REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

World Health Organization
Lebanon

Lebanon National Health Strategy: Vision 2030

Out of the crisis and towards **better health for all**

Delegation of the European Union to Lebanon

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Vision 2030

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Foreword

Lebanon is passing through one of the most severe and complex crises in its recent history. The synergistic effects of a political deadlock, fiscal crisis, economic meltdown and social instability amplified the effects of pre-existing health system inefficiencies, including the predominance of tertiary care over preventive, promotive and primary care; a weakened public health sector; a pluralistic financing system; and supply-induced demand with unsustainable and unrealistic expectations.

Meanwhile, widespread poverty, deteriorating living conditions, health care workforce brain drain, and dwindling and inadequate access to quality care threaten the health of thousands of the Lebanese, migrant and refugee populations. This has rendered radical reforms of the health sector a necessity and the adoption of an innovative health strategy an inevitability.

The Lebanese Ministry of Public Health and the World Health Organization took the initiative to construct a national health sector strategy. Through setting an implementation plan responsive to the immediate health needs as well as longer term objectives, Vision 2030 sets out the framework for a sustained and modernized recovery of the health sector and addresses the challenges of leading a burned-out health system.

The desired restructuring of the health sector requires the endorsement of relevant stakeholders and a high-level political will. Therefore, this strategy was designed through a collaborative and consultative process involving high-level experts. Through this strategy, and under the leadership of the Ministry of Public Health, the different partners of the health sector can jointly respond to the escalating unmet health needs and participate in building a stronger, more resilient health system.

Minister of Public Health

Dr. Firass Abiad

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Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANSM	L'Agence Nationale de Sécurité du Médicament et des Produits de Santé (National Agency for the Safety of Medicines and Health Products)
CBRN	Chemical, Biological, Radiological, and Nuclear
COVID-19	Coronavirus disease 2019
DHIS2	District Health Information system Software
EFS	French Blood Agency
EPI	expanded programme on immunization
EPU	Emergency Preparedness Unit
ESCWA	Economic and Social Commission for Western Asia
ESU	Epidemiological Surveillance Unit
GDP	Gross Domestic Product
GGM	WHO Good Governance for Medicines Programme
GMP	Good Manufacturing Practices
GOARN	Global Outbreak Alert and Response Network
HAS	Haute Autorité de santé (High Authority for Health)
HIMU	Health Information Management Unit
HIV	Human Immunodeficiency Virus
ICT	Information and Communications Technology
IHR	International Health Regulations
JCD	Jeunesse Contre la Drogue
JEE	Joint External Evaluation
LDA	Lebanese Drug Administration
MDG	Millennium Development Goals
MediPIET	Mediterranean and Black Sea Programme for intervention Epidemiology Training
MFE	Mutuelle des Fonctionnaires de L'état
mhGAP	WHO Mental Health Gap Action Programme
NCPR&PC	National Committee for Pain Relief and Palliative Care
NCR	National Cancer Registry
NGO	Non-Governmental Organization
NHA	National Health Accounts
NPTP	National Poverty Targeting Programme
NSSF	National Social Security Fund
PCR	Polymerase Chain Reaction
PM2.5	Particulate Matter less than 2.5 µm in diameter
PM10	Particulate Matter less than 10 µm in diameter
SAMU	Service d'Aide Médicale Urgente
SDG	Sustainable Development Goals
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USJ	Université Saint-Joseph de Beyrouth
VHSD	Vital and Health Statistics Department
WHO	World Health Organization
YMCA	Young Men's Christian Association

Introduction and background

Lebanon in crisis

Lebanon, known for its long-term political instability, has endured for the past three decades a series of crises, including wars, assassinations, government deadlocks, economic distress and migration. In 2011, the country witnessed a massive influx of Syrian refugees, who now represent 30 per cent of its population. All of these crises impacted the Lebanese economy and infrastructure, including increased demand on the health system.

Yet, the health system continued to show resilience.

During the last two years, the county was hit by multiple and compounded crises, including a financial and economic meltdown, political deadlock, the coronavirus disease (COVID-19) pandemic and the Beirut Port explosion. These resulted in high inflation and increasing unemployment and poverty rates, and seriously affected the operation of public and private institutions. The extremely strained health system is becoming unable to cope and is under threat of collapse. In addition, Lebanon started to lose gains made throughout the past two decades across health outcomes and the Sustainable Development Goals (SDGs).

The severe economic downturn, considered to be historically the third worst globally since the mid-nineteenth century, resulted in nationwide shortages of fuel, water and electricity, which severely impacted all aspects of life and different sectors, including health, education, water, energy and nutrition. This has affected almost the entire population, with the result that most people are at or below the poverty line. Since 2019, the Lebanese' currency has lost more than 90 per cent of its value. According to the Economic and Social Commission for Western Asia (ESCWA), 82 per cent of households in Lebanon live in multidimensional poverty,[1] and 40 per cent are classified as suffering from extreme multidimensional poverty.

The economic crisis also had a direct impact on all six building blocks (governance, health services, human resources, information systems, medical products and technologies, and health financing) of the Lebanese health system. It caused migration of highly skilled health care workers; insufficient financing; shortages in medicines, medical supplies and vaccines; and degradation of service delivery at all levels. Consequently, an observed decrease in availability, affordability, accessibility and quality of health care is witnessed with people delaying seeking health care, and resorting to other treatment options that might result in complications that could have been avoided. Thus, the current crisis is having a major impact on population health and communities. At this stage, a comprehensive vision to address the impact of the acute crisis in the health system, and a development plan for sustainability, are required.

The moment for a National Health Strategy: Vision 2030

The Lebanese Ministry of Public Health, with the support of World Health Organization (WHO) developed the Lebanon National Health Strategy: Vision 2030 to inform and guide not only the work of the Ministry, but the sector as a whole, within the context of the prevailing complex crisis. It is worth mentioning that the Ministry had a strategic plan for its work, set for 2016–2020, which was specific to its functions. The Lebanon National Health Strategy will provide a broader scope to the health sector as a whole and not limited to the Ministry.

The intended strategy aims to provide policy options for redesigning the health system in Lebanon to ensure equitable access to quality, people-centred, essential health care services.

The framework aims to provide financial risk protection and efficient use of both public and private resources allocated to health, while setting priorities for the short, medium and long term. The new strategy needs to be endorsed by the Government and is intended as a starting point for restructuring the health system in Lebanon to become more equitable and resilient, absorb shocks and sustain its progress to meet global targets. The framework is proposing strategic directions, strategic goals and strategic objectives to be considered concomitantly to serve this purpose.

[1] Multidimensional poverty **tracks deprivation across** education, health, public utilities, housing, assets and property, employment and income.

Lebanon National Health Strategy

The National Health Strategy integrates the WHO “building blocks” and “essential public health functions” frameworks, and also incorporates SDGs and global priorities, in particular universal health coverage and health security.

The proposed framework that guided the situation analysis to develop the strategy included seven components: governance, financing protection and universal health coverage, health service delivery, health security, health promotion and disease prevention, health workforce and health information system. These components have 31 pillars in total, which are summarized in figure 1. The framework was followed to conduct the sector overview..

The strategy is meant to target the whole health sector, including the Ministry of Public Health, public and private institutions, and all stakeholders.

The sector overview components are presented separately in the framework for conceptual clarity. It is worth noting that the components, pillars and subpillars are interrelated, and some will be addressed jointly in the strategic directions and strategic goals section.

Development of the Lebanon National Health Strategy, strategic directions, goals, and objectives:

Under the leadership of the Ministry of Public Health, the Lebanon health sector strategy was developed by a team of national and international experts, in addition to the WHO Eastern Mediterranean Regional Office team and United Nations health partners. The development process of the strategy followed a stepwise, inclusive, and participatory approach, and involved different stakeholders using different channels of engagement (discussion groups, in-depth interviews, policy dialogues), at different stages of the strategy development, with the aim of reaching agreement on priorities and proposed solutions. Details of the development process of this strategy are found in **annex 1**.

One patient group was consulted, and two non-governmental organizations (NGOs) were involved in the process. We acknowledge that a broader consultation was needed but this was not possible due to time limitations. Once this strategy document is validated by the Ministry of Public Health, we advise publishing it to seek feedback from the public, professionals and stakeholders from different sectors before final endorsement.

The strategy sets immediate actions for relief, and five strategic directions for sector recovery, under which it lists 24 strategic goals and 82 strategic objectives.

Several components and pillars of the sector overview were merged in the strategic directions/goals and objectives as they are interlinked. All set objectives are critical and deserve immediate attention although their achievement is set for a short-, medium- or long-term basis. This “strategic framework” might be perceived as too long and complicated to follow in a complex environment like Lebanon; nevertheless, given the opportunity for reform in the middle of the crisis, we opted to list all areas of work that need to be improved in the health sector.

Figure 1. Health Sector Overview Framework

1.	2.	3.	4.	5.	6.	7.
Governance	**Financial protection and UHC**	**Health service delivery**	**Health security**	**Health promotion and disease prevention**	**Health workforce**	**Health information system**
1.1 leadership and collaborative governance **1.2 Transparency and accountability** **1.3 Regulations** 1.3.1 Health professions 1.3.2 Health institutions 1.3.3 Medical products 1.3.4 Health services **1.4 The Ministry of Public Health** 1.4.1 Organisational structure and human resources 1.4.2 MOPH decentralised units 1.4.3 Public hospitals autonomy **1.5 Normative functions** 1.5.1 Accreditation 1.5.2 Code of ethics 1.5.3 Blood safety	**2.1 Health financing fragmentation vs. diversity:** 2.1.1 Financing agencies 2.1.2 Governance fragmentation of health financing 2.1.3 The NSSF voluntary scheme and financial sustainability **2.2 Institulional arrangements and public-private partnership** **2.3 Health benefits** **2.4 The Lebanese health coverage schemes** **2.5 National health accounts**	**3.1 Outpatient care:** 3.1.1 Primary health care 3.1.2 Private ambulatory care **3.2 Secondary and tertiary care:** 3.2.1 Private provision 3.2.2 Public provision **3.3 Palliative care**	**4.1 Prepardness and response** **4.2 IHR and Joint Extemal Evaluation** **4.3 Functions of department of preventive medicine and communicable disease** **4.4 Epidemiological surveillance program** **4.5 Interministerial overlapping/ coordination** **4.6 Reducing vulnerability to health threats at individual and collective levels** **4.7 Investing in health emergencyand disaster risk management (HEDRM)**	**5.1 Ministry of Health various programmes** 5.1.1 Tuberculosis programme 5.1.2 National AIDS programme 5.1.3 sexual and reproductive health programme 5.1.4 Mental health programme 5.1.5 Expanded programme on immunization **5.2 Health literacy** **5.3 Best buys and NCDs control and management** **5.4 Elderly heatth programme**	**6.1 A situation seriously impacted by the financial meltdown** **6.2 Develop HR retention and production strategy** **6.3 Need for coordination**	**7.1 Administrative information systems:** 7.1.1 Transactions and workflow managememt system 7.1.2 Pharmaceuticals 7.1.3 MOPH website and mobile applications **7.2 Public health information systems:** 7.2.1 Vital and health statistics 7.2.2 Epidemiological surveillance information system 7.2.3 Patient safety indicators **7.3 Health services information systems** **7.4 Health coverage Information system: The unified database on public funds beneficiaries** **7.5 Health information system assessment and recommendations** **7.6 National e-health program**

Abbreviations: IHR, international health regulations; NCDs, non-communicable diseases.

1. Health sector at a glance

A. Pre-2020 health system characteristics

1. Pre-2020 health system characteristics

On the other hand, the decentralized units and public hospital of the Ministry of Public Health are all lacking qualified human resources, office space and equipment. The poor capacity seriously limits the leadership and regulatory role of the Ministry. As a result of the government decision on freezing recruitment in public institutions, important posts at the Ministry remain vacant. However, this has not prevented recruiting, based on “exceptional” Council of Ministers decisions, politically selected staff to fill certain vacancies, within the context of clientelism and benefit sharing among political and confessional factions.

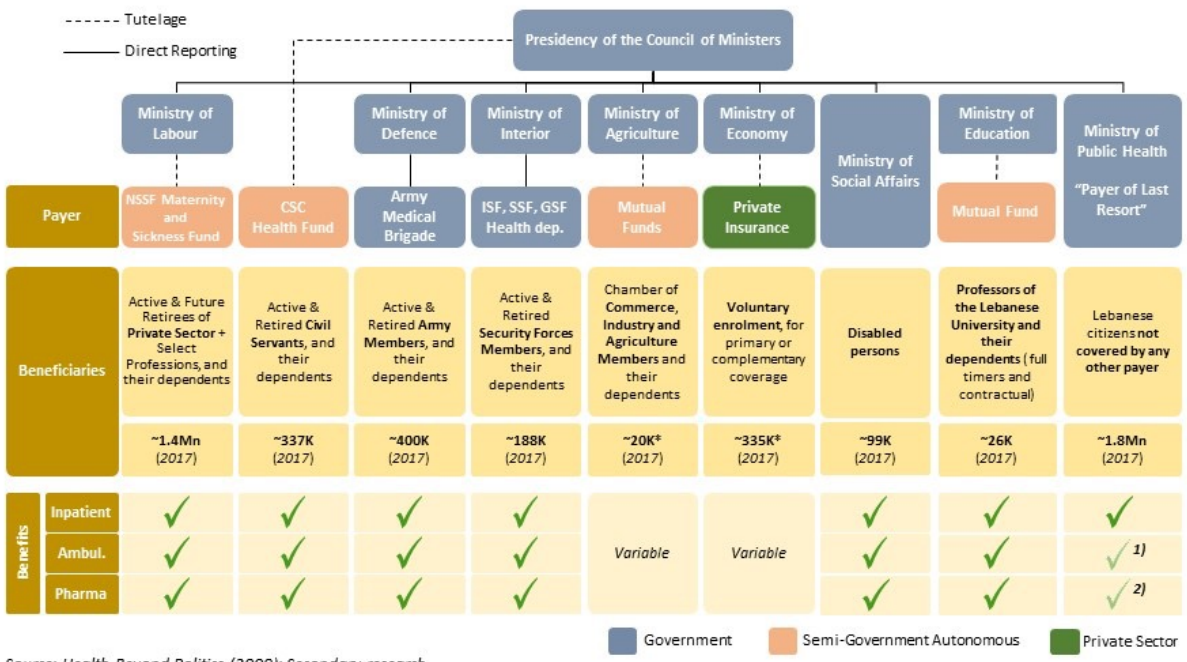
The health protection is characterized by the multiplicity of public funds, which are supervised by seven different authorities other than the Ministry of Public Health (figure 2). Therefore, in addition to financing diversity, the fragmentation of the governance of health coverage has been a major issue. Moreover, private insurance covers around 12 per cent of the population. Citizens not enrolled in any of the existing insurance schemes are eligible for the coverage under the Ministry of Public Health, which is considered an insurer of last resort; this coverage contributes thus to universal health coverage, and ensures affordable options for patients, although legislation making insurance mandatory for all residents is still lacking.

This fragmentation created vulnerability due to the persistence of silos in purchasing of health care along the different funding streams and packages provided (see figure 2). Although these silos segment the population according to the funding stream, the fragmentation of financing is not as such the problem – it has at times even offered welcome tactical flexibility – but it does mean that the package of benefits differs for each population segment. The Ministry of Public Health, for example, which covers hospital care and expensive treatment and supports a network of primary health care centres with vaccines and acute and chronic medications, does not reimburse outpatient diagnostic procedures and specialized care beyond the primary health care centres, which represents an important gap in coverage. This leads to unnecessary hospitalization on the account of the Ministry just to perform diagnostic tests. the Ministry is currently playing the role of coordinator for the primary health care centres network rather than that of the actual implementer, whereas international donors and non-governmental organizations are subsidizing primary health care services, including consultation fees, and supporting hosting communities as a response to the Syrian refugee crisis.

In addition, different purchasers negotiate separate arrangements with the providers of their constituents. These arrangements may include unsustainable components and often rely heavily on fee-for-service payments against itemized bills. The way each purchaser uses – or fails to use – its financial leverage for more sound priority setting, improved equity or better quality of care varies considerably from one to the other. In terms of population outcomes and health system efficiency, this not only translates to inequalities, but also to missed opportunities to get optimal value for money.

Nonetheless, the creation of a unified public fund beneficiaries database, and the institutionalization of the national health accounts (NHAs), were instrumental to overcoming the fragmented governance of health coverage, allowing the Ministry to see the global picture of health utilization and spending. This also led to the elimination of coverage duplications and double billing, and facilitated access to health care by by-passing complex administrative procedures. However, the limited capacity of the Ministry and its lack of authority over the other public funds remained a major challenge for coherent and effective policies and thus it is important to redefine the role of the Ministry of Public Health in the implementation phase of this strategy and to establish institutionalized coordination mechanisms among public funds.

Figure 2. Multiplicity of health care public payers



Source: Health Beyond Politics (2009); Secondary research.
1) Covers only primary care through PHCs.
2) Covers essential and expensive meds only excluding Pharmaceuticals meds.
*Note *: Only beneficiaries relying solely of these payers as primary coverage were accounted for.*

Eid, F. (2019, unpublished). MOPH Universal Health Coverage Reforms, Retrospective Analysis. WHO.

Note: Mutual fund for judges is not included in this figure.

Out-of-pocket costs are not reflected in this figure.

There is also a parallel scheme by UNHCR and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), which covers the Syrian and Palestinian refugees, that is not reflected in the figure.

Box 1 Pre-crisis gaps and challenges

Other chronic gaps and challenges in the system before the crisis included:

- Weak Ministry ability to effectively regulate and provide essential public health functions.
- The outdated organizational structure of the Ministry and lack of adequate number of qualified human resources.
- The absence of relicensing requirements for health professionals or health facilities.
- Absence of strategies to orient the workforce towards needed specialties or rationalizing the number and distribution of health care facilities.
- Lack of gatekeeping to use specialized and hospital services.
- Fragmentation of the health information system and the absence of a comprehensive national electronic health (e-health) strategy.
- Lack of accreditation standards for ambulatory health care facilities, including diagnostic centres and health care accreditation programmes.
- Irrational allocation of financial ceilings for hospitals, subject to the political preferences
- Overconsumption of branded pharmaceuticals, and resistance towards using generics.
- Overlapping of responsibilities related to food and water safety and other public health functions with other ministries, and the inefficient implementation of the One Health approach.
- Absence of systemic reviews of marketed drugs to renew/withdraw the registration according to population health needs.
- High out-of-pocket costs, which remained a heavy burden on households, despite the pre-crisis efforts leading to decrease it to around 33 per cent of total health expenditure.
- Individuals' (public and professionals) behaviour towards curative care with little attention to health promotion and prevention.

Box 2 The Lebanese health coverage paradox

The paradox of the health system in Lebanon is the existence of universal coverage for tertiary care and such sophisticated treatments as open heart and joint replacement surgeries and expensive cancer patient drugs, whereas, paradoxically, preventive care, palliative care and primary health care services are underfunded and not universally covered.

While there are no waiting lists for expensive, advanced surgeries, health promotion is very weak and palliative care is not widely available.

Although good quality vaccines are widely available for free in primary health care centres and dispensaries, many children, usually seeking private clinics, are not vaccinated or have their vaccination delayed because of shortages in the market, which became frequent during the last two years due to the economic crisis.

Also, while generic drugs for chronic disease are made available through the primary health care network, many patients struggle to purchase branded drugs prescribed by their trusted physician from pharmacies.

The poor capacity and limited authority of the Ministry of Public Health following the civil war (1975–1989) were major impediments to regulating a powerful private sector. To deal with this issue the Ministry started, in the mid-1990s, to seek agreement and compromise through a collaborative governance approach on the one hand and using its financing role to steer the health system and achieve national objectives on the other. Although efficiency gains were documented in terms of cost containment and performance contracting, supplier-induced demand remained a major issue.

In the years leading up to the current crisis, the Ministry emerged as the key regulatory institution. It was the driver of initiatives that infused the sector with a sense of purpose and a concern for equity. Its regulatory capacity improved over time, within the limits imposed by political volatility and lack of budgetary visibility. Key in building governance authority was the smart and nimble use of strategic intelligence and reliable, factual information. This allowed the Ministry to develop a portfolio of technical reforms and make effective use of its financial leverage. As purchaser of 30 per cent of the country's volume of hospital care, and with a key role in the circuit of expensive and life-saving medicines, the Ministry used its financial leverage to rationalize the purchase of hospital services. Bit by bit, a portfolio of regulatory activities was constituted, which included the autonomy of public hospitals, quality improvement through accreditation and contracting incentives, utilization of review, third-party administration, value-based hospital contracting, automated district health information system software (DHIS2) surveillance and barcoding of medicines.

For ambulatory care, the Ministry did not have the means to deploy financial incentives and disincentives, so much of the service offer remained unregulated. Yet, in the primary health care network run by NGOs and municipalities, the Ministry and its allies did manage to rationalize packages of ambulatory care benefits.

2. Better health with improved efficiency despite the chronic gaps

Health outcomes in Lebanon improved considerably since the beginning of the century, along with notable advances in health system efficiency.

Lebanon recorded improved population health indicators and was one of the few countries in the world to achieve the fourth and fifth Millennium Development Goals. The maternal mortality ratio had dropped from 104 per 100,000 live births in 2000 to 16 in 2012 (among the fastest reductions worldwide), and under-5 child mortality was reduced from 35 to 8 per 1,000 births in the same period. Meanwhile, 5.1 years were added to life expectancy at birth by 2015, making life expectancy 79.3 years, 11 years above the regional average and 5 years above that of the world's middle-income countries. The country ranked in the world's top quintile for a number of comparative health outcomes indexes such as those of The Economist or Bloomberg. It scored thirty-first out of 195 countries for the Health Care Access and Quality index.[2]

More recently, and relying on donor support, Lebanon was able to respond to the COVID-19 pandemic.

The proactive and information-driven efforts of the Ministry and its allies played no small role in obtaining an acceptable response to the pandemic.

[2] GBD 2016 Healthcare Access and Quality Collaborators. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016 (Lancet 2018; 391: 2236–71), http://dx.doi.org/10.1016/S0140-6736(18)30994-2.

The health gains were the result of many initiatives like (but not limited to) the set-up of a primary health care network in partnership with NGOs and municipalities, and the establishment of the autonomy of public hospitals and the accreditation of hospitals and primary health care centres. The Ministry modernized public purchasing of care with value-based contracting, electronic prior authorization for hospital admission (known as the visa system) and a unified database of beneficiaries, and its investments in the supply chain of pharmaceuticals and medical products and subsidization of essential drugs in the primary health care network significantly brought down the out-of-pocket cost of medicines.

The production of strategic intelligence used to be a critical source of strength in guiding policy formation and system management in Lebanon.

B. Impact of the crisis on the health system components and population health

1. Governance

Lebanon is going through a severe governance crisis in all sectors. In the health sector, the limited regulatory capacity of the Ministry of Public Health is worsened by a high turnover of senior management and a progressive shrinking of the human resources at central and peripheral levels. Moreover, the Ministry is handicapped by an obsolete organigram (for example, it lacks a unit to deal with non-communicable diseases, or emergency preparedness and response, or health technology assessments). Similarly, the governance of public hospitals, where confessional and political power sharing arrangements trump technical and managerial considerations, is particularly vulnerable.

The crises have put the brakes on regulatory and legislative efforts of the Ministry and other stakeholders. Legislative initiatives – on universal health coverage, tobacco taxation and international health regulations – are frozen. Initiatives on drug substitution, electronic medical prescription and tracking of barcoded medicines appear to have stalled despite Ministry efforts to keep them on track. Many of the consultative committees that bring together public, private and academic expertise to support decisions, such as the accreditation committee, the primary health care committee and drugs registration subcommittees, are grinding to a halt. Of particular concern is the lack of progress with the electronic medical record programme, which needs legislation to be standardized and regulation capability to ensure its proper implementation. Without an electronic medical record system, it is not possible to transform the current health care system into a modern, people-centred one able to respond to people's health needs and legitimate expectations, while reducing duplication and over-utilization, and focusing on monitoring quality of care and health outcomes.

On the other hand, the recent financial crisis has impacted all health institutions and threatens the continuity of many normative programmes, including accreditation of hospitals and primary health care centres. Hospitals severely affected by the tremendous local currency devaluation are aiming to attract clientele from abroad, to generate desperately needed hard currency. However, this could hardly be achieved without investing in quality, hence the danger of discontinuing the accreditation programme.

The restricted ability of the Government to regulate the highly privatized sector and the recently invigorated NGO sector, as well as the limited spending on the public sector's workforce, greatly hinder the health system's efficiency and service quality.

A national health care quality policy and strategy is needed to support such policy levers for quality improvement as accreditation and clinical governance.

2. Health financing and universal health coverage

Lebanon is committed to achieving universal health coverage by 2030 and has made significant progress in promoting coverage, equitable access to health care services, and financial protection, in particular for the most vulnerable populations. However, the current economic crisis necessitates a recalculation of the health financing and spending due to the fluctuating health and economic sectors. The overall Ministry of Public Health budget for 2018 was 729 billion LL which, at that time, was equivalent to $485.9 million but is now equivalent to less than $37 million. This holds true to other public funds, including the National Social Security Fund (NSSF), Civil Servants' Cooperative and armed forces.

The pharmaceutical sector was estimated at $1.2 billion per year with local production not exceeding 8 per cent of market share up to 2019. Although this share has been increasing with a growth estimated by around 32 per cent in 2021, the sector remains vulnerable and dependent on foreign currency. Also, the 2020 lifting of governmental subsidies on drugs and medical supplies caused a severe shortage in pharmaceutical products. There is a critical need for the Ministry to enhance local manufacturing, to safeguard funding for medications for chronic disease and other conditions exposing households to catastrophic spending and to ensure the market availability of medicines and medical supplies needed for hospital use.

Before 2020, total health expenditure made up 7.8 per cent of the gross domestic product (GDP). Almost 47.6 per cent of the health expenditure came from the Government and compulsory insurance schemes, whereas 52.4 per cent came from private voluntary schemes and out-of-pocket payments. The out-of-pocket expenditure, estimated at 33 per cent of total health expenditure in 2017, was considered high and in need of further decrease. It has, however, considerably increased since 2020, along with the local currency devaluation, and represents a major challenge, in particular in time of economic and financial crises seriously affecting household purchasing power. In 2017, almost 52.5 per cent of total health expenditure was spent on curative and rehabilitative services, 27.2 per cent on medical supplies, 4.6 per cent on ancillary services, 8.7 per cent on the administration of health and 7.1 per cent on other various services.

In addition, the situation of the different public funds is rapidly deteriorating, for several reasons. First, in the current monetary context their purchasing power has suffered an 80-90 per cent cut, while their sources of funding – particularly of government revenue and social security contributions – are drying up. Second, long delays in government reimbursement to public funds caused delays in paying the hospitals, which caused the debts to lose their real value due to decrease of local currency exchange rates. Third, rising unemployment implies a reconfiguration of the public funds' constituencies, with a shift from the social security segment to that covered by the Ministry of Public Health as insurer of last resort (the Ministry segment is expected to grow from 48–52 per cent of the population to 70–75 per cent). Fourth, the governance of the health sector is becoming even more complex.

Fragile purchasing payers intersect with new prepayment and community insurance initiatives. The number and weight of donor-funded projects multiplies, with the agendas of external technical agencies newly prominent. The health sector is increasingly dependent on financial donors, including international and local NGOs. Most of the local actors are politically affiliated and are major providers of primary health care services. Public funds and private insurers do not contract primary health care centres and rely instead on private providers, which makes the primary health care network dependent on the in-kind support of the Ministry, household out-of-pocket payments and subsidies from international NGOs when and where available.

For example, in 2021 the Ministry established the donor-funded ong-term primary care subsidized protocol, which provides the most vulnerable populations with primary health care packages addressing prevention, maternal and child health, non-communicable diseases, communicable diseases, disability care and psychosocial support. This package of services is totally funded by the international community and implemented in a limited number of NGO-supported primary health care centres.

All this adds to the political complexity of sector governance and the multiplicity of decision-making centres.

The unpredictability of the budgetary space, a chronic source of destabilization of the management of public funds in pre-crisis years, is likely to get worse before it gets better. It will require solutions for the debts of the past and political commitment to overcoming the legal and organizational challenges of unifying funding streams and negotiating health benefits packages.

3. Health service utilization

The multifaceted crisis has also severely impacted access to and utilization of health care services, the main barriers being financial costs, issues of transport and lack of awareness. Increasing impoverishment and inability to pay constitute real barriers to accessing care, which many households find insurmountable. Currently, many Lebanese no longer have the resources to pay for health care. The speed of this deterioration is accelerating; in just six months the share of households having difficulty accessing health care rose from 25 per cent (July – August 2020) to 36 per cent (November – December 2020). Hospitalizations, particularly for surgeries, diminished by 30 per cent in 2021 and the average hospitalization days per month decreased by 25 per cent according to the Syndicate of Hospitals. This fall in utilization of hospital care, in addition to a 90 per cent drop (in real, or fresh, dollars) of third-party reimbursement rates, threaten the continuity of the hospital sector, where most private hospitals have downsized their bed capacity since the beginning of the crisis. Referral to advanced diagnostics is also decreasing as hospitals are operating with around 50 per cent capacity. Excessive

advance payments requested by hospitals from patients seeking emergency services or admissions, represents a big barrier to hospital care and to achieving universal health coverage within the current context.

On the other hand, primary health care centres have seen higher demand for non-communicable disease and acute care services, with more than 220,000 beneficiaries for non-communicable disease medications in 2021 in comparison with 78,000 in 2016 and around 350,000 beneficiaries for acute care, along with an increase in utilization of at least 25 per cent compared with the pre-crisis situation.

Additionally, the 2021 multisector needs assessment survey shows that 45 per cent of Lebanese and 50 per cent of non-Lebanese (Palestinians and migrant workers) who suffer from mental distress do not seek help. This phenomenon is usually explained by the fact that people did not seek care as they did not consider mental health as a health problem. However, other reasons related to aggravated poverty, high cost of services and shortages in medications should not be underestimated. According to the multisector needs assessment, the three main barriers reported by households in the three months prior to data collection that prevented them from accessing health care when needed were not being able to afford the cost of treatment, or the cost of the medical consultation or the transportation to the health facility. Households' coping mechanisms to adjust to the barriers and access health care included going to pharmacies instead of doctors (18 per cent), delaying or cancelling doctors' visits and other diagnostic procedures (27 per cent), switching to public health facilities (12 per cent) or using no coping mechanism at all (40 per cent). If no official measures are taken, timely access to health care will continue to be jeopardized and high percentages of the population will continue experiencing catastrophic health expenses and relying on burdensome coping mechanisms to access health care.

As for medications, the three main barriers experienced by households that prevented them from accessing needed medications included medications being too expensive (75 per cent), medications not being available in private pharmacies (57 per cent) or medications not being available in such health facilities as hospitals or primary health care centres (36 per cent).

According to the Syndicate of Hospitals, 90 per cent of the functional adult intensive care unit beds are occupied and there is an increase in emergency department visits. This is due, among other factors, to acute decompensated heart failure because patients were off diuretics, seizures because patients stopped anti-epileptics, strokes because blood thinners were not available and septic shocks since antibiotics are nowhere to be found.

Even before the crisis, medicines made up 54 per cent of out-of-pocket expenditures of the total health expenditures. In 2020, the government's policy of relying on external sources for medications and medical supplies, coupled with the economic crisis, led to drops in imports, resulting in severe market shortages. This has paved the way to hoarding, smuggling, black market practices, and the entry of illegal, low-quality drugs and supplies into the country. This has also led to the closure of more than 600 of the 4,000 private pharmacies in Lebanon. The inability to pay made people look for more affordable sources of care, including traditional medicine and unsafe practices.

The Ministry of Public Health has used donor funds to safeguard access to critical non-communicable disease medications and vaccines through the primary health care network, and to medications for cancer and catastrophic illness through the central drug warehouse.

However, this represents less than 10 per cent of the total pharmaceutical market in the country. The Ministry encouraged the local pharmaceutical industry to increase its production, which responded successfully, delivering in a sustainable way 37 per cent of the total market volume (in units), with about 72 per cent of the acute over-the-counter and chronic medications.

4. Health security

The recent COVID-19 pandemic showed the importance of strengthening health security in the country.

It highlighted the public sector's limited capacity, the system's **heavy reliance on the private sector** and the latter's lack of willingness to respond. These issues led to reliance on international agency support to hastily expand public hospitals' number of beds, provide **medical supplies**, equipment and **personal protective equipment** and increase staff capacity. Included in the international agency support was the assistance of WHO in preparing the national teams and properly implementing the IHR, which allowed the Rafic Hariri University Hospital to properly accommodate the first wave of COVID-19.

Other public hospitals benefited also from WHO support in many forms during the crisis. The Ministry of Public Health, in collaboration with WHO and the Mediterranean Academy for Learning Health Systems at the Université Saint-Joseph de Beyrouth, came up with an innovative twinning project using the support of the WHO solidarity fund. The project, initiated in 2020, focused on transferring knowledge on COVID-19 case management in intensive care within a framework of twinning public hospitals with private university hospitals through bedside coaching, lectures and trainings. Despite the challenging context, the project succeeded in introducing the culture of quality-of-care monitoring and the establishment of standard operating procedures aiming to harmonize quality of care practices in intensive care units, with gains in quality of care and patient and staff safety.

Nonetheless, the pandemic shifted the routine surveillance activities of the Ministry, impeding its ability to detect other outbreak risks. On the other hand, the COVID-19 vaccination campaign resulted in having a 40 per cent fully vaccinated population within one year of deployment. Vaccine hesitancy and exhaustion of the vaccination centres' capacity constrained the ability of the Ministry to meet the 70 per cent vaccination target set by WHO. The complex crisis also caused a drop in immunization against other diseases due to decreased primary health care operational capacity, low trust in public sector vaccination, and lower purchasing power and scarcity of vaccines in the private market. This was true even though, during the crisis, the Ministry worked with many donors and international organizations to ensure adequate availability of all essential vaccines under the expanded programme on immunization (EPI) with a functional cold chain.

This amplified the risk of outbreaks of vaccine-preventable diseases, and the Epidemiological Surveillance Unit has recorded a rise in such vaccine-preventable and waterborne diseases as hepatitis A, salmonella, rabies and food poisoning cases. Some of these outbreaks are associated with the poor inspection and accountability of water and food safety. In addition, there is risk of cross-border transmission from neighbouring countries that are reporting outbreaks of measles and polio. Furthermore, the economic crisis has contributed to the worsening of environmental conditions, including more than 50 per cent of tap water contaminated with e. coli and 88 per cent of wastewater left untreated, increasing thus the risk for cancers, waterborne diseases, respiratory conditions and other related illnesses.

Efforts have been made to implement the updated national environmental health strategy. However, lack of political commitment and coordination between relevant ministries, and competing interests, halted these efforts.

Among the factors hampering the emergency response of the Ministry, is the lack of a Ministry unit in charge of emergency and crisis management. During the pandemic, a temporary, ad hoc, national, interministerial committee and multidisciplinary task force were formed with poorly defined terms of reference. Other factors include the improper implementation of IHR requirements and the absence of an autonomous central public health lab that would be accountable for the early detection of outbreaks. Instead, this early detection role is distributed to different entities such as the National Influenza Centre, the National Measles Reference Lab, the National Centre for Research and Development for Chemical Hazards, the Université Saint-Joseph de Beyrouth (USJ) Laboratoires Merieux for Tuberculosis and Microbiology Lab for Anti-microbial Resistance Outbreak Surveillance. This chronic problem dates back to 2006 when the central public health lab was closed.

5. Health promotion and disease prevention

The Lebanese health system is characterized by weak disease prevention and control programmes, including systematic early diagnosis of different types of cancer, diabetes, and cardiovascular and pulmonary diseases. Little attention is given to the health of children (except for the routine immunization programme), youth (lack of adolescent friendly services, for example), older persons, persons with disability and women (except for extensive efforts to reduce maternal mortality rates and provide reproductive health services).

Nevertheless, health promotion, prevention and early detection of certain diseases are sporadically done with NGOs, and through primary health care. A few programmes at the Ministry offer awareness and prevention services, such as the national HIV/AIDS programme, tuberculosis programme, national mental health programme or the non-communicable disease early detection initiative in some primary health care centres.

Lebanon is one of the 11 tuberculosis low burden countries of the Eastern Mediterranean Region (below 20 out of 100,000 per population per year of estimated tuberculosis incidence), moving towards tuberculosis elimination.

The pandemic lockdowns, the limitations in transportation because of expensive fuel and the absence of a comprehensive plan for prevention and early detection of priority diseases, have added to the scarcity of awareness and prevention interventions. The complex

crisis has direct and indirect repercussions on population needs and health indicators. More than half of the Lebanese population have been in health need since mid-2021, with surveys showing a growing number of regions reporting high and severe poverty levels. Population health has been deteriorating as evidenced by the tracer indicators monitored. The maternal mortality ratio reached 47 in 2021, with more than half of the deaths associated with COVID-19, while excess mortality rates of 15.4 per cent in 2020 and 34.4 per cent in 2021 were recorded mostly due to non-COVID-19 illnesses. According to the World in Data estimates, the cumulative excess mortality in Lebanon is about 30 per cent. Life expectancy in Lebanon is expected to decrease by as much as 3.4 years (for both sexes).

Additionally, since 2020 routine vaccination coverage is estimated to have dropped by at least 30 per cent, with a higher percentage drop among the new vulnerable groups. Referrals to mental health services have increased by around 50 per cent and self-reported suicidal behavior has increased fourfold. In terms of malignancies, more than 8,000 new cases are identified each year, with five cancer types accounting for 73 per cent of the overall Ministry spending on cancer drugs.

Taking into consideration the changing population needs, the deterioration in the determinants of health and the increase in health risks and outbreaks, efforts to promote population health should target regions with below average indicators. Unfortunately, no such activities are currently being conducted or even planned.

6. Health workforce

The crisis is rapidly depleting the capital of people to conduct the business of governing and operating the health sector. Over the past 20 years, dedicated and competent teams have been assembled within the Ministry of Public Health and among its network of allies. These were the people with the institutional memory and operational knowledge that are indispensable for effective sector governance. In the current breakdown, an important number of that staff has quit, and when that is added to those that have retired and not been replaced, the central and district Ministry departments are functioning with less than 30 per cent of their original staff capacity. This severely affects the regulatory role of the Ministry and the sustainability of its programmes. Even making abstraction on the context of crisis and the loss of capacities, replacing Ministry staff is blocked by a law that prohibits recruitment by public institutions. The remaining staff have had to cut down their output as the crisis disrupts day-to-day activities and reduces operating funds. This exacerbates an ongoing element of fragility and instability in regulatory initiatives and budget allocations. The decline in the number of staff represents a serious threat to the sustainability of the performance of the Ministry, and clearly reflects the lack of political commitment to strengthening public administration. This lack of commitment applies to all the consecutive Governments for the past two decades.

Also, the recent drain of human resources from areas of high competencies and specialization has become an increasing concern, with more than 20 per cent of nurses and around 40 per cent of doctors having already left the country as reported by the relevant professional orders. This includes, within the private sector alone, 760 nurses and 1,740 doctors leaving between January and June 2021, according to the Syndicate of Private Hospitals.

This is in addition to emigration of administrative staff and experts from academic institutions that are needed to train the new generation of health care workers and public health professionals.

Additionally, the layoffs, salary cuts and closures of pharmacies and the reduced activities of hospitals which accompanied the economic crisis, severely affected the numbers of the health care workforce. This caused a shortage in human resources especially in public hospitals and has had a direct negative impact on the quality and availability of health care services.

There is a lack of qualified health care workers who are trained to provide preventive services and run such programmes, thus there is great need to invest in capacity-building in this regard.

Box 3 Summary of the findings of the 2022 national survey targeting nurses

The key reasons that trigger nurses to transition and exit their current occupation include lack of adequate compensation, inadequate incentives and benefits packages, and the high cost of living. Some nurses even lacked comprehensive insurance packages and sometimes relied on personal savings to pay their medical bills. In addition, the nursing workforce is not adequately appreciated and experiences a lack of awareness of the positive contribution of their role to the entire medical fraternity.

These factors affect the motivation of nurses and consequently their overall performance. They have also led to diminishing returns for most nurses, leading them to resort to alternative comparable options (in terms of hospitals) and sometimes other countries in search of better opportunities and employment packages.

Nurses are affected psychologically, physically and mentally by the limited time to sleep as a result of the prolonged working hours, the limited time they spend with their families and inadequate time they have for social activities and leisure. Nurses reported that most of their colleagues are resorting to seeking assistance from psychiatrists to cope with the stress due to their job and are on anti-depressants. These long working hours force nurses to leave inpatient settings and transfer to outpatient settings where work conditions might be less stressful, as shifts are generally shorter and typically do not require nurses to work nights, weekends, or holidays. Nurses make these moves for the sake of their physical and mental well-being or for the sake of their families and being able to care for their children.

7. Health information system

The current crisis is leading to loss of institutional memory and a growing obsolescence of information gathered at great cost in the period before the crisis broke through.

One example is that of national health accounts (NHAs), which is an internationally recognized tool that measures and tracks health care expenditures in a country and explains where the money comes from, and where it goes. The Ministry is in charge of collecting health expenditure from different public funds, mutual funds and private insurance funds. Thus, the NHA is of great significance to policy development and adjustment in health expenditures and for improving the performance of health systems while enhancing transparency and accountability. The information provided by the 2017 NHA can hardly serve as a detailed guide for decision-making in the current context. The same goes for a whole range of other issues, including the distribution of human resources, the trends in out-of-pocket expenditure, the performance of health care providers, funding flows, the epidemiological situation, the unmet needs, among others. Importantly, brain drain (in the Ministry and in academia) risks curtailing the capacity to prioritize, design and launch the surveys and studies necessary to guide recovery.

The hospital-based mortality system has been facing sustainability challenges due to the emerging economic crisis, where the loss of hospital staff to emigration affects the timeliness of reporting and completeness of data, and the high turnover requires frequent training to ensure quality. Moreover, the emergence of the crisis in the end of 2019 halted the efforts to establish the Health Information Management Unit (HIMU) and exposed areas of priority, such as the importance of a unified patient identification number and harmonization of the fragmented systems. For example, during the COVID-19 pandemic it was difficult to track cases from diagnosis to treatment and potential deaths due to the fragmentation of the available systems at that time. This is caused by the absence of a national e-health strategy and the inefficient coordination between the departments of the Ministry, resulting in fragmentation and duplication of data. The hospital-based vital data observatory, which collects data on deliveries and maternal and neonatal mortalities, needs to be strengthened and expanded to collect accurate and timely information. The primary health care network of information communication system (PHENICS) and MERA platforms, which provide data generated by the primary health care network, including data on vaccination, need to be expanded to include the private sector, while ensuring completeness of reporting.

While COVID-19 was an opportunity for the e-health programme to show its true potential, it also highlighted the pre-existing challenges the programme had faced since its formation, and which hampered its efforts in implementing its action plan. These challenges have been exacerbated following the multiple crises since the end of 2019; they include shortages in financial resources, burdensome bureaucratic administrative procedures and, since mid-2020, the absence of proper leadership at the Ministry capable of managing this context of multiple crises, in addition to an insufficient number of motivated and competent staff, particularly in the domain of information and communications technology (ICT).

C. Challenges and strategic issues

Box 4 Context and system-related challenges

Context and system-related challenges in the health sector in Lebanon include:

- Political instability in Lebanon and the region.
- Economic and financial crises with disastrous social consequences impacting all sectors.
- Dramatic decrease, in real terms, of the budgets for the Ministry of Public Health and public funds, with the local currency losing more than 90 per cent of its value since October 2019.
- COVID-19 pandemic and other health security threats.
- High burden of non-communicable diseases.
- Weak public sector regulation capabilities coupled with a powerful private sector.
- Advanced medical facilities and high-tech services, mismatching financial capabilities and a lack of maintenance and qualified personnel.
- Emigration of health professionals, affecting all health and education institutions.
- Competing global priorities and humanitarian needs (including Yemen, Afghanistan, Ukraine, Sri Lanka, Horn of Africa).

In addition to the arduous and threatening context and the tremendous system-related challenges, the health sector has to deal with specific strategic and institutional issues related to universal health coverage, health financing and payment, health security and health governance.

1. Universal health coverage

(a) Health equity in access and continuum of care

- Redesigning the health benefits packages to become more realistic and at the same time acceptable to the population.
- Equitable accessibility to health care and continuity of treatments under the severe financial constraints of both funding agencies and households, and lifting subsidization on chronic medications.
- Technology advancements and people's expectations; continuity of advanced and high-tech services provided by the private sector.

Main Focus:

- Continuity of advanced and high-tech services which made the good reputation of the Lebanese health care system in the region.
- A basic package of services that can be expanded over time.
- Financial protection (will be covered under financing)

(b) Health care delivery models

- Regulating access to and continuity of health care; gatekeeping and referral, hospitals sustainability.
- Health workforce development, retention, and production.
- Defining the role of public hospitals (vs the private) and ensure their service provision sustainability.

Main Focus:

- Transform public hospitals into front-line people-centred institutions.
- Reinforce the value-based PHC contracting framework involving NGOs and municipalities.
- Options of models of primary care engaging the private sector.
- Enhancing access by bringing preventive and promotive services closer to the community.
- Training more public health professionals and nurses, and credentialing all health care provider.

2. Financing and payment

- Financial protection considered as one component of universal health coverage.
- Mixed sources of financing: Taxes, Contributions and OOP
- Multiplicity of public funds [NSSF, CSC, 4 Military Schemes and MoPH (safety net)] with different contribution schemes, HBPs and co-payment policies.

Main Focus:

- Revisit the current payer-provider model by enhancing transparency and accountability.

- Revisit payment and co-payment to rationalize utilization and lower OOP.
- Deal with financing fragmentation.
- Revision of tariffication and subsidization policies.

3. Health security

- Restoring and/or enhancing critical public health functions and programmes, including emergency preparedness and response and vaccination.
- Inter-ministerial coordination for One Health approach and IHR.

Main Focus:

- Establish an Emergency Operations Center at the Ministry.
- Re-establish the central public health lab functions or a network of national reference labs.
- Enhance the Early Waring and Response System.

4. Governance

- Optimizing the role of MOPH to oversee, coordinate and regulate the health sector (public and private) to advance universal health coverage and health security.
- Minimize political interferences and address institutional barriers to implementations.

Main focus:

- Structural and functional review of EPHF and role of MOPH.
- Reviewing existing universal health coverage and health security related regulations to promote accountability.
- Institutionalizing collaborative and participatory governance in health decision making at national and sub-national levels.
- Strengthening governance accreditation institutional and enforcement arrangements.
- Investing in innovative approaches to promote digitalization of health sector response while protecting human rights, equity, privacy, and confidentiality.

D. Mismatch between needs, expectations of the population and resources

The breakdown of normal operations has exacerbated pre-existing gaps and distortions. The Lebanese health care landscape has been shaped by the largely unplanned and hardly regulated post-war proliferation of a multitude of private health entrepreneurs, including commercial and not-for-profit organizations. These have nurtured a culture of supply-induced demand for sophisticated, high-tech, subspecialist care. Political pressure has sustained this trend by directing funds towards tertiary care, ad hoc discretionary interventions and measures to protect the interests of allied providers. Among citizens this has entrenched unrealistic and unsustainable expectations as to what the public purse should support. Critical services less attractive to the public, like quality primary care, prevention and promotion, mental health, palliative care, long-term facilities and emergency preparedness and response, were given less or no attention at all. These remained underfunded by authorities, neglected by professionals and invisible to the public.

The country's heavy reliance on imported medications, which used to represent 90 per cent of the market, and imported medical supplies which covered almost 100 per cent of needs, reveals the necessity of policies to stimulate local production of pharmaceutical products, which require strong regulatory authority.

With the sudden impoverishment affecting the entire society, people now not only have lost access to the sophisticated care they have grown to expect, but also to the basic, minimal care required to cover their objective needs. Power to purchase desired health commodities has dwindled, yet unrealistic expectations for access to high-tech care persist. In the Lebanese context, the disconnection between the health benefits the system can offer, the unmet needs and the unmet expectations, is nothing new. Now, that disconnect adds to widespread dissatisfaction and distrust. It delegitimizes the public service discourse of health authorities. This is gearing up as a major political challenge, as much as a technical one, for the negotiation of health benefits packages in the recovery from the crisis will require consensus between public funds, political will from high-level policymakers and acceptance from the public. An adequate communication strategy and social marketing campaign is essential to inform the public about the new strategic directions.
A detailed overview of the health sector is found in **annex 2**.

2. Rationale for the National Health Strategy

A. Health gains under threat

The interlocking compounded crises, in particular the economic meltdown, local currency devaluation, workforce migration, and insufficient and unsustainable health financing, are threatening to reverse the health gains of the past twenty years, as well as the viability and performance of the health system. At the same time, living conditions are worsening fast, environmental degradation is accelerating and social health determinants are deteriorating. Proliferation of poverty means that three out of four Lebanese and non-Lebanese residing in Lebanon are now classified as poor. At least 40 per cent of households report challenges in accessing food and other basic needs, with unemployment exceeding 50 per cent.

All these conditions will affect the health outcomes that were documented and visible before 2020.

B. Building on strengths

Over the past three decades Lebanon has made significant achievements in terms of health indicators. Such outcomes were comparable to countries with much greater financial resources and health expenditure per capita. Important advances were also accomplished in terms of rationalizing health expenditures. Between 1998 and 2017, the total health expenditure in Lebanon decreased from 12.4 to 7.8 per cent of GDP, concurrent with out-of-pocket payments decreasing from 60 per cent to 33 per cent.

The achievements of the Lebanese health system resulted from and contributed to platforms and systems with great potential for further improvement in the future.

These achievements include the following examples:

- Public funds unified database and coordination mechanisms put in place, could be instrumental for harmonizing the work among all funds, make it more transparent and effective, and ultimately leading to their integration under one authority.
- The institutionalized relationship between the Ministry of Public Health, NGOs and municipalities, as in the case of primary health care, could be considered a solid platform for people-centred health care contributing to achieving universal health coverage. The partnership between the Ministry, WHO and academia, as in the case of the Mediterranean Academy for Learning Health Systems, could provide a framework for evidence-based policymaking and for developing adapted tools for proper implementation and evaluation.
- The law on drugs substitution, combined with an electronic medical prescription and the tracking system of barcoded pharmaceuticals, and an incentive plan for physicians, pharmacists and patients to enhance substitution, constitute a solid base for quality assurance and cost containment.
- The Ministry website, allowing traceability of simplified administrative procedures and providing easy access to administrative decisions, is a valuable platform for transparency and accountability and sets the stage for e-government once the related law is issued. In addition, the Ministry has other well-established databases, such as the EPI and the primary health care network information systems, including monitoring and grievance mechanisms.
- Twinning of major public hospitals with private university hospitals is a promising platform for continuous improvement of their performance and facilitates exchange of residents and referral of patients among them.
- Strong health and education institutions, and a large diaspora of Lebanese health care professionals willing to return to Lebanon once the situation starts resolving, brings hope for a better future.
- The reputation of Lebanon as a centre of health care excellence is an asset to build upon to attract regional investments and patients.
- A strong private sector, provided with pertinent and purposeful regulation, could act as a cushion to absorb the shortcomings of the public sector.
- The country's HIV response is a missed opportunity as we are close to achieving the 95-95-95 United Nations goal. Lebanon sustained good coverage for diagnosis and treatment for many years due to a strong presence and partnership with civil society organizations.
- Lebanon could also build on the model of microelimination of hepatitis C among persons who inject drugs.

Finally, regarding health coverage, despite the disadvantages of the multiplicity of institutions channelling money, the diversity of sources of funding, namely the combination of taxes, contributions and out-of-pocket expenditures, is per se an advantage of the health financing system. However, out-of-pocket expenditures should be reduced to the minimum to ensure equitable accessibility and fair financing.

C. Learning from experience

Several policies were implemented during the past decades that proved to be effective in the particular context of Lebanon, among which are: developing primary health care as a cornerstone for the health system and universal health coverage; pharmaceutical governance and quality reforms; public hospitals' autonomy; quality improvement through accreditation and contracting incentives; and several innovative approaches regarding the payer-provider relationship such as utilization review, flat-rate payments, third-party administrators and value-based hospital contracting.

These policies are documented and provide valuable guidance on how to move forward.

Box 5 Strategies for improved health indicators

Strategies that proved to be effective in improving health indicators while decreasing out-of-pocket expenditures include:

- Developing the national primary health care network in partnership with NGOs and municipalities, and promoting essential generic drugs.
- Creation of an Epidemiological Surveillance Unit at the Ministry of Public Health, which should be formally integrated into the Ministry organigram, and decentralized.
- Issuing a law on the autonomy of public hospitals, that will need to be re-visited to ensure financial sustainability of these hospitals.
- Human resources strategy focusing on enhancing nursing graduation and improving nurses' working conditions, post-graduate training of medical inspectors and controllers and training of family physicians.
- Upgrading the registration process of pharmaceutical drugs with particular attention to the quality of generics, creating specialized subcommittees of independent experts and revisiting periodically the pricing structure.
- Periodic good manufacturing practices audit on pharmaceutical manufacturers performed by the Ministry of Public Health Industrial Committee and reinforced by neutral experts.
- Implementation of the WHO Good Governance for Medicines programme.
- Accreditation of hospitals and primary health care centres.
- The creation, maintenance and updating of a unified beneficiaries database.
- Development of the prior authorization electronic visa system, its decentralization and linkage to the database.
- Value-based contracting with hospitals and cost containment of hospital care, including:
  - Setting of a financial ceiling for each contract with the Ministry.
  - Utilization review and introducing incentives through new payment mechanisms.
  - Value-based contracting.

D. Enhancing health system resilience

The health sector was capable of sustaining and improving achievements over two decades despite wars and repeated political and economic crises, including the massive influx of Syrian refugees in 2011.

While humanitarian assistance helped in absorbing the burden of refugees, the health system was considered resilient in absorbing shocks, adapting and even progressing.

This resilience was attributed to many enabling factors that should be maintained and scaled up, among which:

- Evidence-informed decision-making.
- A dedicated Ministry of Public Heatlh team, relatively protected from political interference and retaliation, providing highly professional work.
- Collaborative governance, including major stakeholders in policymaking and implementation.
- Neutrality and objectivity in developing standards and assessments relying on impartial institutions and experts.
- Active civil society organizations involved in the health sector.
- Resourceful private providers steered by the Ministry, mainly through financial incentives, to better serve national objectives and public interests.
- Good public-private partnerships and contracting schemes that provided flexibility and resilience to the health care system.

E. Addressing health system fragilities

Particular attention should be paid to the root causes of dysfunction within the health system.

Those causes of dysfunction that prevailed before 2020 are considered as inherent (chronic problems) to the health system, although aggravated by the recent compounded crises.

Knowing that political instability is a major factor increasing the vulnerability of the health system, and considering that political hindrance will persist in the foreseeable future, ways should be found to overcome these obstacles, rather than betting on any significant change in politicians' the opportunistic behaviours and attitudes of politicians.

Box 6 Pre-crisis health system fragilities in a nutshell: Internal and external factors

Unsustainable good governance practice:

Despite the tremendous efforts to institutionalize and ensure the sustainability of good governance principles and collaborative leadership, the system remains fragile for the following reasons:

- The protection of qualified, politically impartial staff from political retaliations has always been a major concern, to ensure the sustainability of the system. These worries were recently substantiated by staff transfers and other intimidation measures taken to serve political interests.
- Short-term Governments and ministers in office with different priorities and agendas.
- Weak capacity of Ministry of Public Health decentralized units and autonomous public hospitals:
- Health departments at governorate and district levels are lacking staff and equipment, with poor coordination and oversight from both the ministry and the governorates.
- Public hospitals are poorly governed by a board of directors appointed by the Council of Ministers on the basis of power sharing among confessional and political factions. Public hospitals do not receive their fair share of contractual financial ceilings, compared with the confessionally protected private hospitals (although their autonomy was mentioned as a strength before).
- Absence of an autonomous food and drug agency, and of a national laboratory for drug analysis.

Privately dominated, market-driven health care provision with weak Ministry regulation capabilities:

- Supplier-induced demand for sophisticated expensive hospital services, and overprescribing behaviour.
- Unregulated supply and utilization without gatekeeping or waiting lists.
- Lack of adequate tools such as electronic medical records.
- Accreditation standards are lacking for ambulatory clinics and diagnostic centres.

Health financing skewed towards curative tertiary care, with underfunded primary health care and meaningless budget for health promotion and prevention.

Financing diversity with fragmented governance; multiplicity of public funds with different benefits creating inequity among the population:

- Multiple (inequitable) health benefits packages.
- Unrealistic, costly and unsustainable benefits.
- Mostly fee-for-service payment against itemized bills.

Limited capacity of the primary health care network:

- Long-standing insufficient financing.
- No financing arrangements between insurers and primary health care centres.
- People's reliance on private ambulatory care, including the poor, because of persistent lack of trust in primary health care centres.

High discretionary power of health ministers:

An almost absolute power was granted to ministers by the 1989 Taif agreement, as part of power sharing among confessions. This is occasionally used by making populistic decisions and serving clientelism, leading to systematically exceeding the regular budget of the Ministry. As a result, a huge increase in public debts accumulated over years while extraordinarily raising people's expectations.

Ineffective civil society organizations (beyond service delivery):

- Professional orders failing to fulfil their oversight role.
- Inefficient consumer protection associations.
- Patients' associations strongly influenced by the pharma industry.
- Lack of monitoring and evaluation of NGOs as they got licensed from Ministry of Interior and no reporting or follow up on their funding or activities related to health is taking place, except from certain donors.

F. Post-2020 situation and challenges

Until mid-2020, the health system could sustain all its activities as usual, despite the crisis and the COVID-19 pandemic. It is worth mentioning that the rapid response to the pandemic at its beginning was spectacular, in diagnosing, isolating and treating cases early, and identifying and quarantining contacts. The very first case of COVID-19 was identified by the Ministry of Public Health team at the airport, which enabled immediate diagnosis and isolation and demonstrated the high level of pandemic preparedness.

Although the health system was capable of facing consecutive crises one by one, absorbing shocks and adapting, the current crisis is a very complex one, including a financial meltdown that no system has the capacity to absorb. The sharp increase in the cost of living due to the ongoing political, financial and economic crisis has also been reflected in the considerably increased cost of health care. The consumer private index changes for all goods and services rose by 144 per cent between 2019 and 2021, while that regarding health rose by 212 per cent. It is expected that out-of-pocket payments by patients has considerably increased above past historic levels. Such a context requires revisiting how to reposition Lebanon on the path towards universal health coverage. In the past, coverage had included high-tech and latest-generation medications, with no exclusions or waiting lists, and patients having a free choice of provider.

This is no longer affordable, and a drastic change in health policy is obviously required.

Box 7 The compounded crises of Lebanon

Political deadlock: Growing sectarian conflicts, political divides and struggle on power sharing. No agreement on a national crisis response plan. Expected political instability after parliamentary elections while awaiting the presidential elections.

Financial/fiscal crisis: tremendous decrease in both government and private institutions' revenues and households' budgets, with great impact on health services provision and access.

Economic deterioration: Lebanon depends heavily on imports, including food, energy and health products. Decrease and delay in importation of critical life commodities, including medical and health goods.

Social instability: Brain drain, migration of qualified human resources severely striking the education and health sectors.

Infrastructure collapse: Collapse of infrastructure, including in fuel, electricity, transportation, water and sanitation is sharply affectin.g operational capacity and sustainability of health facilities.

G. Reflections on the way forward

The current health situation is the result of several factors that are either inherent to the health system or strictly related to the complex crises. Any strategy to restructure the health system is expected to address weaknesses, while preserving achievements and capitalizing on strengths. However, no matter how strong a health system might be, it will remain incapable of responding to the population's unrealistic expectations considering the meagre available resources.

As a result of the economic and financial meltdown, the annual GDP of Lebanon is estimated to reach less than $20 billion, which is a sharp decrease from the GDP of $50–55 billion throughout 2015–2019, resulting in a decrease in public funds budgeted for health. This huge decrease in financial resources, affecting at the same time the government budget, private resources and household revenues, is being reflected in lower utilization of health services and goods, as patients are not able to pay out of pocket.

These dramatic changes highlight the need to reorient health spending to more cost-effective alternatives, including health promotion and prevention and primary health care, and to establish gatekeeping and referral mechanisms.

The point of entry would mainly be the primary health care centres, and possibly public hospitals equipped with outpatient departments, and/or through a network of accredited general practitioner/family medicine specialists. These options are meant to capitalize on existing resources in the primary health care, public hospital and health care workforce in Lebanon. Gatekeeping and referral mechanisms would require explicit criteria and monitoring systems, and imply revisiting the laws and regulations related to licensing of primary

health care centres to become more advanced than the existing ones for dispensaries, and reinforcing the quality standards for primary health care centres and public hospital outpatient departments. A standardized electronic health record would be adopted as an essential tool serving health care integration and case management across the referral levels. Specific accreditation requirements for general and family medicine practitioners would be required to join the network, linked to special accelerated training programmes and performance-based assessments. However, classic diplomas remain essential for such specialties as family medicine, emergency medicine and intensive care for neonates. Law number 271, issued on 22 April 2014, requiring new graduates from medical school to complete a minimum three-year residency, should be enforced to ensure a certain degree of good quality care. This needs to be coupled with providing the right incentives for physicians and patients to adhere to the set referral pathways, and imposing extra fees on those who wish to by-pass the gatekeeping system.

The difference in benefits packages among public funds indicates that patients are not enjoying the same type of services at the same level of health care, which needs to be addressed as well. The benefits package should be designed in light of the available resources to include essential cost-effective services based on evidence. It should be issued by law, making it mandatory to ensure universal coverage of the agreed-on benefits, which would be gradually expanded depending on availability of resources and the sustainability of service provision in public hospitals. Regulated complementary packages could be voluntarily purchased and offered by the private sector.

Different options should be finalized, to be approved and owned by all public funds, following a national dialogue that includes a range of stakeholders and the public. Thus, a coordination committee under the leadership of the Ministry of Public Health, with representatives of all public funds and their respective supervising ministries, would be established by the Council of Ministers to achieve this mandate within a set timeline. In parallel, these efforts require a comprehensive and proactive communication strategy to promote a new vision for health, manage expectations and gain trust.

Box 8 Health Financing Coordination Committee

A committee appointed by the Council of Ministers with clear terms of reference and time frame. Its purpose is to unify public funds procedures and working methods, including:

- Common classifications and nomenclatures, tariffication and accreditation of providers.
- Unified forms and electronic tools for prior authorization, discharge summary, billing and reimbursement.
- Join efforts to analyse data, including cost and patients' satisfaction among others, to be used to enhance efficiency and improve services to the patients.
- Pooling resources for auditing and price negotiation.

The committee will also develop strategies and adequate incentives for a successful introduction of gatekeeping and referrals.

Migration of health personnel is a major element threatening the quality and continuity of health care. Therefore, in addition to a national human resources retention strategy, there is a need to upscale nursing educational programmes and promote the enrolment of candidates in the private and public universities through scholarship opportunities, to address the chronic shortage in nurses. Focusing on production of a new health care workforce, including public health professionals with different disciplines, will also require resources and time.

Private and public hospitals are under huge financial pressure; episodic increases of public funds tariffs fall short in compensating for money devaluation, and patients cannot afford the extra cost of imported drugs and medical devices purchased by hospitals in real (fresh) dollars. Many hospitals cannot sustain their services under such financial constraint, where, as an example, the cost of fuel alone exceeds the total amount of salaries.

The system is still suffering from a supply-driven health care system, with largely supplier-induced demand for sophisticated, expensive hospital services, overprescribing behaviour and a small share of generics use in the pharmaceutical market. At hospital level, covering non-cost-effective interventions incurs costs exceeding the regular budget, and the high out-of-pocket expense represents an increasingly important challenge due to the enormous devaluation of the national currency seriously affecting household purchasing power.

Technically, the main issue for achieving universal health coverage in Lebanon remains a lack of accessibility to a comprehensive package of services, including promotive, preventive and palliative care, in addition to early diagnosis and treatment using generic drugs. Particular attention should be given to health care for the elderly and long-term care, considering the ageing population. It is expected that in the future, the population will expect more advanced services than it is used to, or at least to preserve the benefits it has acquired so far. Therefore, as people are anticipating more and more technologically advanced interventions, it is likely public

opinion would not be particularly enthusiastic about enhancing the coverage of preventive and essential health care, such as offering essential basic services at the primary health care level, introducing new vaccines to the immunization calendar, ensuring mental health and safe motherhood services, while limiting hospital care benefits to essential services. Nevertheless, observations show that currently the public might be more tolerant of going through a primary health care referral system due to their inability to afford medical consultations at private specialists' clinics.

Particular efforts should be put into raising awareness on the importance of "affordable, essential, quality care" from equity and sustainability perspectives, in addition to health security, in helping to achieve universal health coverage and to emphasize that this is not a package for the poor.

Rationalizing people's expectations is a long-term goal. In the meantime, there are no indications that politicians would venture a realistic and sustainable universal health coverage plan that may disappoint their voters. Consequently, the main problem in this regard is more of a political and public acceptability one, and not only a system issue. The multiplicity of health coverage funds is another political issue, although one should not underestimate its historical institutional development dimension.

On the other hand, considering the severity of the financial crisis, there should be a redefining/optimizing of the role of the Ministry in a way that allows it to continue to work towards improving the right to health in the most efficient and equitable manner. Hence, it is necessary to reform the way health care coverage is being practised and implemented. An option is to introduce a paradigm shift, as explained in box 9, whereby the focus is diverted from covering more and more people to rationalizing the benefits package that is covered by public financing – equally, or at least equitably, for all.

There should be objective and neutral mechanisms to identify poor and vulnerable people, to waive them from co-payment. The lower-middle income population could have their out-of-pocket payments reduced by income-based waiver schemes, through "equity funds" that could be generated and led by municipalities, the Ministry of Social Affairs or both. In addition to the alleviation of households' financial burden by an increase in government investment, an important part of direct out-of-pocket disbursement upon utilization could be shifted to a prepayment mode, through a community health insurance scheme. The World Bank – financed project that piloted this model by recruiting the extreme poor in a "fidelity" scheme, could serve as a model in this regard.

A reimbursement mechanism is also needed for specialized care provided by the public hospitals within the referral system. This may represent an additional affordable option to reduce out-of-pocket costs and rationalize hospital admissions, assuming good adherence to the set rules, particularly in respect of the referral system.

Some of the key strategic issues include the mixed sources of financing and the multiplicity of public funds. There is a growing belief that this crisis represents an opportunity to unify all public funds under one authority, which needs heavy legislative reform touching on all laws related to the existing funds and the Ministry of Public Health, and therefore requires a strong political commitment. Irrespective of whether this could be achieved in the near future, unifying the benefits packages of these funds and harmonizing their work by unifying contractual agreements and tariffs are absolutely necessary steps for efficiency and equity purposes and are completely feasible. This requires evidence-based decisions and consensus building.

Granting all residents the right for a Basic. common benefits package of essential primary health care and hospital services, needs new legislation. This package could be complemented by well-regulated packages offered by private insurance funds and mutual funds, individually prepaid on voluntary bases.

Schemes for Lebanese citizens are financed from national collective financing mechanisms. The entities responsible for the health coverage of non-Lebanese people living in the country (including but not limited to the United Nations Relief and Works Agency for Palestine Refugees in the Near East(UNRWA) and UNHCR) should join the system. Also, migrant workers should be covered by their employer for at least the same benefits, by private insurance, in order to ensure equitable coverage of all residents.

In order to have a basic health benefits package that is both cost-effective and publicly acceptable, there is a need for a health benefit package task force that takes into consideration the burden of disease, evidence of cost-effectiveness and the fiscal space. It is also of prime importance to build consensus for the adoption of this basic health benefits package by all public funds.

Unification of the health benefits package can serve as the basis for unifying purchaser leverage in negotiations with providers and for defining the legal frameworks for the public purchase of quality-assured care. This would pave the way for a transition to value-based and people-centred services within a gatekeeping and referral framework.

Shifting the people's reliance from private ambulatory care to almost free primary health care requires improving the image of primary health care centres and public hospitals and their quality of service, to enhance population trust in the proposed system.

The referral system from primary health care centres privileging public hospitals should get sufficient financial support to better serve the poor with little or no co-payment as a type of incentive. Meanwhile, the relationship with the private sector still needs much regulation in terms of rationalizing the financial ceilings to match with the regions' needs, enhancing transparency in financial reporting and prohibiting patient selection and illegal out-of-pocket fees.

The Ministry performance contracting agreement with the public and private hospitals proved to be a successful initiative. It should be sustained and scaled up to be used by all public funds to better steer the sector towards efficiency, elimination of fraud and catering to patient satisfaction. This scaling up would be part of revisiting institutional arrangements by all public guarantors, in particular the public financer-private provider contracting.

A national health insurance authority could be established by law as an autonomous body to set all regulations and guidance related to services covered by public funds, including the Ministry. It would regulate all public funds to harmonize their functions, tariffs, benefits, subsidized medication lists, provider contracting and reimbursement criteria. These functions could be done through unified self-administration and audits or by contracting a third-party administrator. Relevant studies and assessment would be conducted to identify all the beneficiaries following the concept of "leaving no one behind" and to coordinate issuing health cards for all beneficiaries using a unique patient identification number. Funding for the functioning of such an authority needs to be explored.

Box 9 A national health insurance authority

A national health insurance authority should be created by law to institute and implement the national mandatory health insurance and health benefits package for all residents. The authority will take over the work developed by the health benefits package task force and by the financial coordination committee, and it will continue the evidence-based updating within a participatory process framework. It will oversee the implementation of universal health coverage laws and regulations, in particular:

- Setting the regulations for entitlement and mandatory enrolment in public schemes.
- Adopting the unified benefits package and ensuring equitable accessibility to the set of essential services.
- Creating a health technology assessment department to assess new products and technologies to inform regular updating of the benefits package. The Lebanese Drug Administration (LDA), once established, can perform this function as it is within its mandate that was issued by law.
- Developing standardized complementary packages to be voluntarily purchased from private insurance funds or mutuality fund, and regulating their cost.
- Monitoring the distribution of health cards, managing the beneficiaries database and assessing utilization patterns.
- Ensuring equitable access to health care, while making sure no one is left behind.
- Setting a mechanism for providers and provider payment methods to be used; this should include management of providers, information and funds.

Once the national health insurance authority is created and begins progressively enrolling the uninsured, the Ministry will start phasing out from its role as the insurer of the last resort, although it still needs to manage and cover the poor and most vulnerable until they are all covered by the new system. This process could be facilitated by contracting with a third-party administrator to identify these beneficiaries and register them at primary health care centres, or by asking the Council of Ministers to establish an autonomous body for this purpose. A public policy dialogue that includes civil society organizations and community engagement are crucial for the success of any reform.

Spending on pharmaceuticals represents a big share of health expenditures and deserves particular attention. Promoting generic drugs requires a comprehensive approach, including monitoring and improving quality, enhancing trust, influencing prescribing patterns and enforcing drug substitution by pharmacists. The current crises could be considered as an opportunity to scale up domestic production of pharmaceutical products to ensure sustainable availability of quality affordable products, reduce cost and hopefully increase exportation and inflow of hard currency. A specific national pharmaceutical strategy was developed and endorsed recently. It should be implemented with its two main pillars: focusing on securing universal and sustainable access to quality medications, including generics, and ensuring early access to innovative medications while maintaining resource optimization through health technology assessments and enforcement of the code of ethics.

The Ministry is highly committed to re-establishing the various functions (including disease prevention, control and surveillance) of the central public health lab, and exploring an option to have a decentralized model of the central public health lab. The governance of both

the LDA and the new form of the central public health lab should be subject to more reflection, considering the variety of options that could be envisaged, and the substantial conflicts of interest to be managed. One of the proposed options is to build a well-equipped central lab and seek partnership with public, private and academic laboratories to operate under a unified system and standards set by the Ministry. Reference labs should be accredited based on WHO requirements, through regular audits by independent experts, in order to be entitled to engage in the formal framework of collaboration, known as the national network of reference labs, while the Ministry ensures a supervisory and coordinating role over the system.

Finally, the Ministry remains particularly fragile because all its past achievements have mostly relied on a small team of dedicated civil servants who are well-trained to provide highly professional outcomes, and many of these people have quit.

The Ministry, at the central and peripheral levels, needs to be capacitated and strengthened to play its role in leading the health sector and coordinating between all relevant stakeholders (public funds, providers, health professionals, patients and others) to implement the suggested stratgey and the restructuring of the system. The Ministry is mandated by law to be responsible for public health and safety. The present structure of the Ministry dates back to 1961 and it is long overdue modernization of its organizational structure and methods of work.

Public hospitals are expected to play a more important role. They should be supported to urgently get in-kind assistance/donations for essential items necessary for running public hospitals like diesel and essential medical equipment, to lower their expenses and consequently the costs of treatment for patients.

Potential sources and mixes for health financing should be further explored, including public sources (for example, earmarked sin taxes, excise and capital gains taxes) and private sources (prepayment schemes and co-payment). However, national resources would not be sufficient to ensure a minimum package of health benefits. Therefore, it might be unavoidable to seek international support for the upcoming period, whether donations or soft loans, as part of the financing of a national recovery plan. This would require the establishment of a trust fund to be earmarked for health crisis response and recovery, and to include all public funds, the Ministry and armed forces. This fund should have the appropriate governance structure to manage it with full transparency and accountability. Meanwhile, there has to be a phased bridge between the humanitarian/emergency phase and the developmental phase to sustain the Lebanese health sector achievements and continue with the unfinished agenda of the SDGs. Thus, the proposed national health sector strategy will suggest a relief and response phase as well as a recovery and reform phase to take place in parallel.

3.
Lebanon National Health Strategy

Lebanon is undergoing one of the most severe and complex crises in recent history. The health system, which showed a great deal of resilience in facing tremendous challenges during the past two decades, could not adapt to the compounded crises of such magnitude in the past two years, which makes its restructuring essential.

A. Vision of the Lebanon National Health Strategy

Implementing the Lebanon National Health Strategy should result in an integrated, equitable and people-centred health system that effectively protects and improves the health status of the population, by ensuring universal health coverage with fair and sustainable financing, and addressing the key determinants of health, while being agile in responding to emerging threats and adaptive with social, economic and political crises.

B. Mission of the Lebanon National Health Strategy

The strategy will help restructure the health system to become more equitable, integrated and efficient, ensuring universal access to value-based and people-centred quality health care, benefiting all residents, while targeting the poorest and most vulnerable.

Adopting and implementing the strategy will build and sustain an effective Ministry of Public Health that can anticipate problems, monitor progress, lead and regulate the health sector, and develop partnerships across the various stakeholders and Lebanese society to achieve sustainable outcomes.

Enhanced investment in the health industry as a result of the strategy being implemented will contribute to economic growth and human development.

C. Expected outcomes of implementing the Lebanon National Health Strategy

The national health sector strategy is expected to contribute to Lebanon becoming a country where:

- Communities, families and individuals live healthier lives and enjoy access to quality health care services.
- Public and private health care providers work together to protect and improve the people's health, by addressing the key determinants of health, organizing universal health coverage and responding to health emergencies.
- Health authorities are trusted to work for the public interest, free from influence of special interests and committed to leave no one behind.

The strategy hence will essentially aim to:

- Sustain strategic networks and partnerships between sector stakeholders around shared agendas serving the public interest.
- Identify priority strategic interventions and mobilize the required resources for a paradigm shift in the governance and organization of the delivery of services and the protection of health and well-being.
- Build the capacity of the whole sector in general and the Ministry in specific for anticipating upcoming challenges and for designing and implementing effective, efficient and equitable responses to the legitimate expectations of communities, families and individuals.
- Respond to acute crisis to sustain the continuum of health services and work on the developmental agenda.
- Promote the health sector as a productive one that, in addition to giving rise to healthy and productive people, creates job opportunities and generates business.

D. A framework for action: Immediate relief and recovery

1. Emergency response and relief

Facing the acute phase of the crises, an immediate response is required to address unmet and escalating urgent health needs. Relief needs to focus on access to essential primary health care and hospital care for a population that can no longer afford its price, in a context where many providers face insolvency, and where the public purchasers of care face ominous financial constraints. Given the urgency and the current disarray of public funding of health care, the immediate relief and response efforts may to some extent have to be formatted as targeted, time-limited project funding focused on access to care. Re-establishing access to care is a necessary response to the effects of the crisis; it is also an essential part of how, beyond the health sector, society can find a way out of the social, economic, and political crises it finds itself in. Thus, immediate action is needed to prevent the interruption of service provision.

2. Recovery and reform

At the same time, there is a need for ambitious structural investment in recovery and reform that supports a realistic and sustainable budgetary framework. Such investment is needed to remedy the harm caused to the population's health and to the health system by the concatenation of crises. It is also needed to protect and sustain such pre-crisis achievements as strides made in controlling the cost and availability of pharmaceuticals, or in using accreditation for quality improvement. Importantly, investment must be accompanied by the reforms necessary to correct the pre-existing systemic distortions that are responsible for inefficiencies and inequities, such as supply-induced demand, or the systemic disincentives in prevention and promotion of health and well-being. Recovery is an opportunity to build a stronger and more resilient system that responds better to the needs and expectations of the population, while considering the context of limited resources.

The proposed Lebanon National Health Strategy is in line with the global SDGs, leaving no one behind and reaching the furthest behind first. Thus, it is important to ensure that emergency response and relief go in parallel with the recovery and reform phase, as they are interdependent. The strategy adopts the humanitarian-development-peace nexus approach, optimizing the resources made available under the various funding tools to address critical needs and gaps in the health sector, while building capacity for a sustainable and resilient health system that safeguards and promotes population health.

3. A framework for action

An immediate response to the current catastrophic situation is required to prevent the collapse of the health sector, and health institutions and communities have clear, concrete and pressing needs to survive the current compounded crisis. However, it remains of prime importance to articulate the required urgent actions, to ensure their sustainability and contribution to achieve the expected short-, medium- and long-term outcomes.

Neither the immediate crisis response nor the investment in recovery and reform can be expected to be financed exclusively from domestic public sources. Proper financing of the sector would be constructed from multiple sources and agencies, including from international donations and/or soft loan support as a transition bridge to move from the ongoing humanitarian/emergency support to sustainable financing.

(a) The Health Crisis Response and Recovery Fund

The Ministry is expected to take the initiative and the lead for engaging agencies and stakeholders in Vision 2030, and for translating that engagement into operational plans and budgetary commitments, with clear and realistic milestones and targets for monitoring investments and progress towards the reforms.

Serving this purpose, a Health Crisis Response and Recovery Fund earmarked for health could be created and managed by a sector-wide and inclusive structure to ensure a transparent and accountable process that respects good governance principles.[3]

[3] A similar fund was established in 2007 and operated through the United Nations after the July 2006 war. The proposed Health Crisis Response and Recovery Fund could follow the same concept, with an earmarked budget line for the health sector

Mobilizing the resources and efforts of multiple agencies and stakeholders constitutes a considerable challenge. It requires all to coordinate and collaborate, while establishing mechanisms and structures to:

- Ensure accountability and transparency, with a focus on performance and outcomes.
- Ensure synergies and coherence between donors, and avoid gaps and duplication.
- Guarantee alignment and harmonization of all contributions.
- Safeguard national ownership and primacy of the public interest in all contributions.
- Attest to the realism of the plans and the plausibility of the costing information.

(b) The National Health Crisis Response and Recovery Council

The Government will set the needed structure in creating, for example, a National Health Crisis Response and Recovery Council, which will bring together, under Ministry leadership, the major stakeholders and agencies that are active players – as funders and/or implementers – in the health sector.

The Council will serve as a forum for **broadening policy dialogue** to develop coherent sector policies and an oversight on the health crisis response and recovery fund.

It will address private and public sector issues, striving for commonly agreed realistic expenditure programmes and monitoring arrangements. It will do so with a formal, legal, five-year mandate that ring-fences it from day-to-day political interference.

The Council terms of reference and by-laws (to be agreed upon with the Ministry, related donors and other stakeholders) would include:

- Setting plans on how funds will be used based on national priorities.
- Mobilizing and coordinating inputs and roles.
- Supporting the implementation plans of the various stakeholders.
- Monitoring and ensuring alignment and harmonization.
- Ensuring proper processes and structures are in place (including for communication with civil society).
- Monitoring progress with recovery, with adequate control and audit mechanisms.
- Adapting the recovery strategy and the related action plans to the evolving situation.

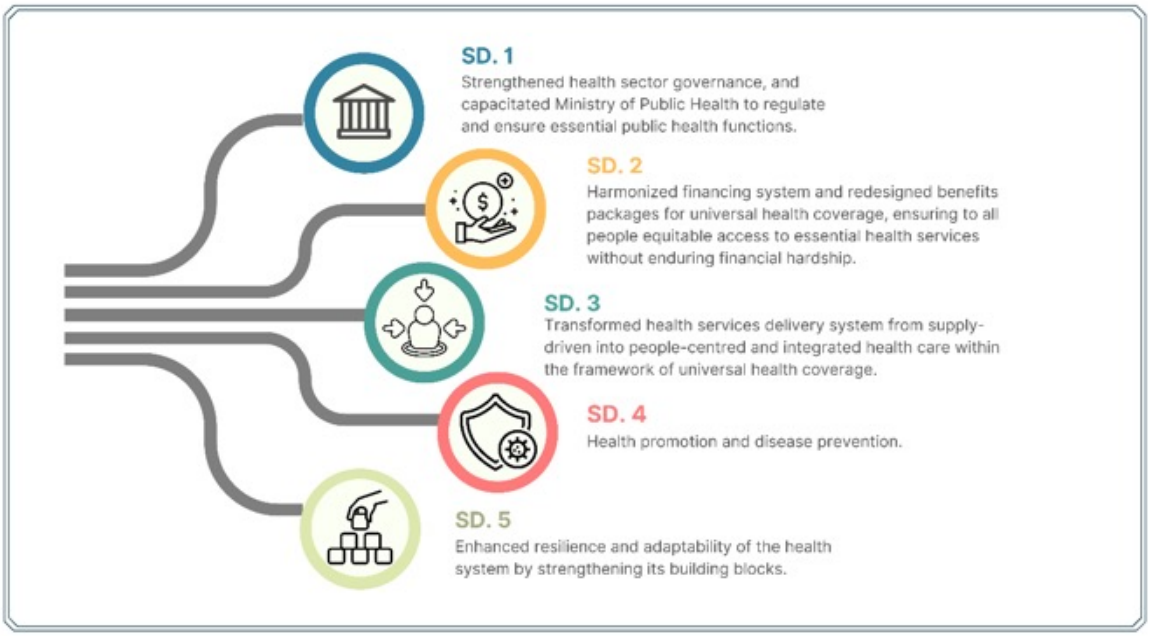
Establishing the Fund with its oversight Council structure prefigures the pooled funding – based universal health coverage system and the other strategic goals and objectives. It allows for ongoing selection of funding options and for building the mechanisms that trust for accountable governance.

Preparatory Steps

Immediate preparatory steps for the establishment of the Fund and the Council include:

- listing the agencies and stakeholders whose participation in the council is strategic and
- negotiating the terms of reference for the Fund and the Council.

E. Strategic Directions, Strategic Goals and Strategic Objectives



SD. 1 Strengthened health sector governance, and capacitated Ministry of Public Health to regulate and ensure essential public health functions.

SG. 1.1 Institutionalize and sustain collaborative governance.

SO.1.1.1 Promote collaboration between the Ministry of Public Health, professional orders, academia, civil society organizations, sector stakeholders and other partners. Collaboration would include, among others:

- Participatory decision-making, for example through licensing committees.
- Provision networks, for example primary health care involving NGOs and municipalities.
- Oversight and advice, for example through vaccine committees (such as National Immunization Technical Advisory Group for policy guidance, EPI committee for operational roll-out and COVID-19 vaccination committee).

SO.1.1.2 Translate gains in terms of collaborative governance into lasting institutional change aligning government and non-government resources to achieve national goals and serve the public interest.

SO.1.1.3 Develop interactive platforms with academia for a learning health system.

SG. 1.2 Enable effective Ministry leadership, intersectoral coordination and community engagement.

SO.1.2.1 Modernize the organizational structure and work of the Ministry:

- Define responsibilities and reporting lines and enhance delegation of authority to narrow the discretionary power of the Minister.
- Strengthen existing units and programmes and establish new ones to respond to current health challenges.
- Create an observatory to follow up on implementation, evaluation and analysis of this strategy.

SO.1.2.2 Build Ministry capacity for effective leadership and regulation:

- Recruit qualified staff to fill critical vacant positions to fulfil its leadership and regulatory role over health providers, including NGOs who are involved in providing health services.
- Revisit regulation criteria and procedures:
  - > Modernize licensing and relicensing legislation related to health facilities, health professions and health products and services, with particular emphasis on safety and quality.
  - > Build the capacity of Ministry staff.

SO.1.2.3 Engage municipalities and local communities:

- Develop district physicians' skills to involve municipalities and communities in their activities.
- Engage municipalities and civil society organizations in epidemiological surveillance and other programmes.

SG. 1.3 Enhance decentralization and autonomy.

SO.1.3.1 Empower existing decentralized Ministry units (regional and district offices).

SO.1.3.2 Strengthen existing autonomous public hospitals:

- Set strict qualifications criteria and merit-based selection process for appointment of boards of directors to minimize political favoritism.
- Establish monitoring and accountability frameworks.
- Provide financial and technical support.

SO.1.3.3 Create new autonomous public institutions:

- Implement the Lebanese Drug Administration (LDA) law.
- Activate the Drug Quality Control Laboratory.

SG. 1.4 Ensure health security and other essential public health functions.

SO.1.4.1 Strengthen preparedness and public health response to disease outbreaks, natural disasters, and other emergencies:

- Invest in health emergency and disaster risk management.
- Strengthen and enhance the current department responsible for preparedness for better prevention, preparedness, detection and response to potential health risks and emergencies; led by the Ministry, involving all concerned ministries, stakeholders, and municipalities.
- Adopt and implement an integrated disease surveillance strategy, including indicator-based surveillance and event-based surveillance components.
- Restructure the Epidemiological Surveillance Unit (ESU) to ensure timely surveillance and timely response within a strong network, including municipalities, the Lebanese Red Cross and other civil society organizations, to detect, manage and withstand emergencies.
- Fulfil IHR and pandemic treaty requirements and update the Joint External Evaluation and National Action Plan for Health Security.
- Strengthen overall emergency management capacities within the Ministry and the emergency medical response system, including optimizing the use of the emergency operations centre.

SO.1.4.2 Perform surveillance and monitoring of health determinants, risks, morbidity and mortality.

SO.1.4.3 Reduce vulnerability to health threats at individual and collective levels:
Strengthen health protection, including management of environmental, food, toxicological and occupational safety.

SG. 1.5 Establish the practice of good governance principles.

SO.1.5.1 Develop rules and implement tools for good governance principles and grievance mechanisms.

SO.1.5.2 Enhance transparency and accountability within the Ministry and in public-private partnerships, with a focus on accountability and a participatory approach, including in the selection of and contracting with private providers and monitoring and accountability frameworks.

SO.1.5.3 Enforce the law on access to information.

SD. 2 Harmonized financing system and redesigned benefits packages for universal health coverage, ensuring to all people equitable access to essential health services without enduring financial hardship

SG. 2.1 Ensure sufficient financing and design a unified basic benefits package for all public funds and the Ministry that is financially sustainable and accepted by the population.

SO.2.1.1 Establish an entrusted consensual mechanism for rationing the collectively financed health benefits, based on equity, continuity of care and financial sustainability. (Consider the political feasibility of removing acquired benefits at high cost and

little added value.). Establish the Health Financing Coordination Committee.

SO.2.1.2 Develop a unified essential benefits package, including promotive, preventive, primary, hospital and palliative care for all citizens, to be adopted by various third-party payers and coverage schemes, in line with peoples' needs and scientific evidence:

- It should be mandatory for employers to insure their migrant workers for the same benefits, whereas refugees' coverage schemes should be aligned with the national package to make sure that all residents have equitable accessibility to the same benefits package.
- Establish the Health Benefits Package Task Force.
- Any additional benefit should be subject to a health technology assessment and conditioned by the availability and sustainability of funding. A health technology assessment committee should be set up, including representatives from public funds and professional orders.

SO.2.1.3 Implement a real-term increase of health financing from taxes based on political economy analysis, with sufficient allocation to primary health care and reduced out-of-pocket expenses:

- Progressive taxation.
- Taxation on capital gains.
- Taxation on harmful products (earmarked to health).
- An active interaction with the Ministry of Finance is necessary to develop prospective studies in taxation areas to be used to increase available resources for health.

SO. 2.1.4 Secure international financial assistance:

- Create a Health Crisis Response and Recovery Fund.
- Establish a National Health Crisis Response and Recovery Council.

SG. 2.2 Develop tools to identify the poor and vulnerable population and adopt mechanisms to better target them.

SO.2.2.1 Upscale the National Poverty Targeting Programme (NPTP):
Revise the proxy means testing tool, under the Ministry of Social Affairs and in collaboration with the World Bank, to identify different household categories with limited spending ability (not only the extreme poor), using a unified patient identification number to manage eligibility and entitlements.

SO.2.2.2 Connect the National Poverty Targeting Programme database to the Ministry of Public Health primary health care and visa and billing information systems.

SO.2.2.3 Develop waiver policies for prepayment and co-payment, graded according to the household category.

SG. 2.3 Formally involve private insurance funds, including mutuality funds, through regulated and standardized complementary coverage, with a focus on the informal sector of the economy.

SO.2.3.1 Private insurance funds and mutuality funds should be better regulated and intentionally involved, in a harmonized financing for universal health coverage.

SO.2.3.2 Public funds should adopt one basic package for all people financed by collective contributions (this may be a combination of income-based taxes and social security contributions).

SO.2.3.3 Standardized designs of voluntary complementary schemes should be privately financed (from premiums and/or saving accounts) for those who can afford it.

SG. 2.4 Revisit and harmonize institutional arrangements and public-private partnerships, with standardized mechanisms across public funds.

SO.2.4.1 Upgrade the unified public funds beneficiaries' database to capture utilization patterns and spending.

SO.2.4.2 Build a common value-based health care framework and promote performance contracting.

SO.2.4.3 Encourage public funds and private insurance funds to have contracts with and/or reimburse bills from the primary health care centres in the national network.

SO.2.4.4 Restrict the services publicly covered in private tertiary care centres to high-tech advanced treatments that could not be provided in less expensive settings like public hospitals.

SO. 2.4.5 Build a health systems institutional arrangement "fit for purpose" for policy development and implementation, and for improved accountability, transparency, and response at national and subnational levels.
Such institutional arrangements include those for overseeing and regulating public-private sector engagement in the health sector.

SG. 2.5 Reset payment mechanisms of the Ministry and public funds to get better value for money in the procurement of goods and services and standardize medical and financial audits.

SO.2.5.1 Upgrade performance contracting through the Ministry, including quality and case mix criteria following performance-based payment schemes.

SO.2.5.2 Unify contracting modalities and payment mechanisms among public payers.

SO.2.5.3 Set new co-payment mechanisms, privileging the use of generic medicines, while emphasizing the coverage of health promotion, prevention, elderly care, long-term care and palliative care.

SO.2.5.4 Primary health care provider payment should be built on capitation and linked to provision of defined packages of promotive, preventive and curative services:

- Capitation should be based on the health centre's enrolees, recruited from the assigned catchment area.
- The budget should take into account the number of households and their income distribution.
- Equitable allocation of capitation among centres with risk adjustment mechanisms.

SG. 2.6 A road map to achieve the long-term objective of unifying public health funds under one autonomous health authority.

- Based on political economy analysis, consider the possibility of a virtual single pool with risk equalization mechanisms as an alternative.
- Establish the national health insurance authority.

SD. 3 Transformed health services delivery system from supply-driven into people-centred and integrated health care within the framework of universal health coverage.

SG. 3.1 Scale up the national primary health care network, define catchment areas for primary health care centres as gatekeepers, and set up a referral system privileging the front-line public hospitals.

SO.3.1.1 Expand the primary health care network and enhance centres' capabilities:

- Develop advanced licensing criteria specific for primary health care centres.
- Extend the opening hours of primary health care centres with a permanent availability of family physicians.
- Upgrade the centres' diagnostic capacities, including medical imaging and lab testing.
- Reactivate the primary health care accreditation programme.

SO.3.1.2 Set gatekeeping rules whereby every citizen should access health care through a primary health care centre of his/her choice, with a referral system privileging public hospitals over private:

- Establish a case management system to guide patients through different health care levels and coordinate their personalized care.
- Additional gatekeepers could be considered, such as public hospitals' outpatient departments, family physicians or trained general practitioners.

SO.3.1.3 Develop home care as an extension of the primary health care network to close the loop of continuity of care to include regulating private home-care providers.

SO.3.1.4 Involve community and ensure that no one is left behind. Ensure that the system is responsive and gain public acceptance of the strategy.

SG. 3.2 Redefine the model of secondary and tertiary care with a focus on front-line public hospitals as "hôpitaux de proximité".

SO.3.2.1 Redefine the role of public district hospitals as front-line general hospitals, with essential specialities to cover all

people's needs at district level while leaving advanced specialized tertiary care services to bigger regional public hospitals and engaging the private hospitals when needed:

- Strengthen the governance of the public hospitals and improve the status of the workforce and financing.
- Re-evaluate the autonomous law and the "real" independence of the public hospitals.

SO.3.2.2 Assign a clear public health mission to public hospitals in addition to providing quality-assured medical services.

SG. 3.3 Redesign the coverage and provision of emergency health care services.

SO.3.3.1 Explicit coverage of emergency services, including transportation and care, should be provided by the Ministry, public funds and private insurance.

SO.3.3.2 Revisit emergency services payment mechanisms by defining packages of emergency care with fair flat-rate reimbursement.

SO.3.3.3 Reorganize and regulate ambulance services and paramedics, and revisit institutional arrangements between insurers and providers.

SO.3.3.4 Promote emergency medical specialty and paramedics vocational training.

SG. 3.4 Transform long-term care towards good professional practice, respectful of human rights, and strengthen palliative care.

SO.3.4.1 Establish and promote elderly homes (hospices) and geriatric care.

SO.3.4.2 Promote specialized long-term medical services.

SO.3.4.3 Expand and fund rehabilitation centres.

SO.3.4.4 strengthen mental health institutions.

SO.3.4.5 Integrate palliative care at different levels of health care with particular emphasis on home care.

SG. 3.5 Involve the private sector beyond provision of hospital care.

SO.3.5.1 Engage private outpatient caregivers (physicians, midwives, psychologists and so on) in the continuity of care cycle and reporting systems.

SO.3.5.2 Promote privately provided and collectively financed home care, elderly care and palliative care.

SO.3.5.3 Link outpatient private providers to the health information system, including regulated use of standardized and user-friendly electronic health records.

SO.3.5.4 Strengthen regulations for the private sector.

SD. 4 Health promotion and disease prevention.

SG. 4.1 Seek intersectoral approach to address social determinants of health inequity, and promote the Health in All Policies concept.

SO.4.1.1 Conduct a national assessment and support implementation of interventions for improving environmental issues, including waste management and air pollution. Allocate additional resources to protect the environment.

SO.4.1.2 Promote multisectoral action and whole of government and whole of society approaches:

- Establish formal intersectoral mechanisms between the concerned groups.
- Ministries should involve their devolved units for day-to-day operations.
- Engage municipalities and communities.

SO.4.1.3 Address social determinants of health, including equity, and regain achievements in SDG 3 related to health (mainly child health and maternal health):

- Include other vulnerable groups like older persons, persons with disabilities, prisoners and refugees, and give special attention to gender equality.

SG. 4.2 Use communication and social mobilization for health.

SO.4.2.1 Enhance community and civic engagement.

SO.4.2.2 Inform people, and enhance knowledge among the general public:

- Empower people to have a voice and take action to promote adequate health-seeking behaviours and aim to build trust in public health services, primary health care centres, hospitals and generic medications, with a focus on the quality of services and commodities.
- Promote the options of the strategy using all channels of media to enhance acceptability.

SG. 4.3 Target the youth and promote the school health programme.

SO.4.3.1 Promote youth health, school health and other health programmes in educational facilities not limited to schools (nurseries, orphanages, vocational educational centres and universities).

SG. 4.4 Design and implement programmes targeting Non-communicable Diseases that are integrated at different levels of health care.

SO.4.4.1 Implement the best buys, including taxes on all tobacco/nicotine products and enforcement of the law.

SO.4.4.2 Address non-communicable disease prevention, including use of primary health care outreach and early diagnosis activities: Benefits packages should be developed for disease prevention and early detection (especially for cancers, diabetes mellitus, hypertension and others) at primary health care centres and public hospitals and integrated into the electronic health records and the case management system.

SO.4.4.3 Ensure access to essential medicines for people living with non-communicable diseases.

SO.4.4.4 Non-communicable disease services, especially at the primary health care level, including facilities to better prevent, early detect, diagnose, treat and manage non-communicable diseases.

SO.4.4.5 Enhance access to mental health and substance use services through scaling up the integration of mental health within primary health care.

SO.4.4.6 Community-based mental and psychosocial support services should promote and protect mental health.

SG. 4.5 Fighting communicable diseases.

SO.4.5.1 Follow and implement The One Health approach which calls for the collaborative efforts of multiple disciplines working locally, nationally and globally to attain optimal health for people and the environment by preparing and responding to communicable diseases.

SO.4.5.2 Vaccine-preventable diseases:

- Strengthen routine vaccination and adult vaccination (including but not limited to yellow fever for travellers, meningitis vaccine for pilgrims, hepatitis B vaccine for health care workers, influenza and pneumococcal conjugate vaccines for high-risk groups, as well as anti-rabies and COVID-19 vaccines).
- Strengthen and expand the existing collaboration with private providers under the national immunization programme for rational use of vaccines provided by the Ministry.
- Ensure a continuous supply of vaccines by engaging in a policy dialogue and advocacy for Lebanon to ensure eligibility to the Gavi Alliance and the global fund after being reclassified as a low- to middle-income country.
- Harmonize funding support should reduce inequities and increase access to vulnerable groups.
- Create trust and confidence in public sector vaccination.
- Ensure the quality of vaccine storage, cold chain and immunization waste management.

SO.4.5.3 Improve water quality and food safety by working with other relevant stakeholders.

SO.4.5.4 Re-establish the central public health laboratory, with a status of autonomy:

- Revisit the central lab functions by establishing a national network of reference labs in Lebanon.
- Set an independent laboratory for drugs analysis to be linked to the LDA.
- Decentralize the food analysis function and coordinate with the Ministry of Agriculture and municipalities.

SO.4.5.5 Address antimicrobial resistance using the One Health approach.

SO.4.5.6 Fight communicable diseases, in addition to vaccine-preventable diseases such as tuberculosis and HIV

- Tuberculosis elimination plan.
- Strengthen the HIV response.
- Hepatitis prevention, testing and treatment.

SG.4.6 Implement the National Nutrition Strategy.

The Ministry of Public Health, in collaboration with WHO, launched the first national nutrition strategy and action plan (2021–2026) for Lebanon, following a multisectoral consultative process involving key nutrition stakeholders. This strategy aims to ensure optimal nutrition outcomes while responding to the most urgent needs in nutrition.

SD. 5 Enhanced resilience and adaptability of the health system by strengthening its building blocks.

Governance, financing and provision of health care are dealt with as strategic directions respectively under strategic direction 1, strategic direction 2 and strategic direction 3. Under strategic direction 5, we are considering health human-power, information systems and medical products.

SG.5.1 Health human-power development, retention and repurposing.

SO.5.1.1 Increase the production of a high-level workforce for the country (and the region), in addition to a retainment strategy with incentives to serve primary health care and rural areas.

SO.5.1.2 Upgrade curricula to better serve national health policies, emphasizing promotion, prevention, primary health care, palliative care, geriatric care, generic medicines, good governance, ethics, patient safety and other critical issues.

SO.5.1.3 Measures to improve health workforce retention include:

- Improve tariffs and provide support to health facilities operating at different levels of the health system to enable them taking concrete measures to improve working conditions, increase salaries and provide incentives.
- Set a national task force headed by the Ministry and including professional orders and other stakeholders (especially professionals that are not organized under an order, such as public health professionals and environmental health professionals) to take rapid and targeted action and keep up with the rapidly evolving situation.
- Encourage and support hospitals to attract foreign clientele to generate hard currency income, by rationalizing cost and improving the quality of their services, to become more regionally competitive.
- Retention strategies of physicians, nurses and other essential health care workers could include rotation with facilities abroad.

SG. 5.2 National health information system.

SO.5.2.1 Develop a health information system master plan with a centralized data centre.

SO.5.2.2 Advance public health research to inform and influence policy and practice:

- Partner with academia.
- Gather information and research for evidence-based medicine and management.
- Learning health system: Create evidence-informed policy.
- Practice-based evidence: Enhance support mechanisms and models for further use of routine data for decision-making in the health system.
- Monitor patient satisfaction and patient safety indicators.
- Establish national disease registries.

SO.5.2.3 Establish and utilize electronic health records:

- Establish regulations for a standardized electronic health record.
- Digital systems should be integrated at all levels of health care.
- Adopt a unique health identifier for all people residing in Lebanon.

SO.5.2.4 Telehealth feasibility and acceptability in Lebanon should be considered.

SG.5.3 Medical products and technologies.

SO.5.3.1 Secure universal and sustainable access to quality medications, including generics:

- Blunt Government subsidization of medicines and medical supplies should be replaced by direct support, targeting people in need.
- Improve registration and quality control of imported and local products, and sustain good storage and distribution practices, and pharmacovigilance.

SO.5.3.2 Ensure early access to innovative medications while maintaining resource optimization using health technology assessments.

SO.5.3.3 Use an operationalized tracking system for medicines and implantable devices.

SO.5.3.4 Optimize, expand, and support the local industry by increasing its production capacities for local and export markets to include new therapeutic areas.

SO.5.3.5 Cost containment and promoted use of generics:

- Rationalize medical prescriptions.
- Enhance transparency of registration to improve confidence of physicians and the public.
- Enforce substitution regulations.
- Enforce the code of ethics.
- Favour the procurement of domestically produced generic medications, especially by public providers.

SO.5.3.6 Promote the rational use of medications by prescribers, dispensers and consumers.

SO.5.3.7 Digitalize the system by using 2D barcodes, Meditrack and health technology assessments.

SO.5.3.8 Promote and encourage localization.

F. Indicators to be considered

A summary of indicators is presented below.

A detailed matrix for indicators by strategic directions, goals and objectives is found in **annex 4**.

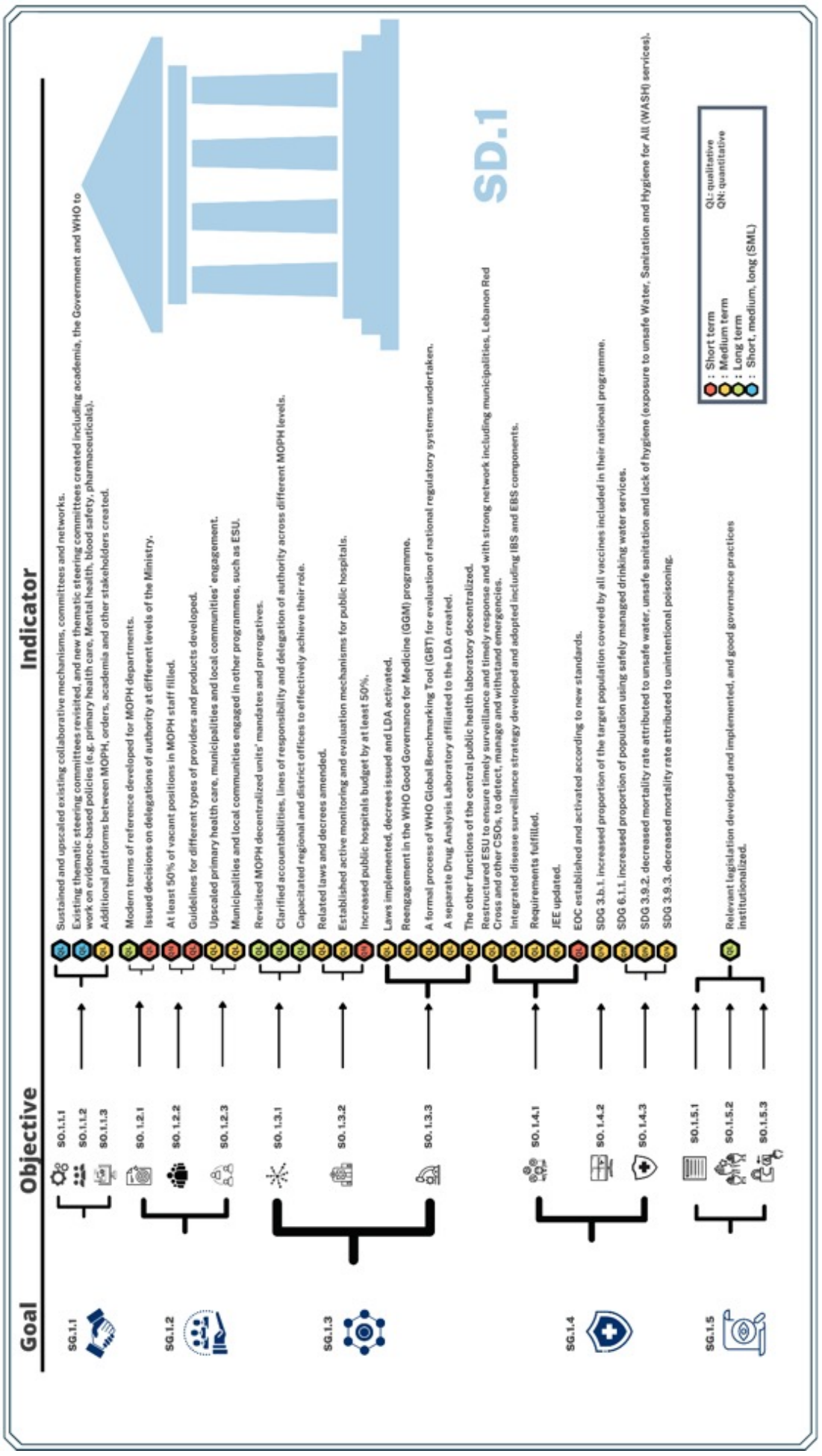


Figure 3. Suggested indicators for strategic direction 1

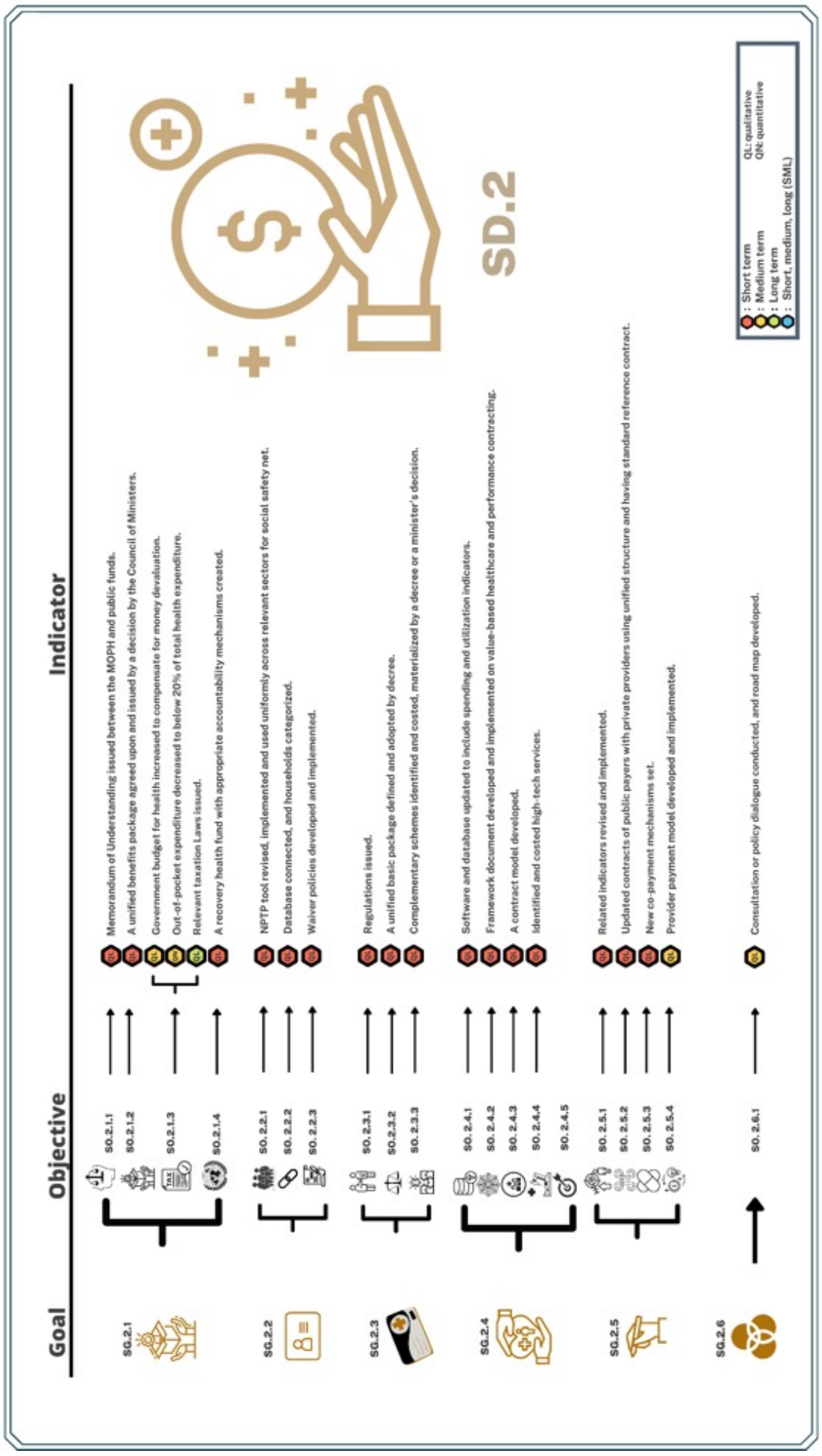


Figure 4. Suggested indicators for strategic direction 2

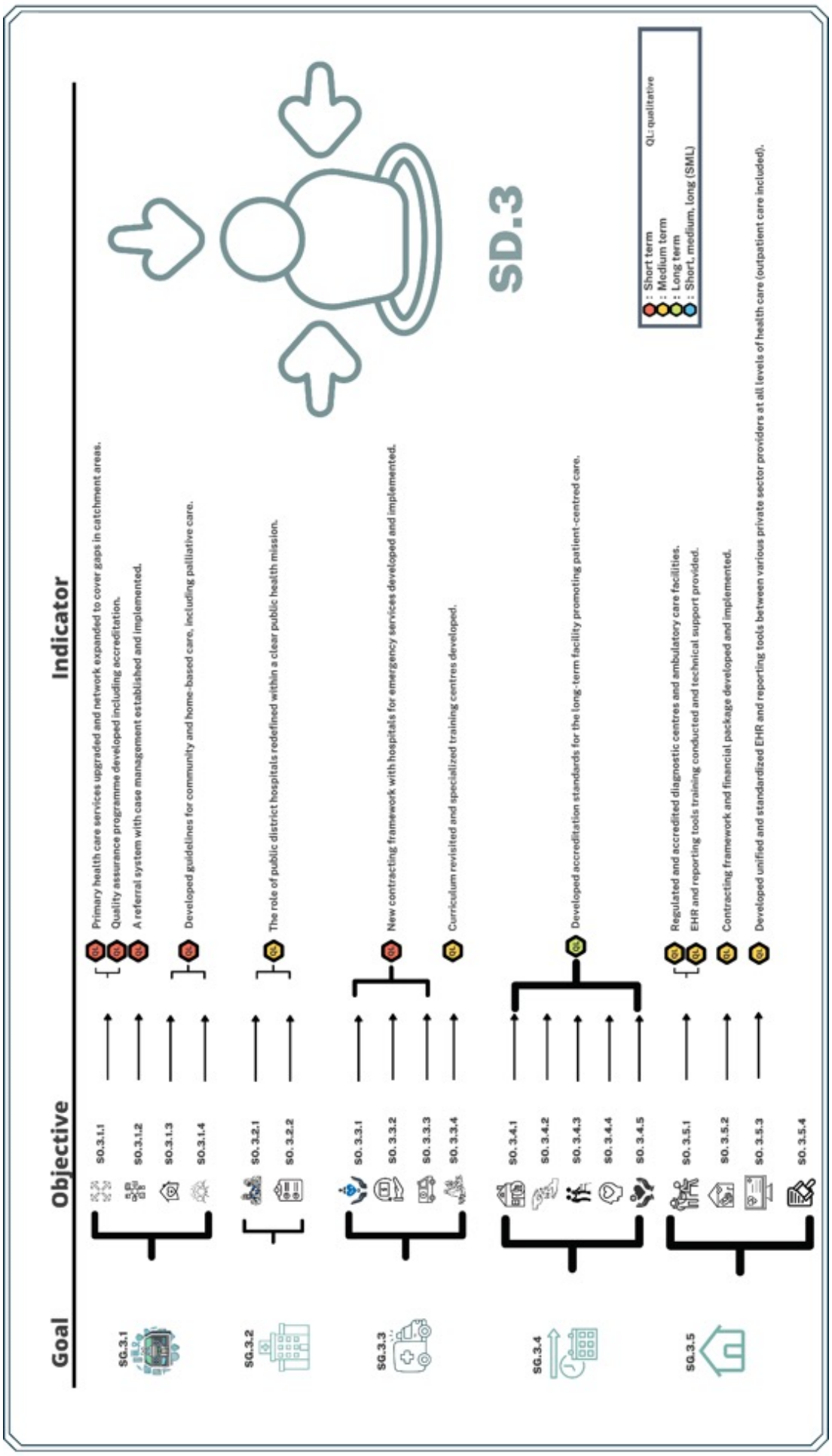


Figure 5. Suggested indicators for strategic direction 3

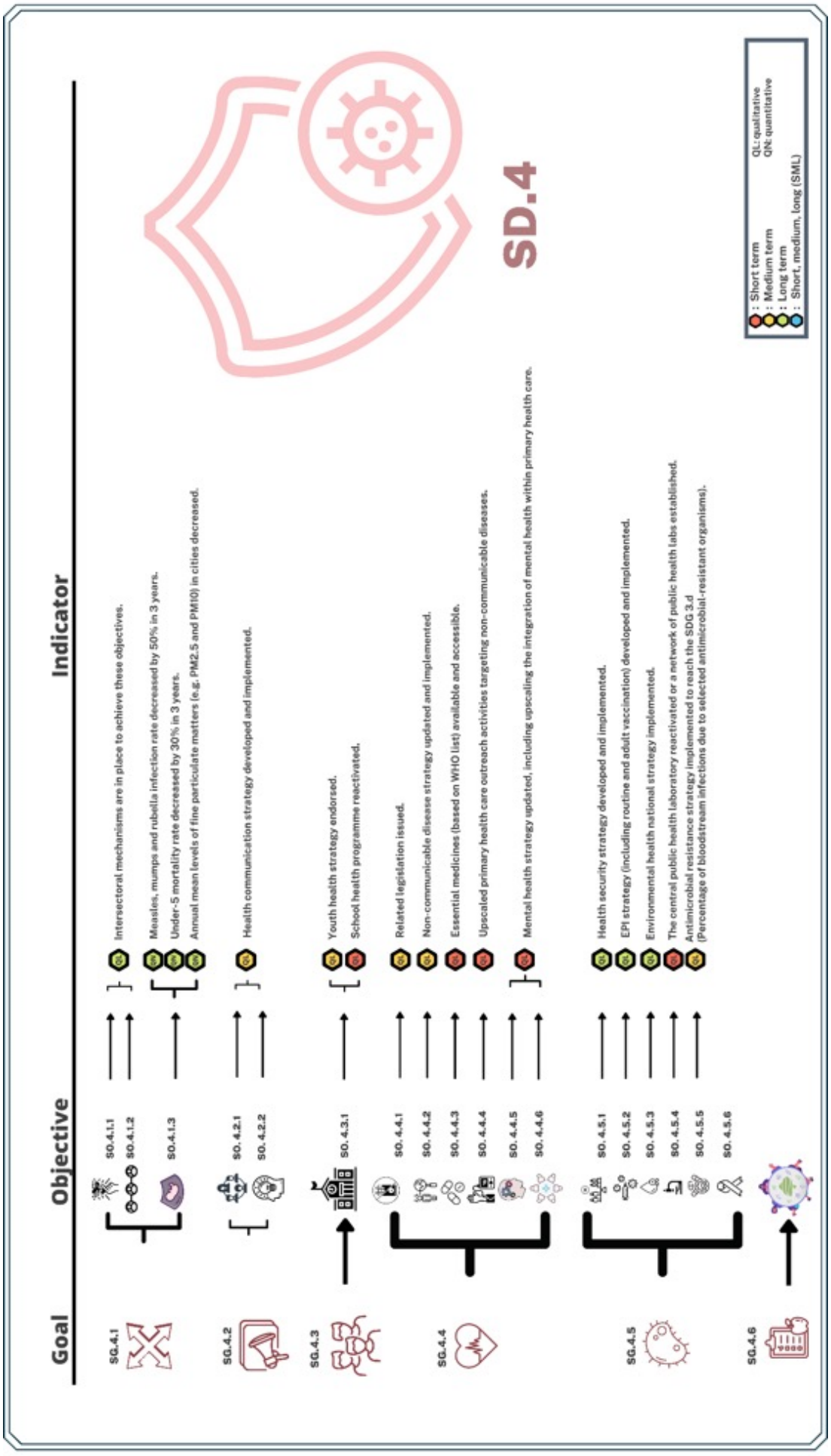


Figure 6. Suggested indicators for strategic direction 4

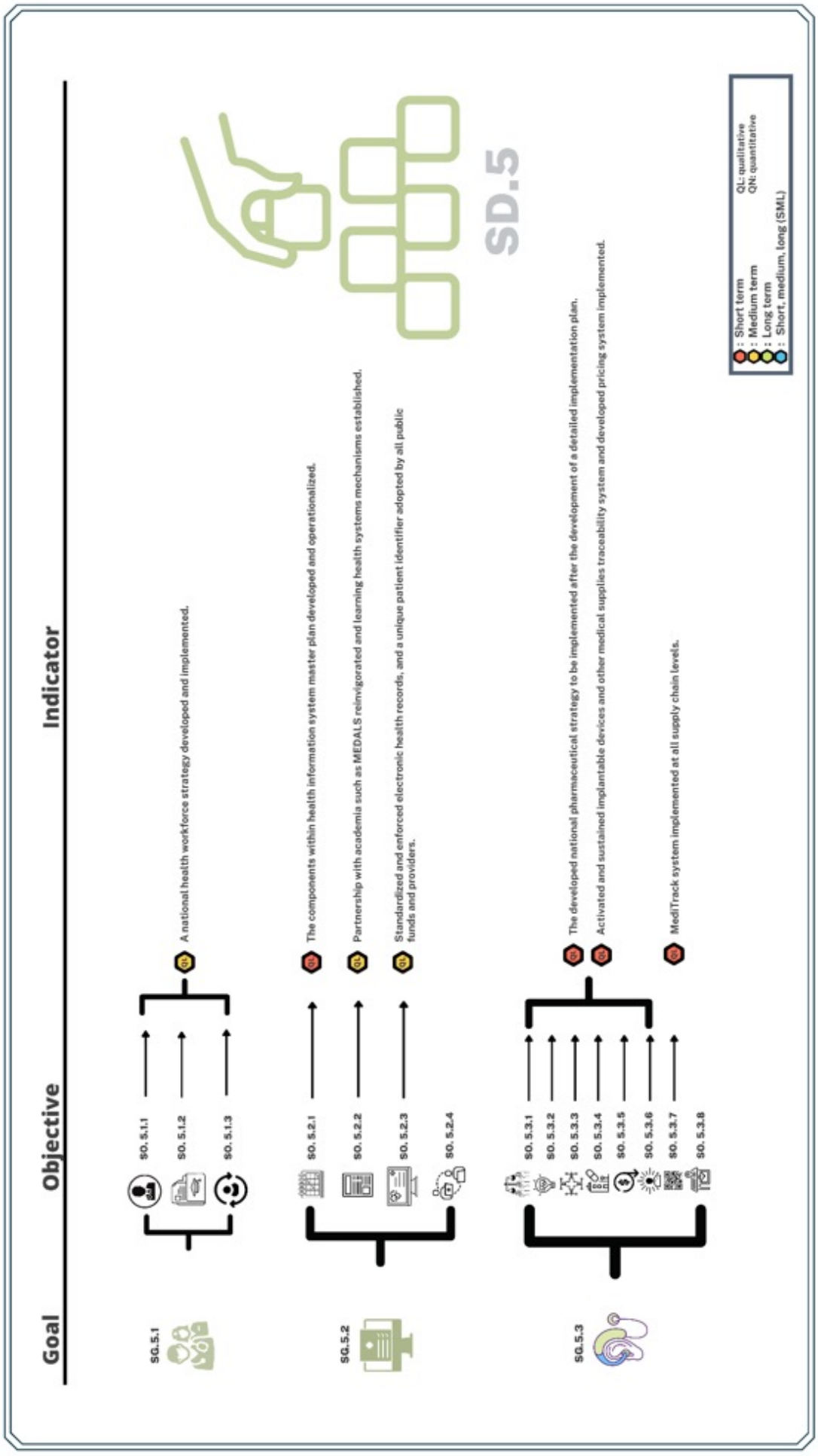


Figure 7. Suggested indicators for strategic direction 5

G. Investment in integrated recovery packages

Four areas are identified for strategic investment in health sector recovery. An additional fifth cross-cutting area on digitalization could be agreed upon with certain donors. An integrated package of actions is proposed for each area within a transparent and accountable framework. These four areas map to the above strategic directions, objectives, and goals.

Emergency project funding for crisis response and relief should be aligned to these four areas for investment, with a focus on re-establishing access to care. Towards the medium term, aid should move along structural support of a realistic and sustainable budgetary framework for the country.

1. Strategic investment, area 1: Expanding universal health coverage – equitable access to better care

Universal health coverage needs to be expanded to ensure access for all to timely, quality, people-centred care, with the necessary arrangements to avoid exposing users to financial hardship.

The package or transformative lines of action for expanding universal health coverage includes:

- Redefining a health benefits package that makes equitable access realistic.
- Redesigning service provision to allow for better quality and more satisfactory patient experiences.
- Investing in the sector's human resources.
- Capitalizing on and expanding achievements made in ensuring affordable access to pharmaceuticals and technology.
- Securing the needed funding from mixed sources: internal and external.

A Health Benefits Package Task Force should be established for overseeing the design, adoption and roll-out of access to a unified, collectively financed, essential services. It will also be responsible for setting up the processes and structures to define the benefits package and building consensus for its adoption.

Unification of the health benefits package can serve as the basis for unifying purchaser leverage in negotiations with providers and for defining the legal frameworks for the public purchase of quality-assured care. This would pave the way for a transition to value-based and people-centred services within a gatekeeping and referral framework.

Integrating the Declaration of Astana of 2018 and investing in primary health care and health services that are of high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well-trained, skilled, motivated and committed will be a major step towards universal health care coverage and achievement of the SDGs.

As pharmaceuticals represent the biggest share of health spending, any reduction in the cost of medicines and medical supplies would be reflected in the affordability of additional services in the benefits package, provided that beneficiaries have trust in the products' quality. It is therefore crucial to focus on safeguarding and regulating the medical products and supplies portfolio in the Lebanese market.

Investment in human resources is necessary to adapt to and compensate for the sudden scarcity of human resources. The priority is to support quality, people-centred ambulatory and hospital care, and to set and monitor gatekeeping and referral mechanisms.

2. Strategic investment, area 2: Healthier living – health promotion and disease prevention

Healthier living invests in an answer to one of the major paradoxes of the Lebanese health system: a sophisticated curative care infrastructure alongside a relative neglect of risk reduction, disease prevention and healthy lifestyles. To correct this paradox, sector stakeholders are to develop programmes and initiatives targeting the following priorities:

- Intervene at the policy, prevention/screening and management levels to reduce high-impact health risks (smoking, unhealthy diet, f environmental pollution, traffic, occupational health, among others).
- Monitor and promote population health through priority programmes such as those for non-communicable diseases (including cardiovascular problems, cancer, mental health), mother, adolescent and child health (sexual and reproductive health, women's health, youth health risk behaviours) and nutrition (breastfeeding, malnutrition screening and other national nutrition strategy components). This can be done by the establishment of selected registries and surveillance systems in partnership with communities of practice and professional orders, among others.
- Engage and better remunerate community pharmacists in prevention, monitoring and other public health initiatives, counting on their proximity and capacity for reaching out and influencing people's perceptions and knowledge.

3. Strategic investment, area 3: Emergency health preparedness response and recovery

Health security intends to pre-empt health emergencies and improve the country's readiness to face catastrophic health incidents and pandemics. Within the all-hazards approach, and in line with international health regulations, the Ministry of Public Health and other sector stakeholders are to develop programmes and initiatives to:

- Ensure emergency preparedness and response capacity by developing high-quality, regularly stress-tested and updated preparedness plans and structures with clear lines of command and control, and risk communication led by the Ministry. The preparedness plans are to be integrated with regional Mediterranean preparedness networks and build on the experience with managing the COVID-19 pandemic.
- Specifically, for the COVID-19 pandemic, it is necessary for the Government to develop and disseminate a strategy for actively preventing new cases, aiming towards containment and avoiding surges. The approach should be people-centred rather than hospital-centred, and therefore not allow infections to become widespread even if hospital capacity is unthreatened.
- Enhance Ministry coordination capacity, which includes establishing an emergency operation unit or team at the Ministry to coordinate health emergencies preparedness and response, develop plans for capacity-building and enhance multisectoral partnership.
- Re-establish critical public health functions, including the central public health lab (through a network of national reference labs), antimicrobial surveillance and a national infection prevention and control programme, and an expansion of the early warning alert and response system through full automation and operationalization of the One Health approach.
- Fighting communicable diseases by following the One Health approach, which is a main component in health security. Revitalize and re-resource the vaccination infrastructure of the country (both routine childhood and adult vaccines, including COVID-19 vaccination) by reinforcing the engagement of the private sector, and considering vaccine as a common good, purchased from collective financing and permanently available to authorized providers. In addition, monitor water and food safety and address antimicrobial resistance as they are also essential components of health security.

4. Strategic investment, area 4: Health governance for the public interest – leadership, steering and regulating

Health governance for the public interest is intended to re-establish trust in health authorities and align governmental and non-governmental resources with national goals and the public interest. To this effect the Ministry of Public Health and other sector stakeholders are to develop programmes and initiatives to:

- Make regulations and sector governance based on facts and evidence by agreeing on a shared agenda and implementation arrangements of studies and research to produce strategic intelligence and regulatory capacity. The agenda is to be designed to directly benefit the work of the health benefits package task force work on expanding universal health coverage. An immediate priority action point within that agenda is to set up the systems for the identification of the poor and vulnerable. Also, the agenda is to include the programming of key surveys and studies, with particular attention to the sustainability of progress towards universal health coverage. It is to serve as a critical input for the design of a national health information system master plan that will contribute to a learning environment for experimentation and innovation. Develop a roadmap to unify all public funds under one autonomous authority with well-defined governance structure. Meanwhile, unify services/packages, tariffs and contracts. Institutionalize and sustain collaborative sector governance through involvement of key stakeholders – including civil society organizations – building on the pre-crisis experience of the Ministry with collaborative governance. It will require investment in the capacity and structures for sector leadership of the Ministry by capacity-building and modernizing the organigram with additional and essential new units needed and continued close coordination with all other key stakeholders.
- Operationalize the One Health and Health in All Policies concepts:
  - First, by institutionalizing intersectoral consultations and mechanisms that aim to ensure legitimate health concerns are prominent in the country's recovery plans, across the various sectors. This requires a consensus from the Government on institutionalizing the commissioning of a systematic ex-ante assessment of the expected health impacts of the recovery plans and projects of the various sectors, as of their design phase.
  - Second, by planning and commissioning the production, collation and sharing across the Government and among key stakeholders of actionable information on the health impact of environmental challenges, with a focus on waste management, air pollution, non-health care sources of antimicrobial resistance and the consequences of global warming.
  - Third, organize the participation of Lebanese human and veterinary public health authorities in regional zoonotic emergency prevention and intervention programmes.

5. Strategic investment, area 5: Digitalization

Investing in a health information system is essential for the proper implementation of all four strategic investment areas. A fifth strategic investment area could be designed to finance the development and implementation of an information management system master plan. This would be done in agreement with donors, based on this strategy document, considering digitalization as a cross-cutting component, and a cornerstone for all of the above investment areas. Digitalization will provide evidence for decision-making, help avoid duplications in coverage and utilization of services, serve to identify the eligibility and targeting of the vulnerable population, include indicators and monitor patient safety, and most of all, ensure transparency and accountability. A key agenda would be to institutionalize the national capacity for evidence-informed policymaking for health, which has been a national objective in Lebanon in the past, in line with the current WHO initiatives.

H. Recovery and reform will take time

The health system in Lebanon presented structural fault lines and distortions that could not withstand the concatenation of crises of the past few years. The damage done is considerable. Things may get worse before they get better, depending on the speed of mobilizing the resources for emergency relief and response, structural recovery and reform. Many households will have to rely on out-of-pocket spending for quite a while. The government capacity to subsidize for the health of the poor and vulnerable is limited and will be dependent on donor funding to a degree that requires new mechanisms to ensure country ownership and alignment to national priorities. Uncritical satisfaction of unrealistic expectations for public subsidy to low-impact, high-tech care will prove unfeasible in the financial context of the coming years. Paradoxically, this increases the leverage of the Ministry of Public Health and its governance allies to revisit contractual arrangements with hospitals, rationalize ambulatory care and expand public initiatives to hereto underinvested public health functions. This calls for a time frame of ten to fifteen years, with substantial new fiscal space for investing in the recovery and reform of the health sector. A coordination mechanism needs to be established for aligned and efficient use of the global health initiatives and donor support like the Gavi Alliance and other donors.