Chapter One

THE CHALLENGING CONTEXT

The Republic of Lebanon, a democratic parliamentarian state, is administratively divided into six provinces (the Mohafazats): Beirut, Mount Lebanon, the North, the Bekaa, the South and Nabatieh. These provinces are further divided into 25 districts (the Qadas). The central administrative power is devolved to the Governor (Mohafez) of each province. Municipalities that are elected by local communities, are the expression of decentralization.

Lebanon's population is estimated around 4 million inhabitants, 80% of which resides in urban areas. The country is witnessing a demographic transition: 28% of the population falls under 15 year of age, and 10% over 60. Demographic studies[1,2] show that the population's annual growth rate is 1.6%, and the total fertility rate is 2.5%. The infant mortality rate is about 28 per 1000 live births, with considerable regional disparities: the lowest (19.6) in Beirut and the highest (48.1) in North Lebanon. Life expectancy at birth is estimated at 71 years (72 for females and 69 for males).

The burden of dependent youth (46%) on the economically active population remains much higher than that of the elderly population (10%).

Table I-1: Demographic Indicators

	Value			Year	Source
Area (sq.km)	10,452				
Population	4,005,000			1997	Households Living Conditions Survey
Urban Pop (%)	80.8			1996	Housing and Population Data Base
Crude Birth Rate (‰)	25			1996	Housing and Population Data Base
Crude Death Rate (‰)	7			1996	Housing and Population Data Base
Pop <15 Y (%)	28			1997	Households Living Conditions Survey
Pop 65 + Y (%)	6.5			1997	Households Living Conditions Survey
Dependency Ratio (%)	62.8			1996	Housing and Population Data Base
TFR (%)	2.5			1996	Estimate from Housing and Population Data Base
Natural Increase Rate (%)	1.8			1996	Idem
Population Growth Rate(%)	1.5			1970-96	Idem
Gross Reproduction Rate	1.464			1996	Lebanon Maternal and Child Health Survey
Differential Mortality		Infant Mortality Rate	Life expectancy At birth	1986-96	IMR : Data from Lebanon Maternal and Child Health Survey e_o : Indirect estimation from Housing and Population Data Base data
	Beirut	19.6	75		
	Mount Leb.	27.6	74		
	North	48.1	69		
	Bekaa	39.8	70		
	South	27.2	73		
	Nabatieh	17.2	71		
	Lebanon	**28**	**71**		

The outbreak of the destructive civil war in 1975 has put an end to the prosperity and economic growth witnessed in Lebanon during the fifties and sixties. This war had a catastrophic impact on both the private and the public sector.

With the end of the war in 1992, meaningful infrastructure rehabilitation was launched in different sectors: electricity, water supply, sanitation and waste disposal, roads, and telecommunications. Big investments were devoted as well, to the construction and rehabilitation of education and health facilities.

Table I-2: Financial Indicators

	1993	1994	1995	1996	1997	1998	1999	2000	2001
GDP (at market prices) billion L.P.	13,122	15,305	18,028	20,417	22,880	24,509	24,872	24,874	25,326
Exchange Rate, L.P./USD (period average)	1,741	1,680	1,621	1,571	1,539	1,516	1507.5	1507.5	1507.5
GDP (at market prices) million of USD	7,537	9,110	11,122	12,996	14,867	16,167	16,496	16,500	16,800
Growth Rate of Real GDP (%)	7.0	8.0	6.5	4.0	4.0	3.0	-0.5	0	1.8
Growth of Nominal GDP (%)	38.0	16.6	17.8	13.2	12.1	7.1	1.5	0	1.8
Budget Deficit (billion L.P.)	1,162	2,963	2,823	3,692	5,409	3,386	3,586	3,318*	
Deficit / GDP (%)	8.86	19.36	15.66	18.10	23.64	13.82	14.4	13.30*	
Net Public Debt / GDP (%)	37.84	52.16	63.07	78.15	95.54	105.13	120.0	127.00*	

Source: - *Lebanon Cooperation Development Report, UNDP 1999 and 2000*
- *Ministry of Finance*
***** *Based on the first semester 2000*

Along with investing in construction, the Government had to maintain recurrent cost of the overstaffed public administration and military forces.

The high cost incurred with these achievements, along with the determination of the Government to maintain low inflation rates and stable currency, have led to important budget deficits and public debts' escalation. In 1998, the net public debt stood at 7.2 million Lebanese Pounds per capita, and debt servicing accounted for 13% of the Gross Domestic Product (GDP). In 2000, the net public debt amounted to 127% of GDP, and is currently estimated at 30 billion USD representing 7500 USD per capita, making the debt service almost equal to total public revenues. The GDP that increased from USD 7,537 million in 1993 to USD 16,167 million in 1998[3], has shown, in real terms, no significant increase since.

Table I-3: Budgetary Resources Indicators (1997)

MOH allocated budget (%)	4.9
MOH expenditure as % of GDP	1.04
Public expenditure on health as % of GDP	2.24
Public expenditure on health as % of total public expenditure	10.5
Annual MOH budget (USD per capita)	46
Total public expenditure on health (USD per capita)	**92**

***Source**: Ministry of Finance, Ministry of Health*

Within this context of economic austerity, the health system should respond to the increasing demand for health services, resulting from the growing need of the growing and aging population, and should also deal with unnecessary demands induced by oversupply of manpower, hospital beds and sophisticated services.

The 1999 figures revealed that 20% of the population above 60 have been hospitalized at least once over a one-year period, and have used ambulatory care at a rate of 6.3 visits per person per year. This is compared to the population mean values of 10.2% for hospitalization and 3.6 visits for ambulatory care[4].

Table I-4: Health suppliers to population and utilization rates

	Value	Year	Source
Physicians (0/000)	22.4	1999	Order of physicians
Dentists (0/000)	10.1	1999	Order of dentists
Pharmacists (0/000)	7.8	1999	Order of pharmacists
Nursing and midwifery personnel (0/000)	10	1997	MOH
Hospital beds (0/000)	26	1999	MOH
PHC centers (0/000)	2.3	1997	MOH
Rate of ambulatory care (per month) (%)	28	1999	NHHEUS
Rate of dental care visits (per 6 months) (%)	16	1999	NHHEUS
Hospitalization rate (per year) (%)	12	1999	NHHEUS

The demographic transition is accompanied by an epidemiological transition: While infectious diseases are still a public health concern, the incidence of non-communicable diseases affecting more and more the poor is increasing. In 1997, the prevalence of diabetes was estimated at 13% of the adult population, and 17.7% of males and 23.1% of females between 30 and 64 years suffered from hypercholesterolemia (≥ 240 mg/dl). In the same age-group, 26% had a systolic blood pressure of 140 mm Hg and above. This percentage exceeded 64% for those aged above 64[5].

The changing epidemiological profile is putting traditional health systems under stress. The double burden of disease requires additional resources and health services adapted to the emerging needs. Conventional curative and preventive ways and means are becoming out-dated in the world of globalization. Unhealthy lifestyles including dietary habits with excessive fatty, sugary and salty food intake, lack of physical activity and smoking, are common risk factors for obesity, diabetes, cardiovascular and cancer diseases. The issue at stake now is human behavior that is conditioned by sophisticated persuasive technologies. This trend can hardly be changed by traditional health programmes, making the integration of marketing techniques to promote healthy lifestyles necessary. This is one example, among many others, showing how the scope of health actions is becoming broader and requires additional expertise.

Providing universal and equitable access to health services with limited financial resources remains a major concern for health authorities. Assessing the burden of disease and the cost effectiveness of interventions has become unavoidable for priority setting, considering the scarcity of resources. Well designed, vertical programmes may achieve targeted objectives yet may lack sustainability, if the overall health system is inefficient.

More emphasis needs to be put on assessing the performance of the health system. The World Health Report 2000[6] could be considered as a starting point for the debate, despite our reservations on data collection, methodology, and cultural issues that are raised in this report[7]. Traditionally, health systems are assessed from two competing perspectives: efficiency and equity. Politicians and policy makers in our country are more concerned by the value of equity. New concepts are emerging and deserve particular attention. The system should be fairly financed and equity should not be considered only in its vertical dimension between different groups defined by age, sex, region or income, but also in its horizontal dimension, i.e. between individuals within the groups. This is a critical issue considering its implication on the design of the social security system. Nevertheless more attention should also be paid to efficiency, starting from the organization of the health system, passing through the different contractual approaches within the system, ending with incentives for quality improvement and cost containment. A health system could hardly be fair if it is not efficient.

The system should respond to the legitimate expectations of the population. This involves a cultural dimension where the patient and the user in general, should be considered as an adult with dignity who knows his/her needs, is able to claim his/her rights, and should be empowered as a consumer. This is a key element to improve quality, rationalize cost, and promote equity.

Facing emerging diseases represents another challenge for the health system. A world wide campaign to fight diseases that have a major human and financial impact has been launched by WHO. A global fund to fight AIDS, Tuberculosis, and Malaria has been put in place. For countries with low prevalence of these

diseases like Lebanon, its is also a challenge to maintain the situation under control.

Military conflicts had a great impact on the population health and on economic growth. Many cases of depression and post traumatic stress syndrome resulting from military violence are still under treatment. On the other hand, the never-ending bloody conflict in neighboring Palestine and threats of war against Iraq necessitate a high level of emergency preparedness.

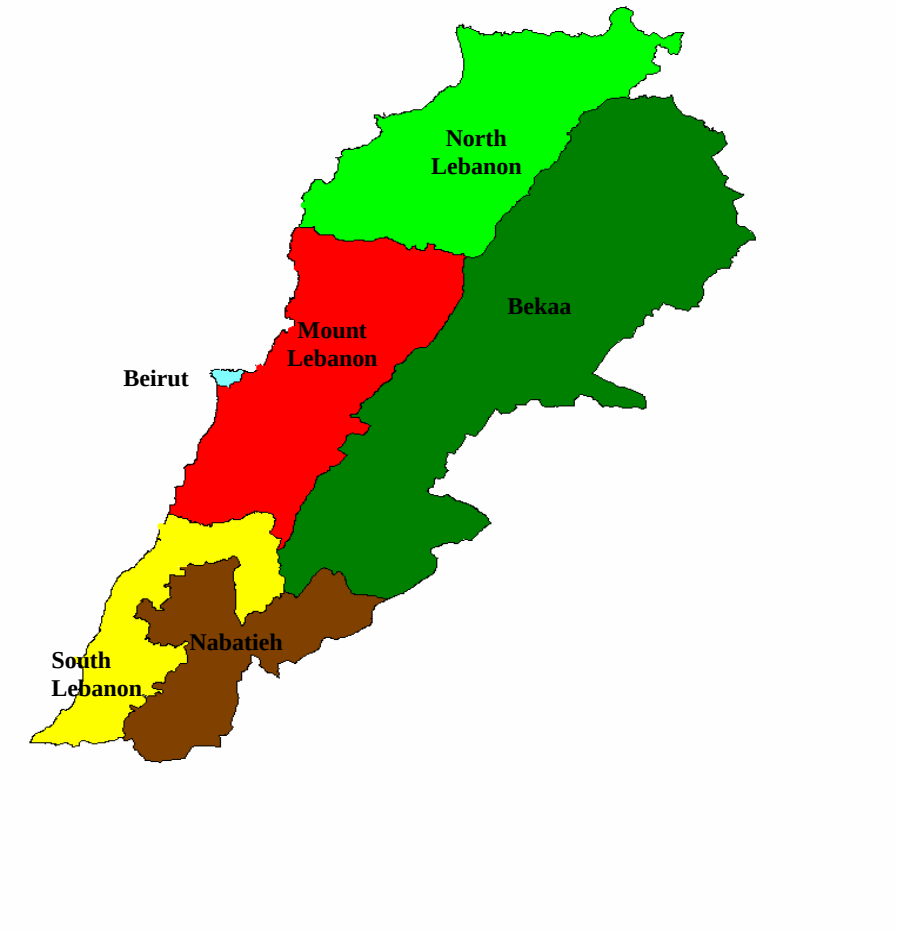
Finally, globalization remains one of the biggest challenges. Major difficulties are encountered in accessing WTO and coping with its regulations. Those are related as we know to goods such as food, drugs and medical equipment, as well as, services including health and health related ones. The TRIPS agreement would have a great impact on the availability and cost of drugs, as well as on the development of the domestic pharmaceutical industry. Like other developing countries, Lebanon has problems meeting the Sanitary and Phytosanitary requirements set by developed countries, while lacking expertise to control imported products. Contamination by aflatoxin and dioxin and the mad cow disease are few recent examples, and similar events may constitute a threat to the health of our citizens in the future.

Most of these challenges are not specific to Lebanon and are shared internationally. This implies not only exchanging experiences with other countries but also assuming responsibility vis-à-vis those global partners.

The link between poverty and ill-health is arousing much interest and debate in the international community. The WHO Commission on Macroeconomics and Health provided evidence that this link is functioning in both directions. In its recent report, it stresses the importance of investing in health to promote economic development and reduce poverty. It states that the world should initiate a partnership of rich and poor to prove that globalization can work to the benefit of all humankind[8].

Donors strategies should be revisited worldwide, and bilateral cooperation between countries should look beyond the projects of construction and physical rehabilitation. In some countries such as Lebanon, protection of individuals from impoverishment to which they are exposed in reimbursing health services, arise as a major challenge in this period of economic austerity. Reforming the health financing system from this perspective, is becoming a priority, along with strengthening primary health care (PHC) services.

ADMINISTRATIVE PROVINCES (MOHAFAZATS) IN LEBANON



REFERENCES

1- Households Living Conditions, Central Administration of Statistics,1997.

2- Housing and Population Database, Ministry of Social Affaires, 1996.

3- Banque du Liban -Quarterly Bulletin, Fourth Quarter 1998.

4- National Household Health Expenditures and Utilization Survey 1998-1999

5- Salti, I et al. Epidemiology of Cardiovascular Risk Factors Among Adult Lebanese Population. Lebanese Technical Reports. Lebanese National Council for Scientific Research, 1998.

6- Health Systems: Improving Performance. The World Health Report 2000. WHO, Geneva 2000.

7- Report of the Scientific Peer Review Group on Health Systems Performance Assessment. WHO, Geneva 2002.

8- Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. WHO, Geneva 2001.