and how these differ between population groups?</li> </ul>
	Incentives and disincentives to collective action	<ul style="list-style-type: none"> <li>• What can we say about power relations between government ministries involved in decision-making on matters affecting health? Has this changed in discernible ways during times of conflict?</li> <li>• How effectively do current governance arrangements within the humanitarian response manage health service provision, and what are the key disincentives to collective action in Lebanon?</li> </ul>
Decision-making	Priority-setting, procurement and use of evidence	<ul style="list-style-type: none"> <li>• How are decisions made (in the MOPH and elsewhere) on how to prioritise spending on health?</li> <li>• What role does evidence play in this process, and at what stage(s)? Who provides this evidence and in what form?</li> <li>• What are the links between MOPH, MOSA and the Treasury?</li> <li>• What influence do Treasury officials have in health policy?</li> </ul>
	Relations between centre and the periphery	<ul style="list-style-type: none"> <li>• How have informal health providers serving Syrian refugees in Lebanon created an operating space for themselves since 2011? By what local bargaining processes has this occurred, and through access to which funding streams?</li> </ul>

Implementation	Better understanding barriers to effective implementation	<ul style="list-style-type: none"> <li>• What strategies do policy implementation bodies use to mitigate the political and economic costs associated with policy transitions (i.e. dealing with “losers” from the policymaking process)?</li> </ul>
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*Table 6. Indicative list of research questions by theme for potential onward investigation (again indicative rather than comprehensive)*



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## Appendices

### Appendix 1: subsidiary PEA questions

<i>PEA domain</i>	<i>Questions</i>
<b>Roles and responsibilities</b>	Who are the key stakeholders in the sector? What are the formal/informal roles and mandates of different players? What is the balance between central/local authorities in provision of services?
<b>Ownership Structure and Financing</b>	What is the balance between public and private ownership? How is the sector financed (e.g. public/private partnerships, user fees, taxes, donor support)?
<b>Power Relations</b>	To what extent is power vested in the hands of specific individuals/groups? How do different interest groups outside government (e.g. private sector, NGOs, consumer groups, the media) seek to influence policy?
<b>Historical legacies</b>	What is the past history of the sector, including previous reform initiatives? How does this influence current stakeholder perceptions?
<b>Corruption and rent-seeking</b>	Is there significant corruption and rent-seeking in the sector? Where is this most prevalent (e.g. at point of delivery; procurement; allocation of jobs)? Who benefits most from this? How is patronage being used?
<b>Service Delivery</b>	Who are the primary beneficiaries of service-delivery? Are particular social, regional or ethnic groups included/excluded? Are subsidies provided, and which groups benefit most from these?
<b>Ideologies and Values</b>	What are the dominant ideologies and values which shape views around the sector? To what extent may these serve to constrain change?
<b>Decision-Making</b>	How are decisions made within the sector? Who is party to these decision-making processes?
<b>Implementation Issues</b>	Once made, are decisions implemented? Where are the key bottlenecks in the system? Is failure to implement due to lack of capacity or other political-economy reasons?
<b>Potential for Reform</b>	Who are likely to be the “winners” and “losers” from particular reforms? Are there any key reform champions within the sector? Who is likely to resist reforms and why? Are there “second best” reforms which might overcome this opposition?

## Appendix 2: literature search approach

### Literature types and sources:

- Peer reviewed: Ovid, PubMed, EMR regional literature database held by WHO
- Grey literature: OpenGrey, EIdis, Humanitarian Info, Reliefweb
- Government: Lebanese ministries of health, social affairs
- Donors/agencies: the World Bank, UN agencies (UNICEF, UNDP, UNHCR, ILO), major bilateral donors (to include USAID, DFID and others)
- Civil society: key civil society actors in each context
- Books: held by Googlebooks

### Languages:

English, Arabic, French

### Inclusions and exclusions:

Publications released before 2000 were initially excluded, but in the second round of searches we included material dating back to the end of the Civil War (taking 1989 – the end of active fighting, rather than the Taif Accords – as our cut-off point). We included all peer-reviewed article types (systematic reviews and meta-analyses, reviews, experimental studies, observational studies, commentaries and editorials). Inclusion of grey literature reports and books was based on subjective assessment of relevance of content material to our work.

### Key concepts and keywords used for peer-reviewed literature searches

- Cluster 1 (system/stakeholders): political economy, political economy analysis, policy, public policy, policymaking, policymaker, stakeholder, government, governance, corruption, corrupt, rents, reform, donor, non-governmental organisation, civil society, citizens
- Cluster 2 (sector): health, healthcare, health services, health system, health sector, medicine, health workforce, health worker, healthcare worker, human resources for health, health finance, health financing, medicines, health information, data/health data, health intelligence
- Cluster 3 (context): conflict, war, civil war, humanitarian, crisis, displacement, development, security, aid, foreign aid, overseas development assistance
- Cluster 4 (country): Lebanon, Lebanese, ?Levant (for synthesis work)

Search order for peer-reviewed paper databases was as follows:

1. Cluster 1
2. Cluster 2
3. Cluster 3
4. Cluster 4
5. 1 AND 2



6. 5 AND 3 AND 4
7. Limit 6 to 2000-current, English or Arabic, full text availability only

### Appendix 3: list of stakeholder organisations for interviews

Category	Informant
<b>International Organizations and UN agencies</b>	<b>UN-ESCWA, Beirut.</b> Mandated to advance regional integration and providing advocacy for the region's needs and concerns on the global stage (sectoral policies). I recommend the Economic Development and Integration, Social Development, and Conflict and Governance divisions
	<b>World Bank, Beirut</b>
	<b>WHO, Beirut</b>
<b>Universities</b> Faculties of Economy, Political Sciences and Health	<b>The Lebanese University</b>
	<b>Saint Joseph University</b>
	<b>the American University of Beirut</b>
	<b>the Lebanese American University</b>
<b>Public Institutions</b>	<b>Line Ministries.</b> Ministry of Labor, Ministry of Public Health, Ministry of Finance, Ministry of Social Affairs (political/minister, and executive/DG levels)
	<b>the Higher Council for Privatization</b>
	<b>National Social Security Fund</b>
	<b>the Central Inspection Department (regulatory body)</b>
<b>Monitoring agencies</b>	<b>The Insurance Control Commission.</b> an independent institution, in charge of maintaining an efficient and stable Insurance market and protecting the interest of policyholders and other stakeholders against eventual unfair market practices emanating from entities and persons that fall under its supervisory mandate
	<b>The Lebanese Transparency Association.</b> LTA, which was established in May 1999, is Transparency International (TI)'s Lebanese chapter. It is the first Lebanese NGO that focuses on curbing corruption and promoting the principles of good governance.

<b>Orders/Syndicates</b>	Physicians, Pharmacists, Pharmaceutical Manufacturers, Hospitals, insurance brokers
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