Annex 1

Strategic directions of the healthcare system in Lebanon

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5- The national health strategy

The health sector reform in Lebanon aims at improving the performance of the health system and achieving the public health objectives of equity in service provision and funding and the continuous development of insurance systems. The main pillars of health reform consist of putting an end to the increasing percentage of the GDP committed to health expenditure, providing just and efficient services and further relieving the household burden. Hence the necessity to implement many programs intended to cover all aspects of the health system, such as the social determinants of health, social security, information systems and primary healthcare services that are primordial to citizens' health improvement. The Ministry covers hospital stays and expensive medicines, but not out-patient services, hence the need to provide affordable and efficient primary healthcare services as an alternative to the expenditures that are normally covered by the private insurance funds (consultation, medication and exams). The network of primary healthcare centers should therefore be extended and accessible to all citizens, especially the underprivileged communities.

Moreover, the public sector should increase its contribution to health funding, first because the government's share of health coverage is limited, compared to the rest of the Middle-East countries; and second because the most efficient way of unburdening the households lies in the improvement of social security and primary healthcare services.

5-1 Restoring the citizens' trust in the MoPH

The MoPH in Lebanon provides services that often beat those offered in many wealthier countries, but the citizens fail to perceive it because of many reasons explained in the following.

- The Ministry spends the largest part of its budget in the coverage of health services in private hospitals that usually belong to the different religious sects, which direct the provided services towards their own benefit. The citizen, therefore, gets the impression he's taken care of by his own sect or community, instead of the government. Not to mention the unjustified intervention of political leaders in securing healthcare services to their followers, thus creating a feeling of loyalty towards the politicians, instead of the government.
- Citizens are sometimes subject to the incompetence and even rudeness of certain employees, which gives rise to resentment and recourse to political intervention.

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- The shortage of staff and equipment in the Ministry compromises the behavior and performance of the employees. Indeed, the inadequate building of the Ministry, where the offices are crowded and tens of citizens are always waiting at the single elevator door, the absence of parking spaces for the employees, the difficult access to the building due to multiple military stations surrounding it, etc., create tension and resentment, instead of gratitude toward the Ministry for the costly and indispensable services provided.

- The MoPH budget cannot cover the provided services and is not compatible with the promises of the successive governments to provide the best and most expensive treatments, without exceeding the 3% of the government budget that are dedicated to the Ministry. The limited resources imply a financial ceiling to all hospitals, including public ones. This creates end-of-month crises requiring the intervention of highly ranked officials and sometimes of the Minister himself to handle individual cases. Shortage of medications is also frequent at the end of each year. Therefore, politicians are urged to adapt their speeches and promises to the potential of the country, and available resources should be well managed to make the most out of them. However, the financial resources dedicated to healthcare should be revised, in order to allow the Ministry to successfully fulfill its responsibilities towards the citizens.
- The media and politicians criticize the system beyond proportion, which creates tension between the citizens and the different public institutions.
  Enhancing the citizens' trust in their government, and particularly in the MoPH, is of one of the citizenship pillars and is of prime importance to the success of any national strategy.

5-2 Organizational restructuring of the MoPH

The present structure of the Ministry dates back to 1961 and cannot keep up with modern requirements, despite the renovation of some departments (and not others due to lack of space) by virtue of several decrees. In collaboration with the Ministry of Administrative Development, we designed a new organizational structure for the MoPH, which will be presented as a law proposal.

5-3 Recruiting the qualified staff

The MoPH, which, like all ministries, is understaffed, is required to determine the human resources needed with respect to present vacancies. The organizational structure of the Ministry and the employment requirements and qualifications (established in 1964) are very old. Therefore, the present staff should be reevaluated in order to determine the human resources necessary to the well functioning of the Ministry, in the modern era.

The total number of positions is 1315 (legislative decree number 112, 12/6/1959 and the revisions of the "employee system"), 344 of which are occupied and 971 vacant.
There are 756 occupied contractual positions (decree number 1434, 24/6/1978), of which 140 will retire within a year.
According to the MoPH employee special system (decree number 5420, 14/5/2001), the number of remunerated employees is set to 336, while there are actually 380 appointees (that is 40 people in excess), most of which will reach retirement age within a year.

5-4 Reinforcing the regional units

The recruitment of personnel to healthcare centers in governorates and districts (dispensaries) should be improved; at least one health engineer should be appointed in each governorate, the number of health inspectors should be increased and a position for university graduates in public health should be created to ensure proper supervision of technical inspectors and the reinforcement of their role in preserving public health and safety.
The MoPH is also collaborating with the Council for Development and Reconstruction to secure the funds necessary for the construction of a new health facility in each district, which would accommodate the renovated centers and consolidate the principle of administrative non-exclusivity.

5-5 Strengthening the surveillance role of the Ministry in the preservation of public health

The MoPH is, by law, responsible for public health and safety. Ministerial departments were conferred the power of controlling, sampling and analyzing any suspicious products in order to take the necessary measures. However, different laws have also implicated other ministries in the process of surveillance. This plurality should create cooperation between the different ministries, instead of conflict of powers, and every citizen, being an employee, a producer or a consumer, is responsible for public health maintenance.
Health in the modern era is influenced by many branching and multisectoral factors, such as: air pollution, absence of waste treatment, road hazards, animal health, toy production for kids, storage of inflammable material, etc., in addition to water and food product hazards; hence the need for the expertise of different professionals and the involvement of all ministries. The MoPH is the primary, but not the only and often not the immediate, responsible for citizens' health. Therefore, the Ministry is in charge of secondary surveillance, divided into: "randomized surveillance" and "selective or guided surveillance" based on sanitary and epidemiological data. It should closely watch over the citizens' health, monitor the situation in order to respond to and contain any outbreak threat. The Ministry should then refer the case to the parties involved in handling the causes of the outbreak, whether environmental, commercial, agricultural, veterinarian, or industrial. The water department, for example, is responsible for daily sampling and analysis of drinking water, from every source, in order to check for contaminants and chlorine levels. However, the MoPH should also randomly take and analyze water samples or perform selective and guided control of suspicious sources, according to epidemiological standards. This also applies to agricultural, animal and alimentary products.

All legislation can be implemented with regard to primary or direct surveillance and secondary randomized or guided surveillance, as clearly stated in the laws governing the functions or the Ministries of Economy and Trade and of Public Health. Article 8 of the consumer protection code number 659/2005 clearly implicated the Department of Consumer Protection in monitoring the quality and safety of all services and merchandise, especially food products, by performing the necessary analyses; thus highlighting the role of the Ministry of Economy in routine surveillance. Article 1 of the legislative decree number 71/1983 on alimentary product safety makes the health inspectors responsible for sampling and analyzing suspicious food products; thus involving the MoPH is the secondary guided surveillance of potentially harmful products.
All tasks assigned to different administrations and departments should be revised, in order to be integrated into a complementary and non-contradictory collaboration, without exempting any ministry from its obligations. The role of local authorities in handling public health threats that cannot be addressed by central authorities, within their premises, should also be reevaluated.

5-6 Public safety and epidemiological surveillance

Citizens' safety in one state depends on the worldwide public safety, which led the WHO to formulate laws known as the IHR, that determine the role of the government in the protection of its citizens and the rest of the world from public safety threats. These regulations apply in Lebanon and the MoPH is in charge of implementing them, especially upon early detection of outbreaks or public health threats. According to the IHR, the WHO is committed to helping the affected country and alerting the rest of the world to take the necessary prevention and protection measures. Examples of such outbreaks and epidemics would be: the Mad Cow disease in 1994, originating in the United Kingdom and transmitted by ingestion of contaminated cow meat, raising a collective anxiety; the Belgium chicken contaminated with dioxins which are carcinogenic substances, distributed throughout the globe before discovering the contamination in 1999; the infant milk of Chinese origin, contaminated with melanin in 2008; and finally the avian flu epidemic in 2004, causing serious fears, followed by the porcine flu (H1N1 virus) in 2009. The Ministry successfully stepped in, identified and isolated the affected cases immediately after infection outbreak and prevented the propagation of the epidemic in Lebanon. The Ministry was able to handle the crises and contain the infections without exceeding its budget, in opposition to most countries. This achievement wouldn't have been possible in the absence of the epidemiological surveillance program that was established in 1996, and that took care of recruiting and forming the excess of employees in the Ministry, with the help of the Council of Civil Service. Around 50 employees, distributed throughout the Lebanese districts, work in this program and perform, in addition to their regular tasks, surveillance activities without any additional remuneration. The present structure of the MoPH does not include such positions, hence the importance of a decree that would turn this program into a department.
Health inspectors at the MoPH have technical high school degrees and are distributed in the governorates health centers and the districts dispensaries. They are mainly responsible for building inspection and reporting to the governor or the Ministry of Industry that grant permits for eligible institutions or investigate complaints. There are no more than 70 inspectors, none of

whom has a university degree. Despite many training sessions they attended on food safety control, their efficiency is compromised by the diversity of their tasks, their limited number and their humble educational level. Negotiations with the Council of Civil Service have been initiated to come up with a legislation proposal to add the position of graduate health inspectors in the Ministry, allowing the recruitment of skilled people, thus building the Ministry's capacity in performing randomized or guided secondary surveillance activities according to the above mentioned standards.

5-7 Rehabilitating the central laboratory

Health reform is impossible without a reference laboratory, essential to public safety when it comes to water and alimentary goods analyses and the quality control of pharmaceutical products. However, scientific advance requires the separation and autonomy of the pharmaceutical lab from the rest of the public health labs, in any future project.

5-8 Improving the health indicators and combining efforts to minimize regional differences as part of the equity principle

The MoPH is committed to achieving the Millennium Development Goals (MDG), especially reducing maternal and child mortality to acceptable levels and combating infectious diseases like AIDS and tuberculosis. However, achieving regional equity depends on the collaboration of many ministries, because regional differences are closely tied to social determinants of health. The MoPH leads the involved ministries and ensures the fulfillment of its share of duties. Similar problems are faced throughout the country: limited resources and hospital beds, excess in physicians and lack of nurses. These problems could be partially addressed by the restoration of public hospitals, awaiting the political decision on the creation of administrative boards and securing necessary funds; in addition to capacity building of the different ministries responsible for public health, of which the MoPH. Focus should be first on regions where health indicators are lower than the national average, knowing that governorate indicators are in turn averages of excellent indicators in district's major cities and mediocre indicators in the villages of Akkar, Menye Donniye, Hermel and the slums of large cities. The enhancement of the health status in these regions depends on the development of health services, but also on the improvement of the social determinants of health, such as poverty, unemployment and illiteracy. It is not surprising to notice that lowest health indicators come from the poorest regions, despite the Ministry's efforts to create health programs and improve healthcare services in these areas.

5-9 Developing the human resources of the health sector

The Ministry is responsible for the human resources of the health sector within its institution and in the country. One of the main challenges is the shortage of nurses, hence the need to enhance the capacities of Nursing Schools in private and in the Lebanese universities, in addition to promoting nursing studies and granting scholarships to those wishing to become nurses. There is also the need to maintain and develop the collaboration between the MoPH and the Faculty of Health at the Lebanese University and the yearly funding of the program of nursing

training in official technical schools. Note that shortage of nurses affects both the hospitals and the development of primary healthcare services.
A few years back, the Ministry initiated the regularization of many health professions, such as nursing, physiotherapy and nutrition. However, psychology and psychotherapy haven't been regulated yet, though they are important for mental healthcare and should be integrated in the primary healthcare services.

5-10 Expanding and improving primary healthcare services

Primary healthcare is very cost effective considering the significant outcomes compared to the limited resources used, especially in underprivileged areas. A few years ago, the MoPH collaborated with the Makased association on a project in the village of Wadi Khaled, area of Akkar, leading to the increase of health indicators, in the poorest village of Akkar, above national levels, in addition to very satisfactory maternal and child mortality indicators!
This experience set the cornerstone for the elaboration of a support project to the pregnant women and their newborns in all districts at the Lebanese terrestrial borders, relying on public hospitals to provide reproductive health services.
The contractual agreement between the Ministry and civil institutions helped standardize health expenditures by allocating more funds to primary healthcare and regulating private healthcare services. This collaboration relies on the commitment of the centers to provide, according to the WHO recommendations, a complete bundle of services instead of only healthcare and medication, and the engagement of the Ministry to provide technical support (protocol shaping and personnel training), vaccines, essential medicines from the UNICEF, and chronic disease medication distributed by the YMCA. This program only relies on donations, and does not involve purchasing of services. The centers work on improving the health status of people living within their premises by providing them with a complete bundle of healthcare services. This program does not encourage consumption but rather targeted and necessary community interventions, and is considered as an efficient alternative to traditional financial aids allocated by the ministries to civil associations without controlling the expenses or assessing the profitability. The services provided by the Ministry in trainings, essential medicines, medical supply and quality control enhancement constitute major achievements and cannot be redirected to different uses. Moreover, the municipalities were included in the contracts, which created an active cooperation of the local community in the management and assessment of healthcare services. In addition, the Ministry of Interior coordinates, through the municipalities, with the district physicians, mayors and ushers to identify children to be vaccinated, leading to complete vaccination coverage in many districts.
The enhancement of primary healthcare network and collaboration with public hospitals through the referral system is considered primordial to the national health strategy. The GIS (geographic information system) helped map the villages with no access to primary healthcare centers, in order to progressively cover all the Lebanese territory.

5-11 Combating chronic (non-communicable) diseases

Chronic illnesses such as cardiac disease, diabetes, obesity, cancer and others constitute the major burden of the Lebanese health system. The WHO particularly addresses this epidemiological transition and provides help in combating those diseases. Lebanon should make the most out of this cooperation with the WHO to build its capacity to fight chronic illnesses. The same risk factors are associated with these diseases: smoking, high-on-fat-and-sugars diets, and sedentary lifestyle. Awareness should be raised among citizens on the risks they are exposing their health to, in order to help them modify their habits, students being one of the most receptive groups; in addition to the major role of the media in this area. Therefore, building on the Ministry's experience and strengths in the matter could help address this part of the national health strategy. For instance:

- The annual national campaign for early detection of breast cancer: over the last decade, these campaigns helped raise awareness on this serious illness that could be fully cured, be it diagnosed at early stages. Studies have shown that breast cancer is now diagnosed at earlier stages, leading to more cures every year. We can build on this success story to combat other types of cancer, such as cervical, prostate, colon cancers, etc. Similarly, the annual awareness campaign on chronic obstructive pulmonary disease can also be extended to cardiovascular diseases, obesity and so on. We can also follow the trail of the diabetes campaign and promote health education in villages, schools and healthcare centers through seminars, for example.
- The tobacco law to control the smoking-caused damage: this law was very popular and the subsequent decrees helped design its implementation process that will be launched upon elaboration of the execution measures. Tobacco control is considered as the most cost-effective intervention is combating chronic diseases.
- The program of chronic disease medication: this program applied by the Ministry in collaboration with the private sector, for over 15 years now, is unique in the Middle-East region and is the basis for chronic disease combat. It consists of early detection campaigns in primary healthcare centers, followed by the patients' enrolment in the program in order to provide them with the treatment during early stages of the disease. This program also designs therapeutic protocols, trains physicians and other healthcare providers on the criteria and procedure of referral to hospitals and the patient's follow-up after discharge.

5-12 Regulating the relationship with the hospitals and promoting quality and efficacy

The creation of the public funds beneficiary database helped prevent coverage overlap and duplication of bills. The automation of issuing of medical cards eradicated virtual bills and improved the administrative and medical outcomes by controlling abuse. The relationship with the private hospitals remains to be regulated, especially when it comes to financial ceilings that should be compatible with the region needs, the prevention of patient selection in hospitals and the payment of illegal fees to secure admission. Hospitals are contracted on the accreditation basis, which ensures high quality services, but should not be the only criteria for contracting, which should be based on performance assessment according to scientific criteria. Therefore, administrative and medical performance, as well as personnel courtesy, will be the standard for

selection and pricing. In addition to health indicators and physicians report inspection, the Ministry will also take into account patients complaints and will handle the subsequent investigations. Hospitals that violate the contract, divert emergencies or burden the patient with illegal charges will be blacklisted. Moreover, expenditure control will require the eradication of unnecessary hospital admissions and treatment abuse.
The Ministry and insurance agencies should also perform an analysis of hospital service costs and the effect of increased living costs on those services, in order to review the pricing; in addition to more interest in secondary institutions and the introduction of new concepts of palliative and home care services.
Public hospitals should be improved to become complementary to and even to compete with the private sector, hence the need for presenting decree proposals to the Ministry Council, which would reorganize the administrative boards and revise the financial ceilings according to the hospital needs; in addition to a quality control and penalty system to assess public hospital performance.

5-13 Creating warranty programs of the hospital and primary care service quality

The hospital accreditation program led to the quick and significant improvement of service quality. The MoPH is committed to respecting the experts' assessment report, to exclusively contracting accredited hospitals and to encouraging insurance agencies to do the same. Moreover, the Ministry will focus on the healthcare center accreditation program in order to improve primary care and promote the citizens' trust in those services, which should directly enhance the health status and reduce the household share of medical expenditure. A better reputation of the healthcare centers will help attract all the citizens, especially those who need them most.

5-14 Ensuring the quality of pharmaceuticals and regulating their prices

The pharmaceutical unit of the MoPH has joined the WHO program of medicine pricing and the results of the assessment were satisfactory; but it still needs improvement and should gain the citizens' trust in order to successfully apply its policies. Therefore, the Ministry should strictly forbid the trades of unregistered pharmaceuticals and, with the help of the Ministry of Agriculture, closely monitor the registration criteria and the selling of veterinarian drugs.
The Ministry works with the AFSSAPS, the French medicine agency, on reviewing the registration criteria of generic drugs, which will be thoroughly studied by experts before submission to the professional committee. The Ministry and the AFSSAPS will also determine the standards and procedure of medical supply registration, starting with implants and other materials inserted in the human body. Dietary supplements waiting to be registered should also comply with the highest European and American standards. The Ministry requires importers to label each dietary supplement container to inform the consumer that this is not a medication and that the merchandise is lawfully registered.
One of the main goals of the health strategy being the reduction of medication prices, the drug pricing system will be revised and a price ceiling will be determined for the generic drug, proportional to the originator medicine and that decreases accordingly. Medicine pricing

regulation does not put an end to elevated expenditure on medications, because the real problem lies in unnecessary prescriptions, physicians' rejection of generic drugs and excessive self-medication. The Ministry and the WHO will be addressing the regulation of medicine prescription and consumption. Note that the irrational use of medication is partly due to unethical marketing and promotion campaigns with no scientific or moral bases. The scientific units (in reality, marketing departments) of large pharmaceutical companies should be closely monitored, knowing that the Ministry Council has canceled the "notification" the Ministry of Interior had granted those companies, as private organizations.

The respect of ethical criteria in the promotion and commercialization of medication comes out as an emergency, hence the charter of honor we suggested, which will be signed by all agreeing parties from importers and pharmaceutical companies to syndicates of physicians and pharmacists, under the patronage of the MoPH. Both syndicates will be empowered, especially their ethics departments that will penalize any infringement.

All local pharmaceutical companies were urged by the Ministry to respect GMP (good manufacturing practices) and will be penalized if they violate any of the highest quality standards. This measure aims at protecting the citizen and enhancing local and international trust in the Lebanese industry.

Finally, a national drug council is needed to apply the legislation on drug use.

5-15 Ensuring a health insurance system that equitably covers all citizens

- Sources of financing of the health insurance expansion

The plurality of insurance agencies compromises the financing equity and efficacy; however, the plurality of financing sources (subscription fees, taxes and household shares) promotes stability and sustainability, and is one of the pillars of the national health strategy. The MoPH strategy showed that increasing and rightfully investing taxes committed to health financing would lead to significantly higher savings on household expenditure on health, validated by the World Health Report published in 2010 by the WHO. This strategy tends to direct public expenditures towards prevention, primary healthcare and public hospitals on one side, and administrative capacity reinforcement of hospitals and pharmacies on the other side. According to the equity principle, taxes dedicated to health financing should be direct taxes on income, personal wealth and annuities, instead of indirect taxes like the VAT. This indirect tax system is considered unfair, except when it applies to harmful goods such as cigarettes, alcohol, animal fat, fast food rich in fats and sugars, hunting weapons and ammunition, etc.

Therefore, a fair and equitable increase in taxes would decrease the household expenditure on health, which is one of the main goals of this strategy. The achievement of this first step towards alleviating the household burden could be followed by a possible reduction of social security subscription fees, in order to relieve the citizens and enhance their chances of employment. However, given the insufficient contributions of taxes and the instability of annuity taxes, there will be no exemption or reduction of social security subscription fees until fair and equitable taxes provide enough resources for health financing.

- Cost of the universal health coverage project

In order to assess the feasibility of exempting lower-income households from any contribution to health expenditure and reducing the share of higher-income people, these social groups should first be defined and their health expenditure evaluated.
Total financing of healthcare budget is as follows:
44% of expenses are OOP purchase of healthcare services.
29% are covered by the State Treasury, accounting for the MoPH budget, one quarter of social security expenditure and the budget of the other insurance funds that take care of treatment coverage.
27% come from social security and private insurance subscription fees, paid in advance by the citizens (16%) and the employers (11%).
According to a study on household living conditions, conducted in 2005 by the Central Administration for Statistics, OOP amounts paid by the citizens depend on income groups: Citizens whose monthly income is less than LBP 650,000 pay 30% of total OOP expenditures, those who get a monthly paycheck between LBP 650,000 and 1,200,000 cover another 30% of total OOP expenditures, and citizens whose paychecks exceed LBP 1,200,000 per month cover the remaining 40% of OOP expenditures. A big chunk of the OOP expenses of this last income group goes to first class service coverage and cosmetic surgeries.
The project on protecting the poor and ensuring equity in health financing aims at exempting the low-income group from their contribution and reducing by 50% the share of middle-income groups.
Total health expenditures represent around 8.5% of the GDP and 44% of them being covered by OOP contributions means that household financing of healthcare is 3.74% of the GDP, distributed among the 3 income groups as follows: 1.122%; 1.122% and 1.496%. Therefore, the expenses that the project aims to cover are equal to 1.122% + 1.122%/2 = 1.683% of the GDP.
The GDP for the year 2009 was LBP 53,000 billion; thus the amount to cover would be LBP 900 billion. This sum is not the actual cost of the project, because healthcare needs are much less expensive when the government covers them, than when the citizens pay for them OOP. The Lebanese experience showed that well-spent public resources are three-fold as profitable as citizens' OOP expenses[5]. Therefore, the actual cost of this project is estimated to LPB 300 billion, provided resources are well managed, as suggested below, especially when it comes to relying on primary healthcare centers, generic drugs and patient referral systems by and to public hospitals, which will contribute to the improvement of these centers and hospitals.

- Mechanisms of universal health coverage

Universal health coverage is one of the main objectives of the national health strategy and it relies on the principle of justice, equity, good management of resources and combating poverty. This can be achieved by quality preventive and therapeutic healthcare services to all the population, by the contribution of the citizens according to their potential and the alleviation of the financial burden on low-income households. The system of universal health coverage relies on the following principles:

- Setting a comprehensive bundle of essential prevention, therapy and hospitalization services, available to all citizens, without exception.
- Providing healthcare centers and public hospitals with the essential service bundles. Note that the government only covers private sector services in case similar services are not provided in the package and exclusively upon prior approval.
- The obligation of all citizens to enroll in a healthcare center, in their geographic region or a neighboring town, in order to be granted access to the healthcare system.
- The commitment of the healthcare centers to offer preventive programs and primary healthcare services: early diagnostic through clinical consults and laboratory and radiology exams, quality generic drug supply, and so on. Patients will be referred to the specialized out-patient clinics in district's governmental hospital or admitted if need be.
- The referral of cases that public hospitals in rural areas cannot handle, to the governorate's public hospital and from there to the governmental hospital in Beirut.
- The Ministry would only cover healthcare services in private hospitals if the patient cannot be treated in any of the public hospitals and only through the regular referral procedure.
- The enrolment in the healthcare network through the medical card that is provided, free-of-charge, to lower-income citizens who are also exempted from contribution to healthcare financing, regardless of the services they need.
- The identification of the poorest citizens through the screening carried out by the Ministry of Social Affairs (proxy means testing), which then covers medical card fees and this group's contribution to health financing.
- The obligation of middle and high income households to subscribe to the health system by purchasing medical cards. Charges are split into 2 payments and below 18-year-old citizens are enrolled free-of-charge.
- The mandatory and free-of-charge medical exams for every new cardholder: laboratory and radiology exams, electrocardiograms and other tests according to the citizen's age and sex; in addition to free vaccination to all children.
- The first payment received by the public hospital or the healthcare center is used to cover out-patient services, according to a common agreement between them. The MoPH is committed to supporting the healthcare center or the public hospital according to the healthcare service and hospitalization contracts.
- The second payment can be collected by private and mutual insurance companies to the government's benefit, and additional services can be offered to those who can afford it.

- The generalization of primary healthcare services as a first step towards universal health coverage

Universal health coverage is a complex procedure that requires political commitment and financial resources. In order to get around these long processes, we suggest the creation of new financing mechanisms ensuring universal primary healthcare, as a first step towards universal health coverage. Those can be summarized as follows:

- Determining geographic areas of 21,000 citizens each, all referring to one center of the 150 national network centers. The center should provide a comprehensive list of all citizens progressively enrolling in it, over a period of 3 years.
- Enrolment fees per person are symbolic contributions, which do not exceed one tenth of the minimal monthly wage, per family, regardless of the number of household members. The center has the prerogative of exempting lower-income families from their enrolment contribution, but will have to compensate for that by collecting more donations, with the help of involved municipalities.
- Each center will submit a list of enrolled citizens to the MoPH that will help issue medical cards and yearly double the sums collected by the centers in enrolment fees.
- The center's revenues can therefore at least double during the first year, which will allow the recruitment of more employees and the enhancement of the center's capacities.
- The center provides free-of-charge out-patient consult and medical exam package to every new cardholder, in addition to vaccination of all children, according to their age.
- The promotion of healthcare activities will lead to an increased demand of essential medicines provided or covered by the Ministry, in addition to more administrative tasks in the department of primary healthcare services. More financial resources should therefore be recruited, hence the need to increase the Ministry's budget from 7% to 12% the first year, all committed to primary healthcare services and distributed as follows: 50% as center support, 25% go to chronic disease medications and 25% will be added to the primary healthcare program budget.
- The relationship between the Ministry and the institutions managing the healthcare centers is regulated by contracts that integrate the municipalities as major partners. These municipalities monitor the healthcare center operations, ensure proper delivery of service, and contribute to service upgrade and specialist recruitment.

  A local supervising committee, including the involved organization, the municipality (or municipal union) and the district physician, is created to reinforce the center's activities and develop the citizen recruitment program to the center, especially the least privileged group. This committee

is also in charge of granting financial exemptions, according to community studies and to compensate for them by creating new donation and fund raising mechanisms.