How politics made a nation sick

The political economy of health in Lebanon

Research for Health in Conflict (R4HC), Global Challenges Research Fund (GCRF)

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Foreword

Lebanon in its current plight is not a hopeless case, as many media commentators tend to portray it. In fact, the present crisis has spurred an extraordinary effort of analysis and policy thinking in civil society, as well as a revived citizens' movement for thorough political reform. The situation in Lebanon is not unique but represents one of the more extreme cases along the spectrum of political flux and turmoil facing citizens across the region.

This ground-breaking and comprehensive report on Lebanon's political economy of health is firstly a tribute to its authors and their determination to describe it as fully and authoritatively as possible. No other work has attempted the same depth and scope on the subject, employing a successful blend of research disciplines. It takes a core area of responsibility of the modern state – the health of its population – and tracks how political paralysis and elite insouciance have left the health sector fragmented and devastated. The human cost is already terrible, and its impact will long continue to be felt, even once reforms are brought in.

The health of a nation and public health should not be a matter of political ideology, nor is it fit to be handled on a sectarian basis (that curse of modern Lebanon). The state is tested by how it creates the right conditions for the health of the population, and that includes those refugees who find themselves, against their will, driven from their homelands. Unfortunately, the case of Lebanon has come to symbolise everything that a government should not do to take care of people's health and wellbeing.

The report deserves full attention from policymakers both in government and among international donors. The hard work has been done here. Policy recommendations are either stated or readily discernible from the picture that emerges. Starting with this soundly researched and objective report, the road to recovery comes into view.

James Watt.

Chairman, International Advisory Board, Research for Health in Conflict – Middle East and North Africa, and former British Ambassador to Lebanon.

Prologue

In September 2020, we published our first Political Economy of Health report for Lebanon.[1] Given the predictably and ever changing economic, social and political events on-the-ground, the report was intended to be a living document. Over the last six months we have updated the report to show how these multiple man-made and politically-driven crises that have enveloped Lebanon have created a failed state, social chaos and a public health disaster.

This report is intended as a resource for academics, journalists, and policy decision makers. It provides evidence and background knowledge on a key public service which has been overlooked in policy and academic debates in the region. As we show, health and health services need to form the foundation of any future international aid and development recovery policies aimed at stabilising and reforming the Lebanese state. Without this the county will become unliveable for millions of Lebanese and refugees.

The multi-pronged crises

The past two years have been turbulent even by Lebanese standards. Formal parliamentary politics effectively ground to a halt in autumn 2019 in the face of widespread protests at worsening economic and social conditions. The present incumbent, Najib Mikati, is the third prime minister the country has had in three years. The massive explosion in Beirut, Lebanon in August 2020 was the culmination of years of state neglect and rent-seeking political decisions. The explosion led to more than 300,000 people being left homeless, over 6,000 seriously injured and 190 dead.[2] Three of the city's biggest hospitals were rendered non-functional, three others incurred substantial damage, and 17 containers of essential medical supplies were lost.[3] To respond to the emergency situation, most hospitals exhausted two months' worth of stock in medical supplies, whose imports were already restricted by the shortage of US dollars.[4] [5] The effects of the blast lingered with more than 400 doctors leaving the country soon after. It is estimated by the Syndicates of Nurses and of Physicians that another 40 percent of doctors and 30 percent of nurses have left throughout 2021.[6] [7]

The 'Beirut blast' arrived on top of a Covid-19 induced public health crisis, a 10 ten-year war and protracted humanitarian disaster in neighbouring Syria, years of environmental degradation, currency devaluation, an energy crisis and an economic meltdown. All of this has impoverished millions of Lebanese as well as the estimated 1.5 million Syrian refugees who have sought sanctuary in the

[1] Research for Health in Conflict (R4HC) "The failed state: how politics and policy shapes population health and wellbeing", https://r4hc-mena.org/2020/09/30/lebanon-the-failed-state-how-politics-and-policy-shapes-population-health-and-wellbeing/

[2] This figure is now tragically higher given that that several critically injured have now passed away. Olivia Giovetti, "Tragedy in Beirut: What Lies Ahead," *Concern International*, August 11, 2020, https://www.concernusa.org/story/beirut-explosion-humanitarian-impact/

[3] World Health Organization, "Lebanon Explosion Update for Partners," *WHO,* August 18, 2020, https://www.who.int/docs/default-source/documents/emergencies/who-leb-partners-update-18-august-2020.pdf?sfvrsn=820c93ad_4

[4] Michel D. Landry, Mohamad Alameddine, Tiago S. Jesus, Saydeh Sassine, Elie Koueik, and Sudha R. Raman, "The 2020 blast in the Port of Beirut: can the Lebanese health system 'build back better'?," *BMC Health Services Research* 20, no. 1040 (2020), https://doi.org/10.1186/s12913-020-05906-y

[5] Jasmin Lillian Diab and Fouad M. Fouad, "Navigating Access to Healthcare in Lebanon: The Political Economy of Health across Conflict, Revolution and Applicability," *E-INTERNATIONAL RELATIONS*, March 20, 2020, https://www.e-ir.info/2020/03/20/navigating-access-to-healthcare-in-lebanon-the-political-economy-of-health-across-conflict-revolution-and-applicability/

[6] Samia Nakhoul, and Issam Abdallah, "Hundreds of disillusioned doctors leave Lebanon, in blow to healthcare," *Reuters,* November 12, 2020, https://www.reuters.com/article/us-lebanon-crisis-healthcare-insight/hundreds-of-disillusioned-doctors-leave-lebanon-in-blow-to-healthcare-idUKKBN27S14W?edition-redirect=uk

7 The report authors have contacted WHO, EMRO and the MoPH. The statistics apparently originate from the Syndicate of Nurses and Physicians order in Lebanon. However, the authors have been unable to access the original data. Percent of total number we do not know! http://www.emro.who.int/media/news/joint-statement-by-dr-tedros-adhanom-ghebreyesus-who-director-general-and-dr-ahmed-al-mandhari-regional-director-for-the-eastern-mediterranean-on-lebanon.html .

country. More than a million Lebanese now live below the World Bank poverty line, half the country has no health insurance, and one third have lost their jobs due to decades of economic mismanagement and corruption within government and public services.[8] [9]

This sequence of crises has wrecked the daily lives of people in Lebanon; the population has been thrown into a state of flux with little hope of stability. The health sector – a key public good and a potential stabilising force - is now itself experiencing multiple challenges: a severe lack of medications across frontline health services; the departure of thousands of staff from the health work-force; and the dwindling finances and basic operational resources needed to keep the system going.[10] As recently as November 2021, all health services now demand an out-of-pocket payment of 20 percent of medical bills regardless of any level of insurance coverage.[11] Consequently thousands are abandoning the health system due to costs, which threatens to create a public health crisis in the not-too-distant future.

A neglectful state

Since the end of the Civil War Lebanon has been portrayed by the media, academics, Lebanese politicians, Lebanese diaspora, and international diplomats as a modern and progressive country, where the food is world class, different religions live in harmony and the citizens are 'resilient' to episodes of political trauma – '*It's the Paris of the Middle East*; *the branch that always bends but never breaks!'* When they are not talking about the food and nightlife the dominant policy, media and academic narrative surrounding countries like Lebanon concerns security, sectarianism and terrorism. What many academics, journalists, and international donors overlook is how public services and social policies – and contestation over them – greatly affect people's day-to-day lives. There is little understanding of the policy-making process and the endemic socio-economic problems, such as the income and health inequalities that years of state corruption and policy neglect have created.

In this report, we show how health and health services cut across religious and political boundaries. These supposed public goods have become highly politicised issues used for private gain and, as we show, the policy and political structures of the Lebanese health and social welfare system have clearly had a negative effect on the health of the nation. As one leading humanitarian involved in the Lebanon response privately commented to us '…Desperation and dependency are good for patronage and politics…No one in power really wants the state to fulfil its mandate'. Meanwhile international donors and multilateral agencies have been keen to promote Universal Health Care (UHC) for Lebanon over recent years. However, in a country where over half (two million plus) of the Lebanese population are not formally covered by any health insurance, whether public or private, universal health coverage seems like wishful or naïve thinking. This number is now surely higher given the state of the economy and financial ruin in which many Lebanese now find themselves.

[8] Aljazeera, "COVID-19: Almost half of Lebanon now lives below poverty line," *Aljazeera*, April 1, 2020, https://www.aljazeera.com/news/2020/04/covid-19-lebanon-lives-poverty-line-200401124827120.html

[9] https://www.worldbank.org/en/country/lebanon/publication/economic-update-october-2021#:~:text=Poverty%20is%20on%20the%20rise,28%20pps%20by%20end%202021. According to the World Bank 'the share of the Lebanese population under the US$5.50 international poverty line is estimated to have increased by 13 percent by January 2021. It is expected to increase by as much as 28 percent by the end 2021

[10] World Health Organization Regional Office for the Eastern Mediterranean, *"Joint statement by Dr Tedros Adhanom Ghebreyesus, WHO Director General, and Dr Ahmed Al Mandhari, Regional Director for the Eastern Mediterranean, on Lebanon,"* EMRO WHO, September 19, 2021, http://www.emro.who.int/media/news/joint-statement-by-dr-tedros-adhanom-ghebreyesus-who-director-general-and-dr-ahmed-al-mandhari-regional-director-for-the-eastern-mediterranean-on-lebanon.html

[11] Rana Saarati, "قبل الدخول الى المستشفى... أمّن 20 % من الفاتورة بالدولار!" [Up Before entering the hospital... Secure 20% of the bill in USD!], *Al Joumhouria*, November 6, 2021, https://aljoumhouria.com/ar/news/622156/

In a country where over 80 percent of hospital beds are in the private sector, it costs money to be healthy and recover from illness.[12] [13] [14]Refugees and a growing population of deprived host communities reliant on the support from the United Nations or International NGOs fair even worse. The dominance and reliance on the private sector and an ever-expanding population of those who cannot afford to buy basic goods let alone access healthcare creates a huge barrier for establishing any form of social stability. Multiple attempts have been made by the World Bank, United Nations and European Union to strengthen and reform the Lebanese public health care system. However, this has been met by a sclerotic political management keen instead to bolster the private health care industry from which many Lebanese politicians have benefited financially. Above all the Lebanese population do not trust the political system to deliver a decent government to run public health services.

How Lebanon became a 'sick nation' is even more depressing when over the last ten years the country was spending between 8 to 10 percent of its GDP on health care and treatment, which is comparable to many European countries. However, this high health expenditure did not translate into better care, services and improved health for the Lebanese or refugees, even for those able to pay. A major problem is that this expenditure is concentrated in many curative and high-tech-high-cost interventions used by a small number of patients suffering from chronic or serious illnesses. Little thought has been given to preventive healthcare despite supporting calls to implement UHC policies in Lebanon. In addition, a cartel of medical suppliers who import pharmaceuticals have made hundreds of millions of dollars over the past twenty years, driven in part by lucrative government subsidization.[15] Little effort has gone into developing a local pharmaceutical industry capable of withstanding economic shocks. Health and social welfare policies in Lebanon and across the region are concerned with profit and cure rather than access and prevention. Thousands of poor Lebanese and Syrian refugees have been severely affected as a consequence of this state neglect and market failure.

What next?

Any form of quick recovery looks bleak for many Lebanese and refugees who remain in the country. In the ongoing miasma of hyper-inflation, wage devaluation, extreme poverty, Covid-19, increasing security risks and a humanitarian disaster in neighbouring Syria, thousands of citizens and key workers have left the country, leaving the economy and key public services even more weakened. International donors and multilateral agencies have urged all interested parties to 'find opportunity in the present crisis'. However, the time for reasoned and gradual policy change have passed. Now it is crucial for the Lebanese state, its regional patrons and international donors to immediately support moves toward economic and social stability. The security and health of the nation depend on it.

Research for Health in Conflict, Political economy of health research team.

January 2022

[12] Private hospitals represent the largest component of health system overall capacity. 84% (11,406) of hospital beds and 68% (299) of dedicated COVID-19 treatment beds are located within private hospitals thereby providing the bulk of in-patient capacity within the country upon which all Lebanese rely, not just the wealthy. See Ismail SA, Coutts AP, Rayes D, Roborgh S, Abbara A, Orcutt M, Fouad FM, Honein G, El Arnaout N, Noubani A, Nimer H, and Rutherford S (2018) Refugees, healthcare and crises: informal Syrian health workers in Lebanon. IIED, London. http://pubs.iied.org10856IIE

[13] Fahad al-Sudaid (2021) Hospitals for the lucky: Health and wealth in Lebanon. March Synaps.https://www.synaps.network/post/lebanon-health-hospitals-clinics

[14] Ministry of Public Health (September 2021). See also Ammar, Walid et al. "Health system resilience: Lebanon and the Syrian refugee crisis." Journal of global health vol. 6,2 (2016): 020704. doi:10.7189/jogh.06.020704

[15] Pharma companies made thousands of submissions for reimbursement of subsidies in 2019 and 2020. The BDL has refused to pay bills retroactively as most of the medicines claimed for were subsequently exported and re-sold elsewhere.

Executive summary

This report presents the results of a political economy analysis (PEA) of the health sector in Lebanon. It is based on a literature review of multiple source types and findings from key informant interviews with stakeholders in Lebanon.

- The health sector in Lebanon has been greatly influenced by conflict, varying in intensity and geographical scope. This has been an almost continuous feature of the Lebanese landscape since the mid-1970s. The disruptive effects of the 1975-90 Civil War on the health sector were particularly profound, re-shaping power relations and the financing model for health in ways that continue to influence activities today.

- The multiple crises and now ten-year old war in Syria presented the health sector with multiple challenges: as of September 2020, there are over 1.5 million displaced Syrians in the country; many live in informal or semi-formal settlements, geographically concentrated in outlying areas that have historically been neglected by the state and consequently suffered from poor public services.

- Lebanon's economy collapsed in late 2019, and the country's economic situation has continued to deteriorate ever since. Since the end of 2019 and throughout 2020-21 the Lebanese have seen the value of their currency depreciates in a period of hyperinflation. The repercussions of this economic collapse have had significant effects on the healthcare sector. The immediate impact has been for hospitals to close entire wards, and in some cases whole hospitals have ceased operations. This situation is further exacerbated by a failure to pay healthcare workers that has led to hundreds of medical workers leaving the country.

- This economic crisis has severely affected the livelihoods of people and their ability to purchase goods, fuel, and medicines, and consequently their physical and financial ability to access healthcare services. In August 2021, it was estimated that 75% of Lebanese people are living below the World Bank's poverty line. This figure is now surely much higher. Beirut now ranks first among Arab cities on the costs of living index (2021). Unemployment rates are surging in the country and more Lebanese continue to face the threat of unemployment.

- The Covid-19 pandemic has added a further downward pressure on livelihoods in Lebanon, which experienced an almost 20% loss in GDP during 2020. The management of the pandemic and the measures that were adopted by the government to contain its spread worsened the situation further. Lebanon experienced a much more severe second wave, with the number of Covid-19 positive cases peaking in January 2021. A third wave now looms. The pandemic placed a huge strain on bed capacity in hospitals (both wards and intensive care), which were rapidly overwhelmed. Many private hospitals were reluctant to undertake covid care for fear of "losing" income from more lucrative services, losing their physician and nursing staff; and lack of trust that they would actually be reimbursed by the GoL (WHO and others stepped in the guarantee the payment)

- The Covid-19 pandemic further exposed the depth of the country's economic and social malaise, as well as long-standing problems arising from the chronically underfunded, under-staffed and overburdened public health system.

- All of this was compounded by the massive Beirut explosion which hit the city in August 2020, a result of years of state neglect and rent-seeking political decisions. This explosion led to over 6,000 seriously injured and 190 dead. In the aftermath of the Beirut blast, three of the city's biggest

hospitals were rendered non-functional, three others underwent substantial damage, and 17 containers of essential medical supplies were lost. The explosion caused many health and rehabilitation needs among survivors. It also caused many patients to miss routine care for a variety of conditions, including care critical therapy such as cancer treatments, with many having to move to other hospitals leading to delays and a lack of continuity of care.

- The recent economic and political pressures, the Covid-19 epidemic, and the Beirut blast have compounded to create a "perfect storm" in terms of their effect on mental health and wellbeing. It has been shown that economic pressures and government policy responses to economic downturns are a major psychological stressor for the population affected, with a clear increase in anxiety, depression, and suicidal ideations. Recent reports have indicated an increase in mental health distress in the population directly affected, with PTSD rates reaching 67% in people who were adjacent to the blast and up to 37% in the general population.

Governance

- Successive crises in Lebanon have given rise to a health sector which displays a dualism between what might be considered the "mainstream" health system (run by and for Lebanese residents) and what is referred to as the "humanitarian health response system" (which has evolved primarily to serve the needs of multiple waves of refugees). This dualism operates at almost every level, from high-level decision-making down to service delivery at a local level. It reflects a well-recognised normative and institutional divide between development and humanitarian agendas at the global level, and more particularly a persistent policy by successive generations of Lebanese decision-makers of designating responsibility for refugee needs primarily to international agencies and NGOs.

- Significant investments have been made at the PHC level and *mainstreamed access for all*. This is a main aim for the LCRP health strategy – i.e., health systems strengthening with a focus on access for all vulnerable populations. Until recently, most Lebanese still preferred to use the private system, but this is now changing in response to the economic situation with a huge increase in people trying to access the MoPH run PHC network.

- The mainstream public health sector comprises a patchwork of actors and services. The Ministry of Public Health (MOPH) is the leading government Ministry but has long-standing human resource issues and is challenged by an unwieldy remit that spans the complete spectrum from technical support, regulatory and oversight functions, and third-party financing through to direct service delivery. Its authority in the sector is also undermined by the division of key sector roles and responsibilities (notably health financing) with other Ministries, and the presence of powerful parastatal organisations (notably the National Social Security Fund) with sometimes divergent priorities. The Ministry of Social Affairs also operate health care delivery units (SDCs)

Financing

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

Service provision

- The provider landscape in the mainstream sector is mixed, with a dominant role for the private sector and for NGOs/not-for-profit organisations, including those with strong confessional and political affiliation, and separate service provider networks for the army and security services, and the civil service. The emergence of overlapping confessional – or sectarian – and politically-affiliated providers in recent years has contributed to the growing use of health service provision as a political clientelist (electoral) bargaining chip in Lebanon, although the relationship between group membership and service access and provision is rather complicated. Importantly, provision across the sector continues to be skewed towards cost- and technologically-intensive secondary and tertiary care services at the expense of prevention and broad-based primary care.

- The humanitarian health response system is also fragmented, partly because it has evolved piecemeal in response to a succession of crises of differing natures and origins, but also because consent for international agencies such as UNHCR to operate in Lebanon has always been granted with significant constraints. Donor-driven priorities and *internal redlines* further undercut any centralized approach to health system response.

- Governance of the response to the Syria crisis is particularly fraught, with uncertainties over leadership roles between key international actors and opaque financing mechanisms contributing to coordination and service delivery problems. There is a lack of clear lines of accountability. The Lebanon Crisis Response Plan is governed by a steering committee with MoSA acting as the chair.

- Service provision varies according to the refugee population concerned. Displaced Palestinians benefit from a well-established and comprehensive provider network through UNRWA, albeit subject to the vagaries of international donor funding. While international actors have tried to meet escalating health-needs arising from displacement from neighbouring Syria, a combination of the limited political space for action and heavy financial constraints means that displaced Syrians suffer from chronic service access and affordability barriers. A burgeoning informal service provider system has evolved to help fill gaps in the service offer, but there are major questions about scope, regulation and quality assurance in this space.

Bargaining and decision-making in the health sector

- Overall, the financing envelope for refugee health service provision is coming under considerable strain, and there are increasing signs that agencies are imposing tougher constraints on the costs of services they are prepared to cover – especially for complex care for chronic conditions (a major driver of the disease burden among displaced Syrians).

- Processes of bargaining and decision-making in the health sector vary according to the policy question concerned, but in general policymaking is a fairly closed, elite-driven process with limited opportunities for public consultation. Interviewees highlighted a strong tendency to maintain the sector status quo as a result of constrained economic conditions, the political system in Lebanon and the powerful influence of personal and other vested interests. Influence over policymaking, where exerted by external stakeholders, often operates through elite political intermediaries – partly explaining the powerful role played by major system actors such as the professional orders and the Syndicate of Private Hospitals. This work found little evidence that documented the processes of decision-making in the humanitarian health system.

- While there are established bodies that generate evidence for policymakers in Lebanon (such as the Knowledge to Policy (K2P) Centre and the Centre for Systematic Reviews on Health Policy and Systems Research (SPARK) at the American University of Beirut), the ways in which evidence is procured and used in decision-making are not documented in a systematic way. We found that

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

- We found no literature or evidence on the role of corruption and rent-seeking in the health sector (although the rise in confessional- and politically-affiliated providers is indicative of some recent trends in this regard), and particularly on policy *implementation*. The shortage of evidence on the former may reflect political sensitivities in carrying out work on corruption and rent-seeking in relation to health in the Lebanese context. The shortage of evidence on the latter is harder to explain. It provides ideas for future research to explore the implementation of flagship initiatives such as the National Mental Health Strategy and Lebanon Crisis Response Plan.

- The report concludes with a series of suggested political economy research questions on cancer specifically, and more general questions for the operation of the sector as a whole, to inform future research proposal development in the PEOH stream.

Policy Recommendations

- *For the new government:* establish robust healthcare reform plans, led by the Ministry of Public Health in close collaboration with the other relevant ministries (e.g., the ministries of economy, education, social affairs, labour, sports and youth, and industry). The reform plans should coordinate all healthcare stakeholders in the country, whereby Private-Public Partnerships (PPPs) are put in place and healthcare needs are covered based on urgency.

- Provide a clear political commitment to securing the health and wellbeing of Lebanese, migrants and refugees who reside in the country. Signing a WHO declaration on Universal Health Care is not sufficient.

- *A more balanced health and welfare system:* reliance on the private sector to act as the main health care provider is now at an end. It is unable to respond to public health crises or withstand economic shocks. The future model of health system provision needs to be a balance between public and private. This means that donors and multilateral need to focus future investment in the state based public healthcare and welfare sectors. This will provide a much-needed buffer against future crisis for the millions who lack insurance or sufficient incomes. However, the lucrative nature of the private sector is partly what attracted so many highly skilled physicians and nurses to Lebanon. Future health system reform needs to maintain some element of a profit-driven approach in order to re-attract human resources for health.

- Agreements on task allocations and coverage of certain gaps that public hospitals face through support by private hospitals can help to reduce the burden on the health system. However, this does not mean a return to the dominant provision by the private sector. The health system must become more balanced between public and private in order to avoid repetition of the gross inequities in terms of access and affordability witnessed over the past twenty years.

- *For national and international stakeholders:* establish a comprehensive strategy for Universal Health Coverage and social insurance as a core element of health service change. The strategy must include support for reforms to the wider social insurance and social security system in order

to ensure accessibility to essential healthcare and welfare services for all population groups (including all refugees and migrant populations). This includes immediately establishing a commission to examine how medical staff and affiliated cadres who are refugees in Lebanon can be integrated into the health system.

- Any Public Private Partnerships should be set up gradually, whereby service and management contracts are signed between private hospitals and the government. However, proper due diligence must be carried out and a third-party monitoring system established by donors to ensure accountability, credibility, and trust. The third-party monitoring system should not be Lebanon based. One of the most critical issues at present is the medical reimbursement scheme. The World Bank is trying to address this. However, the GoL can only reimburse in Lebanese Lira with the exchange rate fixed at 1500lira. These administrative process challenges need to be dealt otherwise contracting becomes an impossibility.

- To set consolidated national emergency preparedness and response plans for anticipated health, economic and political emergencies / shocks. The plans would include a clear allocation of tasks between the different stakeholders in the country including state and non-state actors. The current approach is primarily focused on outbreak-style health emergencies. This needs to be expanded to include a wider set of health emergencies such as political breakdown which presents serious threats to public health.

- To set a clear and concise crisis exit strategy and to prioritise exiting the financial crisis (this being a core determinant of the current state failure). Allocation of funds must follow urgency of needs; for example, to ensure hospitals are operating and covering all urgent needs, and to prioritise the availability of fuel and essential medications.

- To expand preventative low-cost mental health services through increased investment in psychosocial community initiatives and programs. These programs might include outreach activities in communities and schools, prioritising groups that are most affected by Covid-19 and the Beirut blast, such as low-income neighbourhoods and refugee camps or areas.

- To expand and support access to the national hotline with public campaigns to increase awareness and fight stigma, including the National Mental Health Program to use guided self-help interventions that could be accessed through mobile phones (to help with access issues).

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Abbreviations

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

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1. Introduction

1.1 Background

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

1.2 Purpose of the report

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

1.3 Conceptual aspects

Defining conflict

Two operational definitions of conflict are pertinent to this work:

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

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

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

In this report, we define conflict according to the second of these two definitions, involving armed conflict. We have taken the view that the first definition – focused on social conflict of all varieties – is too expansive to be analytically useful. As will become clear later in the report, however, one of the challenges in Lebanon is to recognise the fluid boundaries between overt, armed conflict, internal disturbances or tensions, and sometimes prolonged periods of precursory political instability that directly precipitate or predate active unrest. The conflict in Syria offers an example. The first waves of displacement from Syria into Lebanon in 2011-12 occurred as internal disturbances unfolded that nevertheless could not be categorised as having reached the level of non-international armed

conflict.[16] We also draw on operational definitions for crises related to conflict as follows (although it is notable that there is currently no universally agreed definition of the foundational term, "humanitarian emergency".

[16] Samer Nassif Abboud, *Syria* (Cambridge UK; Medford, MA: Polity Press, 2018).

Complex emergency: a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict, which requires an international response that goes beyond the mandate or capacity of any single agency, and which has been assessed to require intensive and extensive political and management coordination.[17]

Protracted crisis: instances where a significant proportion of the population is vulnerable to death, disease or disruption of their livelihoods over a long period of time.[18]

Health system focus

The focus of this report is on the political economic aspects of health in Lebanon. From a health system perspective (consider the WHO's six building blocks[19]), we focus principally on governance and leadership, financing and service delivery - areas in which the evidence base for Lebanon turns out to be strongest. In view of our broader interest in this work stream on the potential for achieving universal health coverage (UHC) in the R4HC partner countries, this report also considers how priorities for spending are set in Lebanon. The report considers human resource, supply chain and health information system questions to the extent to which they cast light on wider aspects of bargaining, decision making and evidence use in the health sector in Lebanon.

1.4 Guiding research questions

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

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

[17] Inter-Agency Standing Committee (IASC) Working Group, "XVIth Meeting - Definition of Complex Emergencies," (November 30, 1994).

[18] FAO, "Countries in protracted crisis: what are they and why do they deserve special attention? state food insecurity world," *FAO*, 2010, http://www.fao.org/3/i1683e/i1683e03.pdf

[19] Don de Savigny and Taghreed Adam, "Systems thinking for health systems strengthening,"*Alliance for Health Policy and Systems Research*, *WHO*, 2009, https://apps.who.int/iris/bitstream/handle/10665/44204/9789241563895_eng.pdf;jsessionid=FF036DB7B2E410077715A05747174555?sequence=1

1.5 Structure of the document

Section 2 describes the methodologies used in the report. Section 3 gives an overview of the economic and social collapse in Lebanon. Section 4 covers the Covid-19 spread and response in Lebanon. Section 5 discusses the epitome of state failure: the Beirut blast. Section 6 gives an overview of the mental health situation in Lebanon. Section 7 gives a meta-review of literature sources describing the kinds of material on political economy of health in Lebanon that are available and who produces them. Section 8 outlines some of the contextual features (political, macroeconomic, social and conflict-related in broad terms) that have shaped the evolution of the health sector in Lebanon, before providing a detailed assessment of the health sector picture today in Sections 9 and 10. This covers institutional forms and functions in the health sector, and current dynamics in the formulation and implementation of health policy - including ideological stances, power relations between key stakeholders. We also consider some of the key, long-range reform options in the health sector, and barriers and facilitators to their realisation. The report concludes by summarising key findings and then outlining a tentative forward research agenda on the political economy of health in Lebanon, focusing particularly on intersections with conflict.

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

2. Methodology

2.1 Security and ethical considerations

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

2.2 Approach to the literature review

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

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

2.3 Interviews

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

2.4 Data analysis and synthesis

For the literature review, data extraction was carried out using a standardised template, developed for this study, to extract data from included studies. The template was based around themes derived from selected political economy analysis tools. Barriers and facilitators were identified and categorised by the study authors, with disagreements over categorisation and prioritisation resolved by consensus across the group.[20]

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

[20] Claire Mcloughlin, *Political Economy Analysis: Topic Guide* (2nd Ed.), (Birmingham, UK: GSDRC, University of Birmingham, 2014).

3. The economic and social collapse in Lebanon

3.1 Brief background

At the end of the Lebanese Civil War, the country's consociational democracy* allowed a culture of clientelism to be established among political parties and sects.[21] In parallel, a post-war economy centred around the service industry – namely banking and real estate – was set in place. In the background, a political ruling class began to engage in mismanagement and corruption to bolster its position.[22] Nearly two decades later, in 2011 warning signs of the fragility of the Lebanese economy appeared when the influx of capital decreased and a negative balance of payments was generated.[23] This, coupled with the Central Bank's insistence on pegging the LBP to the USD at a fixed exchange rate (LL 1,507.5/$), led the banks to set an ever-higher interest rate, reducing economic activity in the country and encouraging capital owners to deposit their funds rather than to invest them.[24]

Alongside this, a full-scale civil war broke out in neighbouring Syria in 2011, which created the largest refugee crisis since the Second World War. Foreign investments and tourism steadily decreased and gross mismanagement by the Central Bank increased. As a result of these 'multi- pronged' crises, Lebanon's economy collapsed in late 2019. The economic crisis coincided with rising discontent among the Lebanese public with regard to the government's performance and its shambolic public service quality and delivery, as well as the beginning of the "October 17 Revolution." At the end of 2019 and throughout 2020-21, the Lebanese saw the value of their currency depreciate as they entered a period of hyperinflation.[25]

3.2 Impact of the economic crisis on healthcare services

The repercussions of this economic collapse have had significant effects on the healthcare sector. As the economic crisis developed, it became harder for depositors – individuals, businesses, and hospitals and other medical institutions – to access their USD reserves. This money was usually used by these entities to buy pharmaceuticals and import medical equipment from abroad.[26] Access to medical care was also challenged by the new economic reality, with patients reporting difficulties when trying to secure the funds needed to pay their medical bills.[27] The route of using the NSSF to cover healthcare costs for the many who could not afford full private insurance completely stopped.

*Consociational democracy is a form of democratic power sharing, where the state has major internal divisions along ethnic, religious, or linguistic lines, with none of the divisions large enough to form a majority group, but which remains stable due to consultation among the elites of these groups.

[21] Lydia Assouad, "Lebanon's Political Economy: From Predatory to Self-Devouring," *Malcom H. Kerr Carnegie Middle East Center,* January 14, 2021, https://carnegie-mec.org/2021/01/14/lebanon-s-political-economy-from-predatory-to-self-devouring-pub-83631?utm_source=carnegieemail&utm_medium=email&utm_campaign=announcement&mkt_tok=eyJpIjoiWldVMVpHUmhZVE0wTkdGaiIsInQiOiJPYmFhc1E4TjlLcTNYR2FyZlBycGpmTmhwNjNSaDFsYlk5MDZNVFwvSHdCXC9zNjhpZHJ4QU1mSlpqRGZDVzNvVE40WjYyY2JBRkxtSklsUTJGRUEwXC95TlJ1ZVZJbldtaFZnbEJubXZpa2ZOeGd4bm5Dd3Y1eGhyYnI5bmVUd1pmdCJ9

[22] "Story of an Economy | قصة اقتصاد," YouTube video, 22:36, posted by "Megaphone," December 5, 2020, https://www.youtube.com/watch?v=FZoWWBmRkkQ

[23] Blominvest Bank, "LEBANON REPORT – An Overview of Lebanon's Economic Performance in 2011," *BLOMINVEST BANK*, March 12, 2012, http://www.databank.com.lb/docs/An%20Overview%20of%20Lebanon's%20Economic%20Performance%20in%202011.pdf

[24] Toufic Gaspard, "Financial Crisis in Lebanon," *Maison du Futur,* August 2017, https://www.globaltaxjustice.org/sites/default/files/39-policy-briefs-numero-12-en.pdf

[25] Dana Khraiche, "Lebanon Inflation Soars Past 100% in Latest Sign of Meltdown," *Bloomberg,* August 26, 2020, https://www.bloomberg.com/news/articles/2020-08-26/lebanon-inflation-soars-past-100-in-fallout-from-currency-shock

[26] Raya Jalabi, "'A matter of survival': Lebanon's hospitals on the brink as COVID cases surge," *Reuters,* October 5, 2020, https://www.reuters.com/article/health-coronavirus-lebanon/a-matter-of-survival-lebanons-hospitals-on-the-brink-as-covid-cases-surge-idINKBN26Q1XL

[27] Ibid.

The challenges faced by the health sector were further worsened by the government's failure to reimburse private hospitals, which compromised their ability to provide urgent care and respond to the Covid-19 pandemic. It is estimated that private hospitals are now owed 1,3 billion USD by the Lebanese government.[28] The immediate impact has been the closing of entire wards by hospitals, and in some cases whole hospitals have ceased operations.[29] This situation has been further exacerbated by a failure to pay healthcare workers, which has led to medical workers leaving the country.[30] To date, some 400 doctors and nearly 500 nurses out of the respectively 15,000 registered doctors and 16,800 registered nurses have emigrated.[31]

According to Dr Firass Abiad, Lebanon's newly appointed Minister of Health (since September 2021), there are currently four main challenges to the healthcare system in Lebanon; (1) lack of medicines and medical equipment, mainly due to hoarding subsidized medical equipment and medications in order to sell them on the black market or smuggling them; (2) high expenditure on healthcare services; (3) migration of healthcare workers, due to feelings of helplessness with regard to the lack of medical equipment and medicines; and (4) the spread of Covid-19 pandemic. Recommendations by Dr Abiad to address these challenges include: (1) in the short term, allocating more donor aid, and prioritising locally produced and generic medicines to reduce their cost in the long term; (2) increasing payments, and prioritising preventative care in the long-term; (3) the increasing cost of services will help to increase the salaries of healthcare workers and encourage them to stay in Lebanon; and (4) intensifying vaccination campaigns against Covid-19 and maintaining preventative measures such as compulsory mask-wearing.[32]

3.3 Poverty and jobs

Lebanon has experienced exponential increases in the proportion of the population falling into poverty which has been translated into civil security issues. For example, there has been an increase in the number of thefts reported by the Internal Security Forces (ISF), which recorded 863 incidents in just the first half of 2020, compared to 650 incidents in all of 2019.[33]

At the time of writing (December 2021) it is estimated that 75% of Lebanese people are living below the World Bank's poverty line.[34] With the fall in Lebanon's USD reserves, the Central Bank has warned about the possibility that it might interrupt its support for subsidised goods like fuel, wheat, medicines, and essential goods.[35] If implemented with no alternative plan in place, these changes will impact the most vulnerable, who rely on the availability and affordability of goods.[36]

[28] Sharmila Devi, "Economic crisis hits Lebanese health care," *The Lancet* 395, no. 10224 (February 22, 2020): 548, https://doi.org/10.1016/S0140-6736(20)30407-4
[29] Ibid.
[30] Ibid.
[31] Dalal Saoud, "Lebanon's brain drain: Doctors, nurses, engineers leaving amid crisis," *UPI,* December 22, 2020, https://www.upi.com/Top_News/World-News/2020/12/22/Lebanons-brain-drain-Doctors-nurses-engineers-leaving-amid-crisis/9091608581590/
[32] Firass Abiad (@firassabiad) on Twitter, October 9, 2021, https://twitter.com/firassabiad/status/1446688426485600257?s=21
[33] France24, "'Hunger crimes' on the rise in crisis-hit Lebanon," *France24*, July 15, 2020, https://www.france24.com/en/20200715-hunger-crimes-on-the-rise-in-crisis-hit-lebanon
[34] Michel D. Landry, Mohamad Alameddine, Tiago S. Jesus, Saydeh Sassine, Elie Koueik, and Sudha R. Raman, "The 2020 blast in the Port of Beirut: can the Lebanese health system "build back better"?," *BMC Health Services Research* 20, no. 1040 (2020), https://doi.org/10.1186/s12913-020-05906-y
[35] Tony Akleh, "Why the World Bank wants Lebanon to scrap its subsidy system," *ArabBusiness/Global,* January 5, 2021, https://www.arabianbusiness.com/politics-economics/456790-why-the-world-bank-wants-lebanon-to-scrap-its-subsidy-system
[36] The World Bank, "Lebanon Subsidy Reform: Short-term Patch Pending More Comprehensive Macroeconomic Reform," *The World Bank*, December 22, 2020, https://www.worldbank.org/en/country/lebanon/publication/lebanon-subsidy-reform-short-term-patch-pending-more-comprehensive-macroeconomic-reform

Another livelihood concern that resulted from the current crisis was the drop in the value of people's incomes caused by the 80% devaluation of the LBP, which was met by an increase in the prices of goods.[37] Given Lebanon's strong reliance on imports, which are usually bought in USD, the prices of food and drinks rose by 423%. The government showed no willingness to discuss an adjustment of people's salaries to cope with drastic cost of living changes.[38] As such, Beirut now ranks first among Arab cities on the costs of living index (2021).[39]

In addition to these challenges, many Lebanese now face the threat of unemployment. By January 2020, 350,000 jobs have been lost since the start of the economic recession, adding to the pre-recession unemployment number of 200,000.[40] This rise in unemployment was coupled with a brain drain as 43,764 Lebanese people emigrated in the first twelve days following the Beirut blast to find job opportunities and stability abroad.[41] It was reported that in 2020, 380,000 immigration applications were submitted to different embassies in Lebanon.[42]

In the case of women, these poverty concerns have included *period poverty*. The inflationary rise in the prices of basic products is making it difficult for women to secure menstrual hygiene and sanitary products. The price of sanitary products is reported to have increased by 500% during this economic crisis.[43] This rise in period poverty is raising health concerns regarding the management of their periods by girls and women, for many are expected to start relying on unsanitary and potentially dangerous methods to cope with their periods, causing infections among other side effects.[44]

The Covid-19 pandemic has added a further downward pressure on livelihoods in Lebanon, which experienced an almost 20% loss in GDP during 2020.[45] Indeed, the management of the pandemic and the measures that were adopted by the government to contain its spread, including general lockdown and night time curfew, worsened the situation further. As the pandemic has yet fully to run its course in Lebanon and the region, its impact has yet to be realised.

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[37] Samia Nakhoul, and Issam Abdallah, "Hundreds of disillusioned doctors leave Lebanon, in blow to healthcare," *Reuters,* November 12, 2020, https://www.reuters.com/article/us-lebanon-crisis-healthcare-insight/hundreds-of-disillusioned-doctors-leave-lebanon-in-blow-to-healthcare-idUKKBN27S14W?edition-redirect=uk

[38] Megaphone (@megaphone_news), " مؤشّر كلفة المعيشة (2021)" [Cost of Living Index (2021)], Twitter post, January 26, 2021, https://twitter.com/megaphone_news/status/1354157870896570369/photo/2https://twitter.com/megaphone_news/status/1354157870896570369/photo/2

[39] Numbeo, "Western Asia: Cost of Living Index by City 2021," *Numbeo*, 2021, https://www.numbeo.com/cost-of-living/region_rankings.jsp?title=2021&region=145&displayColumn=0

[40] Consultancy-me.com, "Lebanon's unemployment rate surges past 30% amid meltdown," *Consultancy-me.com*, June 30, 2020, https://www.consultancy-me.com/news/2900/lebanons-unemployment-rate-surges-past-30-amid-meltdown

[41] Ali Faour, "موجات مقبلة من الهجرة: لبنان في خطر وجوديّ" [Upcoming Waved of Migration: Lebanon in an Existential Threat], *Al Akhbar*, September 21, 2020, https://al-akhbar.com/Issues/294104

[42] Ahmad Shantaf, "تاريخ هجرة اللبنانيين منذ النشأة الى الإنكفاء في فترة رفيق الحريري.. وصولًا الى ذروة «زلزال 2020»" [The history of the Lebanese's immigration from the inception of Lebanon to the Rafik ElHariri episode of sufficiency… all the way to the '2020 earthquake'], *Al Liwaa,* August 27, 2020, http://aliwaa.com.lb/%D8%A3%D8%AE%D8%A8%D8%A7%D8%B1-%D9%84%D8%A8%D9%86%D8%A7%D9%86/%D8%AA%D8%AD%D9%82%D9%8A%D9%82%D8%A7%D8%AA/%D8%AA%D8%A7%D8%B1%D9%8A%D8%AE-%D9%87%D8%AC%D8%B1%D8%A9-%D8%A7%D9%84%D9%84%D8%A8%D9%86%D8%A7%D9%86%D9%8A%D9%8A%D9%86-%D9%85%D9%86%D8%B0-%D8%A7%D9%84%D9%86%D8%B4%D8%A3%D8%A9-%D8%A7%D9%84%D9%89-%D8%A7%D9%84%D8%A5%D9%86%D9%83%D9%81%D8%A7%D8%A1-%D9%81%D9%8A-%D9%81%D8%AA%D8%B1%D8%A9-%D8%B1%D9%81%D9%8A%D9%82-%D8%A7%D9%84%D8%AD%D8%B1%D9%8A%D8%B1%D9%8A-%D9%88%D8%B5%D9%88%D9%84-%D8%A7-%D8%A7%D9%84%D9%89-%D8%B0%D8%B1%D9%88%D8%A9-%D8%B2%D9%84%D8%B2%D8%A7%D9%84-2020/

[43] Ban Barkawi, "Rags to reused pads – why more Lebanese women face period poverty," *Reuters*, July 17, 2020, https://www.reuters.com/article/lebanon-crisis-women-idUSL5N2EM6PT

[44] Emily Lewis, "Period poverty in Lebanon rising amid unprecedented economic crisis," *Al Arabiya English*, July 3, 2020, https://english.alarabiya.net/features/2020/07/03/Period-poverty-in-Lebanon-rising-amid-unprecedented-economic-crisis

[45] Ishac Diwan and Joelle M. Abi-Rached, "Covid-19, trust and rising economic challenges in the Arab world," *The Forum ERF Policy Portal,* December 22, 2020, https://theforum.erf.org.eg/2020/12/20/covid-19-trust-rising-economic-challenges-arab-world/

4. Covid-19 spread and response in Lebanon

4.1 Overview

Research published by the Arab Barometer has found that a successful country performance in terms of compliance with public health and safety measures is correlated with greater trust in the government, while unsuccessful compliance is linked to low trust.[46] This study also identified Lebanon as a country where the population has little trust in its government, revealing that only 6% of the surveyed participants trusted the government.[47]

This distrust had become apparent through the recurrent protests following October 2019, though the spread of Covid-19 halted what is now known as the "Second Arab Spring," a movement of revolutions that had been taking place in several Arab countries including Lebanon. The pandemic and the ensuing lockdowns were perceived by sectarian organisations as an opportunity to lure back their supporters. Thus, Lebanon saw a hyperactivity in the delivery of services to the constituencies of sectarian groups, with initiatives including street disinfection campaigns, the distribution of food boxes, and lobbying campaigns to help their supporters come back from abroad.[48]

Like many countries, Lebanon experienced a much more severe second wave, with the number of Covid-19 positive cases peaking in January 2021. This placed a huge strain on hospital bed capacity (wards and intensive care), with hospitals being rapidly overwhelmed, in addition to the impact of this second wave on healthcare workers, many of whom became ill themselves (See Table 1, and Figures 1 and 2). In December 2020, for example, 200 doctors in Lebanon were in quarantine due to Covid-19 at a time when the need for medical support was urgently rising.[49] It should be noted that due to the poor level of testing (Lebanon has a high positivity rate, indicating under-testing), confidence in the accuracy of reported data, such as clinical information on bed occupancy and ascertaining the true number of deaths, is low. However, the data does reflect broad trends and gives some idea of the true (under-reported) impact.

Since the second peak in January 2021, cases have fallen dramatically, dropping to their lowest point since the start of the pandemic. This was likely the result of strict nationwide lockdown measures.50 Despite this drop, however, cases have started to rise again recently, with concerns that the Delta variant of Covid-19 might cause a third wave.[51]

	Cumulative number
Confirmed cases in Lebanon	740,814
Confirmed local cases	728,103
Confirmed imported cases	12,711
Deaths	9,913

[46] Ibid.
[47] Mohamed Abufalgha, "Arabs' Evaluations of their Governments' Response to COVID-19," *ARAB BAROMETER,* December 17, 2020, https://www.arabbarometer.org/2020/12/arabs-evaluations-of-their-governments-response-to-covid-19/
[48] Ishac Diwan and Joelle M. Abi-Rached, "Covid-19, trust and rising economic challenges in the Arab world," *The Forum ERF Policy Portal*, December 22, 2020, https://theforum.erf.org.eg/2020/12/20/covid-19-trust-rising-economic-challenges-arab-world/
[49] Megaphone (@megaphone_news), "الكورونا تستنزف الجسم الطبي" [Corona Overworks the Medical Staff], Twitter post, December 7, 2020, https://twitter.com/megaphone_news/status/1335949989512699904/photo/1
[50] Reuters, "COVID-19 Tracker – Lebanon," Reuters, https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/lebanon/
[51] Houshig Kaymakamian, "Fears a new COVID wave could overwhelm Lebanon's health system," *Al Jazeera*, July 17, 2021, https://www.aljazeera.com/news/2021/7/17/lebanon-faces-new-coronavirus-wave-amid-economic-collapse

Table 1. Cumulative number of Covid-19 cases in Lebanon – until January 4, 2022 (Source: Ministry of Public Health (MOPH) – Covid-19 Surveillance in Lebanon)[52]

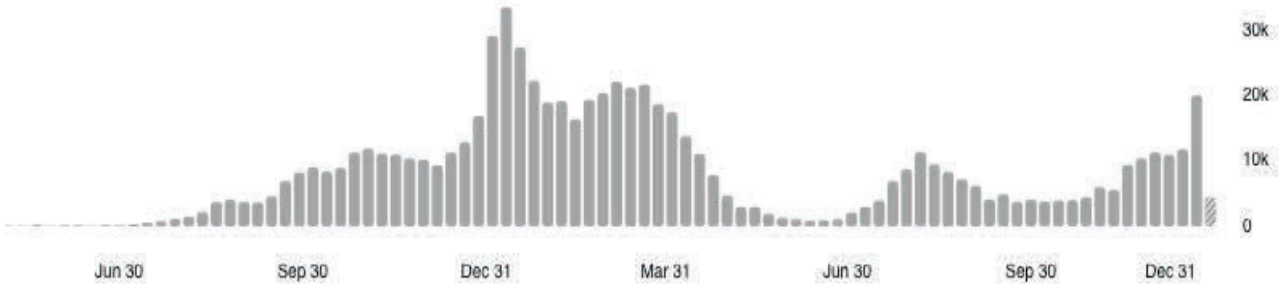


Figure 1. Number of confirmed Covid-19 cases in Lebanon - until January 3, 2022 (source: WHO Country Report)[53]

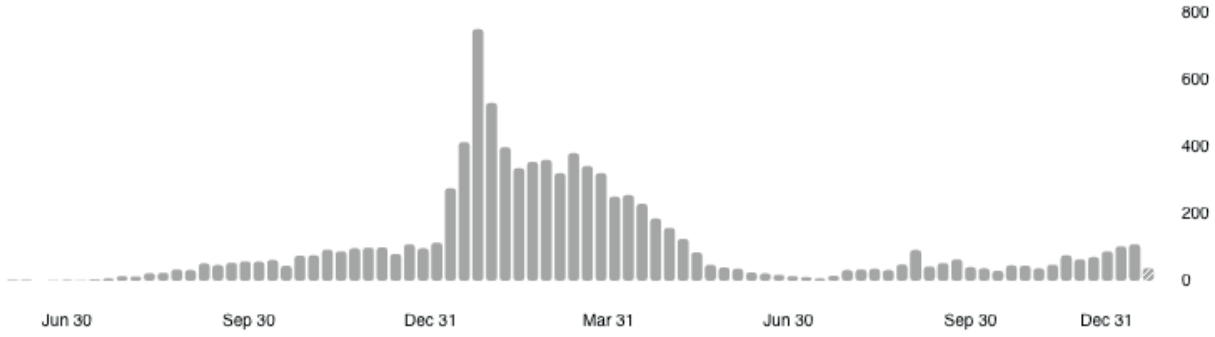


Figure 2. Number of recorded deaths from Covid-19 in Lebanon- until January 3, 2022 (Source: WHO Country Report)[54]

This surge in cases between January and March overwhelmed hospitals' capacities as beds filled up and the number of patients in the intensive care unit (ICU) multiplied (See Figure 3). However, this rate subsided with the reduction in infections. In February 2021, the fatality rate of Covid-19 in Lebanon reached 1%, as the number of cases per million attained 44,403; this has since dropped to 4,427 active cases per million as of August 1, 2021.[55]

[52] Ministry of Public Health (MOPH), "COVID-19 surveillance in Lebanon," *MOPH*, July 29, 2021, https://www.moph.gov.lb/en/Media/view/43750/1/monitoring-of-covid-19-

[53] World Health Organization (WHO), "Lebanon," *WHO*, July 26, 2021, https://covid19.who.int/region/emro/country/lb

[54] Ibid.

[55] Global Health Institute, "COVID-19 Arab Monitor (COV-AM)," *Global Health Institute*, August 1, 2021, https://ghi.aub.edu.lb/cov-am/ See also: https://www.docdroid.net/YP61BD5/lebanon-covid-19-vaccine-rollout-plan-ministry-of-public-health-pdf#page=10

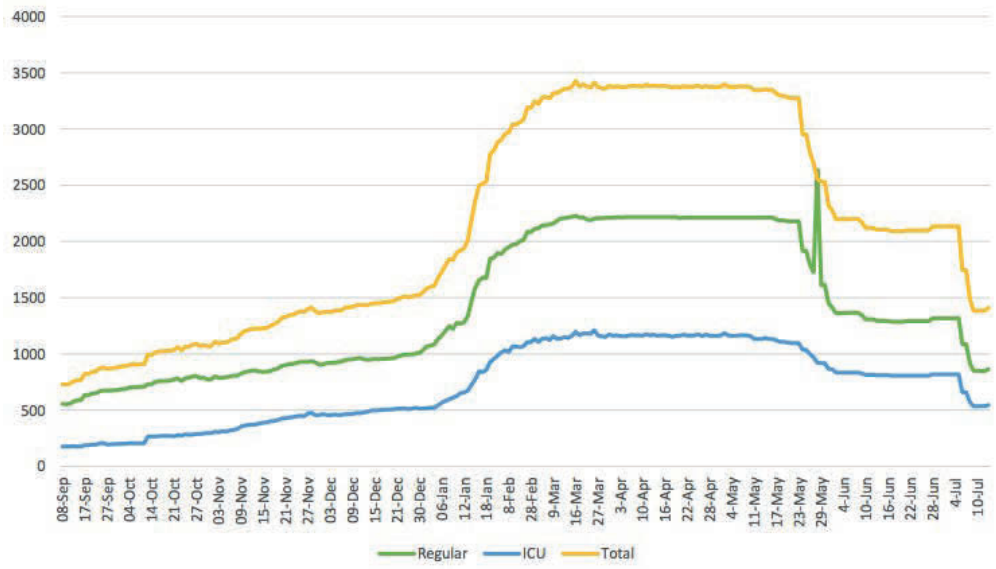


Figure 3.Covid-19 Regular and Intensive Care Unit (ICU) bed occupancy per day in Lebanon – until July 19, 2021 (Source: MOPH – Covid-19 Surveillance in Lebanon)[56]

4.2 The Government Covid-19 response

The MOPH had no national infection prevention and control programme in place when Covid-19 rates began to increase in Lebanon. Personal protective equipment (PPE) procurement, deployment and monitoring was fragmented.[57] The readiness and capacity of the state to respond to the pandemic were challenged by its already fragile public health infrastructure.[58] It was estimated that the MOPH needed a 10% budget (40 to 60 million USD) increase to cover the extra health care costs generated by the Covid-19 response.[59]

The Lebanese government adopted a strategy of intermittent lockdowns of varying intensities and durations (4 lockdowns to date), Emergency Social Safety Net (ESSN) packages to vulnerable households, and a request to the banking sector that it reschedule loans to small and medium-sized enterprises (SME) and lower interest rates.[60] [61] It is unclear whether this request to the banks was honoured or had any impact.

By mid-January 2021, the Lebanese government had finalised an agreement on procurement of the Covid-19 vaccine, securing nearly 6.33 million doses, with 2.10 million doses from Pfizer-Biontech, 1.50 million doses from AstraZeneca Oxford, and 2.73 million doses through the WHO COVAX initiative.[62] However, serious concerns have been raised about the absence of implementation plans, the

[56] Ministry of Public Health (MOPH), "Monitoring of COVID-19 Infection In Lebanon – 29/7/2021," *MOPH,* July 29, 2021, https://www.moph.gov.lb/en/Media/view/43750/1/monitoring-of-covid-19-

[57] WHO, "WHO COVID 19 Response Review Lebanon – Preliminary Findings and Recommendations – 7 to 11 December 2020," (PowerPoint Presentation, December 2020).

[58] Michel D. Landry, Mohamad Alameddine, Tiago S. Jesus, Saydeh Sassine, Elie Koueik, and Sudha R. Raman, "The 2020 blast in the Port of Beirut: can the Lebanese health system 'build back better'?," *BMC Health Services Research* 20, no. 1040 (2020), https://doi.org/10.1186/s12913-020-05906-y

[59] Joelle M. Abi-Rached and Ishac Diwan, "The Socioeconomic Impact of COVID-19 on Lebanon: A Crisis Within Crises," *euromesco*, June 2020, https://www.euromesco.net/publication/the-socioeconomic-impact-of-covid-19-on-lebanon-a-crisis-within-crises/

[60] Ibid.

[61] Ishac Diwan and Joelle M. Abi-Rached, "Covid-19, trust and rising economic challenges in the Arab world," *The Forum ERF Policy Portal*, December 22, 2020, https://theforum.erf.org.eg/2020/12/20/covid-19-trust-rising-economic-challenges-arab-world/

[62] Human Rights Watch, "Lebanon: Gaps Remain in Vaccine Program Planning. Build Public Confidence; Ensure Equitable Distribution," *Human Rights Watch*, January 28, 2021, https://www.hrw.org/news/2021/01/28/lebanon-gaps-remain-vaccine-program-planning

uncertainty regarding who will oversee the vaccination campaign, and the lack of awareness and trust among the public.[63] In addition, there have been calls to ensure a logical needs-based roll out, a control of black market activities, and the inclusion of marginalised populations like refugees and migrants workers.[64]

As of July 29, 2021, roughly 25% of the population had received one dose of the vaccine, with 18% having received two doses, amounting to 2,138,071 doses administered cumulatively.[65] So far the vaccine roll-out has suffered from inconsistent shipments of vaccines on the part of suppliers and vaccine hesitancy on the part of the population. Regarding the latter, a recent cross-section survey with the general public found that 40% of participants 'strongly disagreed' with receiving the vaccine; this was particularly prevalent among women, married people (according to the study, married people tend to think and worry about the vaccine side effects, such as an irreversible illness that could lead to reduced family functionality and their inability to raise their kids), and those who are generally hesitant towards vaccines.[66]

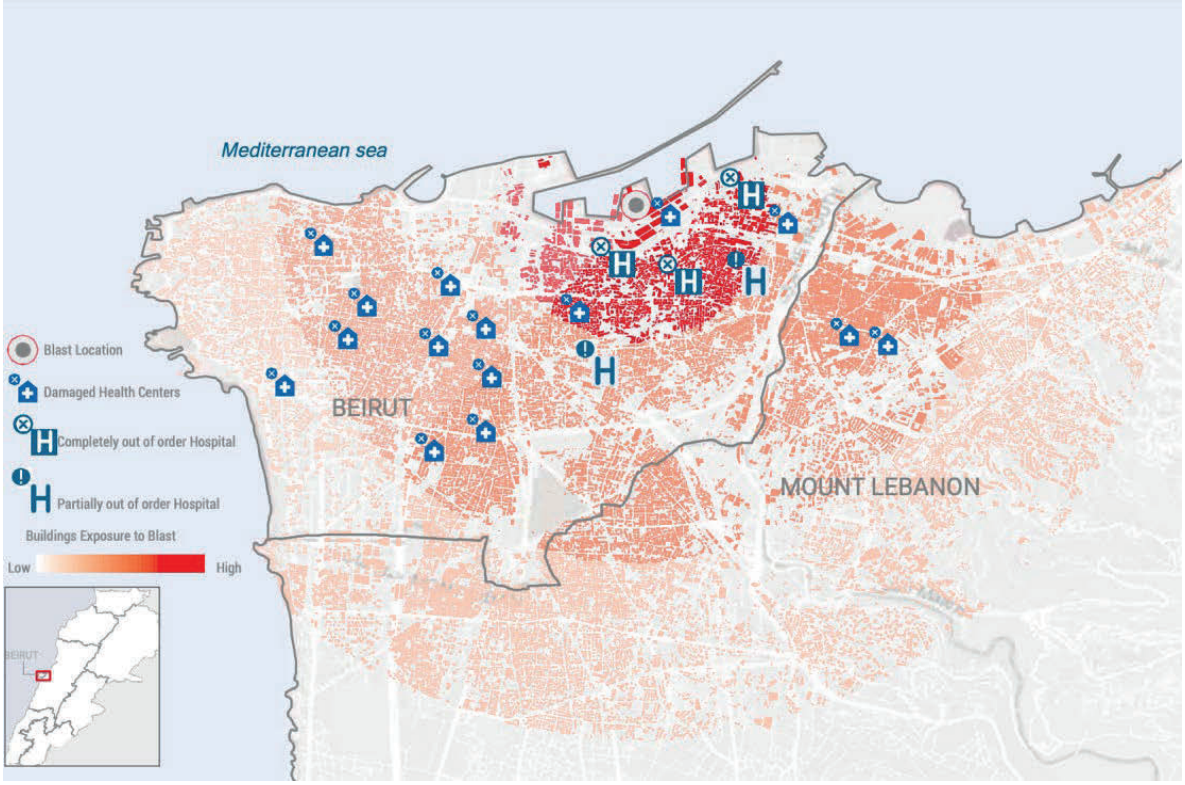
In relation to the impact of Covid-19 on mental health, the government developed a number of policy responses, but only at a minor level. The National Mental Health Program (NMHP) at the MOPH produced a leaflet for patients on "How to Cope with Stress within Quarantine."[67] The NMHP also trained nurses in Covid-19 units in mental health skills and provided support group sessions for frontline workers to enhance their well-being.[68] None of these programs or interventions has been evaluated or monitored to see if they are working.

[63] Ibid.
[64] Nadeen Hilal, Abdul Rahman Bizri, Nour Ataya, and Fadi El-Jardali, "Countdown to a COVID-19 Vaccine: Spotlight on Lebanon," *K2P COVID-19 Series*, January 7, 2021, https://www.aub.edu.lb/k2p/Documents/K2P%20COVID19%20Series_Countdown%20to%20a%20COVID19%20Vaccine.pdf
[65] Ministry of Public Health (MOPH), "Monitoring of COVID-19 Infection In Lebanon – 29/7/2021," MOPH, July 29, 2021, https://www.moph.gov.lb/en/Media/view/43750/1/monitoring-of-covid-19-
[66] Carina Kasrine Al Halabi, Sahar Obeid, Hala Sacre, Marwan Akel, Rabih Hallit, Pascale Salameh and Souheil Hallit, "Attitudes of Lebanese adults regarding COVID-19 vaccination," *BMC Public Health* 21, no. 998 (May 2021), https://doi.org/10.1186/s12889-021-10902-w
[67] COVID and Beirut Blast Response Health Sector Meeting Minutes, December 1, 2020, Google Drive (Online), Beirut.
[68] Ibid.

5. The epitome of state failure: The Beirut blast

5.1 Overview

The culmination of multiple crises, and the state's failure to address them adequately, occurred on August 4, 2020, when the strongest recorded explosion since World War II took place in the Port area of Beirut.[69] The blast claimed the lives of 220 people, injured 7,000 others, and left 300,000 homeless.[70] Injuries varied from polytrauma through to upper extremity injuries, ophthalmologic, maxilla-facial and minor lacerations.[71] The explosion also damaged health facilities, with three of the major hospitals in Beirut being rendered non-functional, while three others kept functioning but significantly below their capacity.[72] Fifty-five medical and healthcare institutions were recorded as having been destroyed and it was estimated that some USD 76 million would be needed to rebuild infrastructure, replace destroyed medical supplies and restore hospital capacity (See Figure 4).[73] [74]



[69] Reuters Graphics, "How powerful was the Beirut blast?," Reuters Graphics, August 14, 2020, https://graphics.reuters.com/LEBANON-SECURITY/BLAST/yzdpxnmqbpx/

[70] Michel D. Landry, Mohamad Alameddine, Tiago S. Jesus, Saydeh Sassine, Elie Koueik, and Sudha R. Raman, "The 2020 blast in the Port of Beirut: can the Lebanese health system 'build back better'?," *BMC Health Services Research* 20, no. 1040 (2020), https://doi.org/10.1186/s12913-020-05906-y

[71] Ibid.

[72] World Health Organization, "Lebanon Explosion Update for Partners," *WHO,* August 18, 2020, https://www.who.int/docs/default-source/documents/emergencies/who-leb-partners-update-18-august-2020.pdf?sfvrsn=820c93ad_4

[73] BBC News | Arabi, "انفجار بيروت: منظمة الصحة العالمية تحذر من توقف نصف مستشفيات العاصمة عن العمل" [Beirut blast: the WHO warns about the halting of activities in half of the capital's hospitals], *BBC News | Arabi*, August 13, 2020, https://www.bbc.com/arabic/middleeast-53760744

[74] World Health Organization, "Lebanon Explosion Update for Partners," *WHO*, August 18, 2020, https://www.who.int/docs/default-source/documents/emergencies/who-leb-partners-update-18-august-2020.pdf?sfvrsn=820c93ad_4

Figure 4. Map of Beirut showing the damaged hospitals and health facilities (Source: Flash Appeal Response)[75]

The total cost incurred to Beirut's infrastructure has now been estimated at around USD 3.115 billion, while its impact on the economy was set at USD 920 million.[76] Furthermore, the incident hindered the education of 67,000 students through the damage to schools and Technical and Vocational Education and Training centres (TVETs), and also generated an estimated USD 230 million loss of salaries within a 4.1km radius of the blast.[77]

In the immediate aftermath of the Beirut blast, the remaining functional hospital capacity utilised two months' worth of medical supplies within a few days.[78] This situation was exacerbated when four days later – on August 8, 2020 – protests erupted in a demonstration of anger against the government's neglect and evident lack of concern for the public's safety and health in its failure to address the conditions that created the explosion. This civil unrest was met with violence by the Lebanese security forces, causing more injuries and hospitalisation.[79] This was closely followed by its compounding of the impact of the Covid-19 pandemic, which saw infection rates rise by 220% in the weeks following the blast.[80]

5.2 The immediate response in the aftermath of the catastrophe

Six days after the blast in Beirut the entire Lebanese government resigned, leaving the post-blast political space essentially ungoverned.[81] Meanwhile, the MOPH mobilised its national primary healthcare network, assessed the needs of the primary healthcare centres (PHCs), distributed equipment to the impacted PHCs, and disseminated tetanus vaccine shots among the affected PHCs and hospitals in and around the capital.[82]

Simultaneously, *ad hoc* partnerships arose between the public sector, NGOs, and INGOs. The Immediate Response Model developed after the blast was implemented by the International Medical Corps (IMC), Première Urgence – Aide Médicale Internationale (PUI-AMI), Médecins du Monde (MdM), and Amel, which came together to support PHCs that were impacted by the explosion.[83] This response plan ensured the availability of subsidised services (consultations and diagnostic tests), enhanced access to needed medicines and immunisation services, supported PHCs that were trying to cope with the incurred damages, and raised awareness about available services at the PHCs among the most impacted communities.[84]

An initiative was rolled out by the World Bank Group (WBG), United Nations (UN), and the EU, in coordination with civil society, the Lebanese government, and the international community, under the

[75] United Nations Office for the Coordination of Humanitarian Affairs (OCHA), "Flash Appeal Lebanon," *OCHA*, August 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/Lebanon%20Flash%20Appeal%20FINAL%2014%20Aug%202020.pdf
[76] Strategy&, "Beirut explosion impact assessment," *Strategy&,* September 10, 2020, https://www.strategyand.pwc.com/m1/en/beirut-explosion/beirut-explosion-impact-assessment.pdf
[77] Ibid.
[78] Michel D. Landry, Mohamad Alameddine, Tiago S. Jesus, Saydeh Sassine, Elie Koueik, and Sudha R. Raman, "The 2020 blast in the Port of Beirut: can the Lebanese health system 'build back better'?," *BMC Health Services Research* 20, no. 1040 (2020), https://doi.org/10.1186/s12913-020-05906-y
[79] Ibid.
[80] Rescue.org, "COVID-19 cases increase 220% in month since Beirut explosion," *Rescue.org*, September 1, 2020, https://www.rescue.org/press-release/covid-19-cases-increase-220-month-beirut-explosion
[81] Ben Hubbard, "Lebanon's Government Resigns Amid Widespread Anger Over Blast," *The New York Times*, August 10, 2020, https://www.nytimes.com/2020/08/10/world/middleeast/lebanon-government-resigns-beirut.html
[82] MOPH, "National Primary Health Care Network Beirut Port Explosion Response Plan – Lebanon," (Report – shared in personal communication, August 27, 2020).
[83] MOPH, "Beirut Blast PHC Response – Coordination Platform Immediate Response Model – a temporary primary healthcare services subsidization protocol," (Report – shared in personal communication, 2020).
[84] Ibid.

title 'Reform, Recovery and Reconstruction Framework' (3RF).[85] The 3RF is intended to be a comprehensive response, supported by USD 2.5 billion, with two tracks: a people-centred recovery track, and a reform and reconstruction track, to bridge the immediate humanitarian response with the medium-term recovery and reconstruction efforts to lead Lebanon on the way to sustainable development.[86]

Other major responses included the Flash Appeal Response, EU donations, and the Basecamp initiative. The first of these, the Flash Appeal Response of USD 33.4 million, was launched by the UN Office for the Coordination of Humanitarian Affairs (UN – OCHA) and focused on providing an immediate humanitarian response to lifesaving and recovery needs following the blast.[87] Secondly, the EU also donated EUR 32.2 million to support vulnerable Lebanese and Syrians impacted by the explosion.[88] Finally, civil society organisations and the Lebanese public took to the streets, joined forces, and set up the Basecamp initiative to help clean up the streets, repair houses, deliver food, and provide mental health support.[89]

Due to the varying exchange rates of the LBP to USD (such as the officially pegged rate, electronic banking platform rate, and the black market rate), as well the deterioration of the LBP through inflation, the appropriate method of distributing cash benefits to Lebanese citizens is currently being explored. This mainly includes two options: 1) disbursing LBP at a preferential rate, or 2) disbursing in USD. It remains to be seen how the aid money will be distributed.

5.3 Public health and recovery

The explosion generated multiple health and rehabilitation needs among survivors.[90] It also caused many patients to miss routine care for a variety of conditions, including care critical therapy such as cancer treatments, with many having to move to other hospitals, which led to delays and a lack of continuity of care.[91]

The mental health impacts of the explosion have only now started to become apparent, with survivors experiencing anxiety, depression, and post-traumatic stress disorder.[92] In the first ten days after the explosion, 77% of survey respondents reported feeling nervous, anxious or on edge once a day or once every other day, while 80% stated that they felt low in mood, depressed, or hopeless during that time.[93] Additionally, it was estimated that 145,000 people impacted by the blast would need mental health support.[94]

[85] International Bank for Reconstruction and Development / The World Bank, "LEBANON REFORM, RECOVERY AND RECONSTRUCTION FRAMEWORK (3RF)," *International Bank for Reconstruction and Development / The World Bank,* December 2020, https://reliefweb.int/sites/reliefweb.int/files/resources/Lebanon-Reform-Recovery-and-Reconstruction-Framework-3RF.pdf
[86] Ibid.
[87] WHO, "Health Sector Coordination Meeting," (PowerPoint Presentation, December 1, 2021).
[88] European Civil Protection and Humanitarian Aid Operations, "Lebanon," *European Civil Protection and Humanitarian Aid Operations*, December 12, 2020, https://ec.europa.eu/echo/where/middle-east/lebanon_en
[89] Caline Malek, "Lebanon's Basecamp sets the pace for citizens' initiatives in fragile states," *Arab News*, November 13, 2020, https://www.arabnews.com/node/1762641/middle-east
[90] Bethan McKernan, "'Our stitches ran out': Beirut's struggle to deal with injuries from port blast," *The Guardian*, August 24, 2020, https://www.theguardian.com/world/2020/aug/24/our-stitches-ran-out-beiruts-struggle-to-deal-with-injuries-from-port-blast
[91] Michel D. Landry, Mohamad Alameddine, Tiago S. Jesus, Saydeh Sassine, Elie Koueik, and Sudha R. Raman, "The 2020 blast in the Port of Beirut: can the Lebanese health system 'build back better'?," *BMC Health Services Research* 20, no. 1040 (2020), https://doi.org/10.1186/s12913-020-05906-y
[92] AP, "Survivors of Beirut's explosion endure psychological scars," *Egypt Independent*, February 1, 2021, https://www.egyptindependent.com/survivors-of-beiruts-explosion-endure-psychological-scars
[93] Embrace, "EMBRACE'S MENTAL HEALTH DISASTER RESPONSE PLAN TO THE BEIRUT EXPLOSION," *Embrace*, September 2020, https://embracelebanon.org/wp-content/uploads/2020/12/Embrace-Blast-Response-Report-September-2020-1.pdf
[94] Strategy&, "Beirut explosion impact assessment," *Strategy&,* September 10, 2020, https://www.strategyand.pwc.com/m1/en/beirut-explosion/beirut-explosion-impact-assessment.pdf

These impacts to mental health came on top of the poor mental health drivers from the pre-blast economic crisis, increased loneliness following the isolation brought about by Covid-19 safety measures, and the significant stress load placed on caregivers at a time of economic collapse and poverty.[95] (see Section 6)

In particular, marginalised and at-risk groups have experienced great hardships during the current pandemic and economic crisis. It has been reported that women and children were subject to an increase in domestic violence during the lockdown periods. The Kafa organisation, which fights against violence towards and the exploitation of women, reported that its hotline had received 938 calls in May 2020, four times the number of calls from March 2020.[96] The organisation revealed that husbands were the primary abusers and engaged in psychological, verbal, and physical abuse.[97] This change may well be linked to the fact that many men have recently lost their jobs, challenging their role as primary breadwinner in the household in Lebanon's patriarchal society, and impacting their mental health and perception of self.

Meanwhile, refugees also experienced a rise in hardships. It has been reported that 88% of Syrian refugees are living in extreme poverty.[98] Similarly, cuts to the United Nations Relief and Works Agency (UNRWA) funds at a time of economic crisis and pandemic created medical risks and obstacles for the Palestinian refugees who rely on this organisation for primary health care services.[99]

Additionally, domestic workers living in Lebanon were exposed to difficulties following the economic crisis. Having come to Lebanon to earn their salary in USD, the crisis made it impossible for them to be paid in that foreign currency, so numerous employers abandoned their employees at the doorsteps of their respective embassies amid the pandemic.[100] With no funds to purchase plane tickets and return home, dozens of migrant workers were left homeless, camping on Beirut's sidewalks while waiting for support.[101]

[95] Aya Iskandarani, "'People are definitely not OK': Lebanon struck by self-immolation and other suicide attempts," *The National News,* January 13, 2021, https://www.thenationalnews.com/world/mena/people-are-definitely-not-ok-lebanon-struck-by-self-immolation-and-other-suicide-attempts-1.1145565
[96] Kafa, "Violence against women is soaring and the State is in deep sleep: Kafa's May report," *Kafa*, June 8, 2020, https://kafa.org.lb/en/node/415
[97] Ibid.
[98] Human Rights Watch, "Lebanon: Sharp Decline in Human Rights; Urgently Address Economic, Political Crises," *Human Rights Watch*, January 13, 2021, https://www.hrw.org/news/2021/01/13/lebanon-sharp-decline-human-rights?fbclid=IwAR2KSHqczTEaiXr7A5lDl4xlDqYuN7heT8t6mnmUw9zA1rfut3zJA0eq10M
[99] Joelle M. Abi-Rached and Ishac Diwan, "The Socioeconomic Impact of COVID-19 on Lebanon: A Crisis Within Crises," *euromesco*, June 2020, https://www.euromesco.net/publication/the-socioeconomic-impact-of-covid-19-on-lebanon-a-crisis-within-crises/
[100] Michelle Randhawa, "Hardships for Lebanon's Migrant Domestic Workers Rise; Port Explosion Led to Increased Homelessness of Workers Abandoned by Employers," *Human Rights Watch*, September 14, 2020, https://www.hrw.org/news/2020/09/14/hardships-lebanons-migrant-domestic-workers-rise
[101] Ibid

6. Mental Health in Lebanon

6.1 Mental health policy in Lebanon

Lebanon has experienced repeated political and conflict related traumas that have impacted the mental health and wellbeing of the population – as manifested by high levels of mental disorder and a constant increase in the suicide rate.[102] The recent economic and political pressures, the Covid-19 epidemic, and the Beirut blast, have worked together to create a "perfect storm" in terms of their effect on mental health and wellbeing.[103] It has been shown that economic pressures and the ways governments deal with them are a major psychological stressor for the population affected, with a clear increase in anxiety, depression, and suicidal ideation. Rising unemployment and the devaluation of the lira have significantly affected the population, and there is a clear link between rising unemployment and mental health distress and suicide.[104] In addition, governments and medical institutions have a responsibility to help the population manage their anxiety and stressors, and it has been documented that a lack of trust in the response of public institutions during a pandemic can exacerbate stress.[105] However, mental health services in Lebanon are privatized, with the government playing only a small role in subsidizing inpatient hospitalizations. Moreover, private health insurance does not cover mental health treatment, obliging patients to pay for their treatment out of their own pockets, which adds to their economic stress.[106] Even though the Lebanese population has a tendency to consider itself "resilient", given its long history of surviving adversity, it is very clear that this self-image is often used to accept the status quo rather than make efforts to recover from distress by using positive coping mechanisms.[107] The concept of a "resiliency reserve" might be helpful in the discussion, with the suggestion that this ability can be exhausted when dealing with repetitive stress, leading to an inability to recover.[108]

In the wake of the Beirut blast, although still preliminary, reports suggest a significant increase in mental health distress in the population directly affected, with PTSD rates reaching 67% among people who were adjacent to the blast and up to 37% in the general population.[109] What is particularly worrying is that only 20% of people with mental health disorders sought mental health help, despite the avalanche of MH services offered by INGO and local NGOs following the blast.[110] The explosion was perceived by the population not as a natural disaster but as murderous negligence by the government.[111] Any attempt to respond to the situation only through individually-focused mental health interventions is inadequate since this overlooks the societal and political structures that affect

[102] Rami Bou Khalil, "The psychological wellbeing of the Lebanese society lies between incremental suicide rates and financial stress," *Asian Journal of Psychiatry* 42, (2019): 85-86, https://doi.org/10.1016/j.ajp.2019.04.002
[103] Fouad M. Fouad, Andres Barkil-Oteo, and Jasmin Lilian Diab, "Mental Health in Lebanon's Triple-Fold Crisis: The Case of Refugees and Vulnerable Groups in Times of COVID-19," *Frontiers in Public Health* 8, (2021): 2296-2565, https://doi.org/10.3389/fpubh.2020.589264
[104] Pascale Salameh, Aline Hajj, Danielle A. Badaro, Carla Abou Selwan, Randa Aoun, and Hala Sacre, "Mental Health Outcomes of the COVID-19 Pandemic and a Collapsing Economy: Perspectives from a Developing Country," *Psychiatry research* 294, (2020): 113520, doi:10.1016/j.psychres.2020.113520
[105] Rusi Jaspal, Moubadda Assi, and Ismael Maatouk, "Potential impact of the COVID-19 pandemic on mental health outcomes in societies with economic and political instability: case of Lebanon," *Mental Health Review Journal* 25, no. 3 (2020): 215-219, https://doi.org/10.1108/MHRJ-05-2020-0027
[106] Joseph El-Khoury, Riwa, Haidar, and Raghid, Charara, "Community mental healthcare in Lebanon," *Consortium Psychiatricum* 1, no 1 (2020): 71-77, doi: 10.17650/2712-7672-2020-1-1-71-77
[107] Samer El Hayek, and Maya Bizri, "Beirut blast and mental health in Lebanon: Finding ways out," *Asian Journal of Psychiatry* 54, (2020): 102458, doi:10.1016/j.ajp.2020.102458
[108] Ibid.
[109] Campbell MacDiarmid, "Spate of self-immolation attempts in Lebanon highlights mental health crisis," *The Telegraph*, January 24, 2021, https://www.telegraph.co.uk/news/2021/01/24/spate-self-immolation-attempts-lebanon-highlights-mental-health/
[110] Ibid.
[111] Hala Kerbage, and Martine Elbejjani, "Mental Health in the Aftermath of the Beirut Blast: Community Healing and the Quest for Justice," *Psychiatric services (Washington, D.C.)* 72, no 2 (2021): 234-235, doi:10.1176/appi.ps.202000666

individuals and communities. When the sources of distress are structural in this way, then helping people to cope with stress must take place in conjunction with helping them to understand their sociopolitical realities and advocating the need to change them. In the end, justice is essential for individual and community healing.[112]

The National Mental Health Program in the MOPH was launched in 2014, with the support of the International Medical Corps (IMC) and UNICEF, to reform the mental health sector in Lebanon and to provide treatment at the community level while assuring human rights and evidence-based practices. In 2015, the NMHP launched the Mental Health and Substance Use Prevention, Promotion, and Treatment Strategy for Lebanon for the period of 2015-2020.[113] This strategy focuses on providing integrated, evidence-based mental health services at a community level through integration with primary care for everyone, with a focus on vulnerable groups. Mental health services in Lebanon are concentrated in large psychiatric hospitals and a few medical centres, creating several barriers for the population in accessing care. To integrate mental health care in the essential healthcare package in PHCs is an essential step towards increasing access to these services nationwide. The NMHP played a key role in coordinating the mental health response to the Syrian refugee crisis with WHO, UNICEF, and the NGO sector in Lebanon, with the goal of harmonising mental health services and improving access.[114] Currently it is playing an important role in leading the Covid-19 and Beirut blast responses.[115] Notable successes have been: its expansion of the National Emotional Support and Suicide Prevention Hotline scope and its being made available for free; its expansion of training in mental health topics and referral sources for frontline health workers; its urging of hospitals with psychiatric wards to provide mental health care free of charge; and finally, due to Covid-19 and the blast, its placing of a greater focus on public awareness campaigns regarding mental health and fighting stigmas attached to it.[116]

However, there are still many obstacles to overcome. Despite all the efforts to activate the role of PHCs in providing mental health care,[117] there were several barriers that prevented its successful implementation. Only 32% of PHCs deliver mental health services,[118] and training efforts by MOPH for capacity building among staff was less than effective due to the turnover of staff. In addition, there are limited financial and human resources for supporting community initiatives, and the devaluation of the lira created shortages in essential psychiatric medications (despite the price being supported by the government).[119] Finally, despite the efforts of MOPH, Covid-19 and the financial difficulties faced by hospitals created acute shortages in inpatient psychiatric beds, with many hospitals being unwilling to admit psychiatric patients.[120]

[112] Ibid.
[113] MOPH, "Mental Health and Substance Use- Prevention, Promotion, and Treatment- Situation Analysis and Strategy for Lebanon 2015-2020," 2015, Beirut: Lebanon.
[114] Elie Karam, Rabih El Chammay, Sami Richa, Wadih Naja, John Fayyad and Walid Ammar, "Lebanon: mental health system reform and the Syrian crisis," *BJPsych International* 13, no 4 (2016): 87-89
[115] Rabih El Chammay, and Bayard Roberts, "Using COVID-19 responses to help strengthen the mental health system in Lebanon," *Psychological trauma: theory, research, practice and policy* 12, S1 (2020): S281-S283, doi:10.1037/tra0000732
[116] Ibid.
[117] Zeinab Hijazi, Inka Weissbecker, and Rabih Chammay, "The integration of mental health into primary health care in Lebanon," *Intervention* 9, (2011) 265–278, DOI: 10.1097/WTF.0b013e32834d14b1
[118] Hady Naal, Emile Whaibeh, and Hossam Mahmoud, "Guidelines for primary health care-based telemental health in a low-to middle-income country: the case of Lebanon," *International Review of Psychiatry* 33, no 1-2 (2021): 170-178, DOI: 10.1080/09540261.2020.1766867
[119] Rana Tabbara, "At a time of unprecedented strain on mental health, psychiatric medications are in short supply," *L'Orient Today,* February 17, 2021, https://today.lorientlejour.com/article/1252295/at-a-time-of-unprecedented-strain-on-mental-health-lebanese-find-antidepressants-and-other-psychiatric-drugs-in-short-supply.html
[120] Sunniva Rose, "Lebanon's health experts warn of national 'mental health pandemic'," *The National News*, June 18, 2020, https://www.thenationalnews.com/world/mena/lebanon-s-health-experts-warn-of-national-mental-health-pandemic-1.1035391

6.2 Multilateral and donor support

The WB secured USD 40 million for Lebanon's Health Resilience Project to support the MOPH in its Covid-19 response through equipping public hospitals, increasing the testing capacity, and improving the ability to treat cases.[121] The WB also set up a multi-year fund to support social safety nets through the Emergency Crisis and Covid-19 Response Social Safety Net Project – the ESSN project mentioned earlier in this report – in partnership with the Lebanese government.[122] The WB allocated USD 246 million for this project, with which it intends to provide aid for 147,000 extremely poor Lebanese households (an estimated 786,000 beneficiaries) through cash assistance (LBP 100,000 per household member, in addition to a flat amount of LBP 200,000 per household) for a full year, starting January 2021.[123]

The WHO also intervened to aid the Lebanese Healthcare sector through supporting public hospitals, assisting patients in getting admitted to the supported hospitals, and training nurses and nurse supervisors recruited and deployed to ICU and Covid-19 wards.[124] The WHO also helped to setup active community isolation centres for medical professionals, provided hospitals with provisions of PPE, and guided them on managing their provisions at times when there are severe shortages.[125] Lastly, there were initiatives by the United Nations Population Fund (UNFP), the United Nations International Children's Emergency Fund (UNICEF), and the United Nations High Commissioner for Refugees (UNHCR), which included the conducting of training sessions on preventing and controlling for Covid-19 during pregnancy, the distribution of disinfection kits, and launching a safe return to school campaign.[126]

[121] Joelle M. Abi-Rached and Ishac Diwan, "The Socioeconomic Impact of COVID-19 on Lebanon: A Crisis Within Crises," *euromesco*, June 2020, https://www.euromesco.net/publication/the-socioeconomic-impact-of-covid-19-on-lebanon-a-crisis-within-crises/

[122] The World Bank, "Lebanon Emergency Crisis and COVID-19 Response Social Safety Net Project," *The World Bank*, January 2021, https://projects.worldbank.org/en/projects-operations/project-detail/P173367

[123] The World Bank, "US$246 Million to Support Poor and Vulnerable Lebanese Households and Build-Up the Social Safety Net Delivery System," *The World Bank*, January 12, 2021, https://www.worldbank.org/en/news/press-release/2021/01/12/us246-million-to-support-poor-and-vulnerable-lebanese-households-and-build-up-the-social-safety-net-delivery-system

[124] WHO, "Health Sector Coordination Meeting," (PowerPoint Presentation, January 5, 2021).

[125] Ibid.

[126] WHO, "Health Sector Coordination Meeting," (PowerPoint Presentation, December 1, 2021).

7. The literature on political economy and health in Lebanon: a brief overview

There is an expanding body of literature, published in English, Arabic and French, that addresses various topics in Lebanon under the broad banner of "political economy of health" (indicative references are given in the discussion that follows). This includes some peer-reviewed, academic research work, predominantly published in English, and originating particularly from a cluster of researchers based at AUB, which explores from the perspective of political economy the development and implementation of specific health policy initiatives,[127] [128] attempted health policy reforms,[129] [130] and more limited discussion of the dynamics of "street-level" implementation.[131] [132]

In terms of "state of the sector" analyses (including the historical evolution of current arrangements), the range of sources is smaller, and comes predominantly from either long-term health sector insiders, including current and former senior officials in the MOPH,[133] [134] [135] or international agencies and donor organisations with their own institutional perspectives and evidentiary biases.[136] [137] There is an emerging body of academic material on the role of confessional factors in determining allocation of public resources across sectors in Lebanon, including for health, produced by both Lebanese and overseas researchers.[138] [139] [140] [141]

[127] Fadi El-Jardali, Lama Bou-Karroum, Nour Ataya, Hana Addam El-Ghali, and Rawan Hammoud, "A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure," *Social Science & Medicine* 1982, no. 123 (2014): 45–54, https://doi.org/10.1016/j.socscimed.2014.10.044

[128] Fadi El-Jardali, Rawan Hammoud, Lina Younan, Helen Samaha Nuwayhid, Nadine Abdallah, Mohammad Alameddine, Lama Bou-Karroum, and Lana Salman, "The making of nursing practice law in Lebanon: a policy analysis case study," *Health Research Policy and Systems* 12, no. 52 (2014), https://doi.org/10.1186/1478-4505-12-52

[129] Rima Nakkash, Lina Torossian, Taghreed El Hajj, J Khalil, Rima Afifi, "The passage of tobacco control law 174 in Lebanon: reflections on the problem, policies and politics," *Health Policy and Planning* 33, no. 5 (2018): 633–644, https://doi.org/10.1093/heapol/czy023

[130] Rima Nakkash, and Kelley Lee, "The tobacco industry's thwarting of marketing restrictions and health warnings in Lebanon," *Tobacco Control* 18 (2009): 310-316, https://doi.org/10.1136/tc.2008.029405

[131] Fadi El-Jardali, Racha Fadlallah, Rami Z Morsi, Nour Hemadi, Mounir Al-Gibbawi, Magda Haj, Suzan Khalil, Youssef Saklawi, Diana Jamal, and Elie A Akl, "Pharmacists' views and reported practices in relation to a new generic drug substitution policy in Lebanon: a mixed methods study," *Implementation Science* 12, no. 1 (2017), https://doi.org/10.1186/s13012-017-0556-1

[132] Jade Khalife, Nadwa Rafeh, Jihad Makouk, Fadi El-Jardali, Bjorn Ekman, Nabil Kronfol, Ghassan Hamadeh, and Walid Ammar, "Hospital Contracting Reforms: The Lebanese Ministry of Public Health Experience," *Health Systems & Reform* 3, no.1 (2017): 34-41, DOI: 10.1080/23288604.2016.1272979

[133] Nabil M. Kronfol, "Rebuilding of the Lebanese health care system: health sector reforms," *Eastern Mediterranean Health Hournal = La Revue de Santé de la Méditerranée orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit* 12, no. 3-4 (2006): 459-473, https://applications.emro.who.int/emhj/1203_4/12_3-4_2006_459_473.pdf?ua=1

[134] Walid Ammar, Ola Kdouh, Rawan Hammoud, Randa Hamadeh, Hilda Harb, Zeina Ammar, Rifat Atun, David Christiani, Pierre A Zalloua, "Health system resilience: Lebanon and the Syrian refugee crisis," *Journal of Global Health* 6, no. 2 (2016), https://doi.org/10.7189/jogh.06.020704

[135] Walid Ammar, *Health System and Reform in Lebanon* (Beirut, Lebanon: Entreprise universitaire d'études et de publications, 2003).

[136] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.

[137] The Work Bank, "Lebanon's Economic Outlook - October 2018," *The Work Bank,* 2018, https://thedocs.worldbank.org/en/doc/756401538076843074-0280022018/original/mpoam18lebanonlbn2.pdf

[138] Melani Cammett, *Compassionate Communalism: Welfare and Sectarianism in Lebanon* (Cornell University Press, 2014), http://www.jstor.org/stable/10.7591/j.ctt5hh11g.

[139] Melani Claire Cammett, "Partisan Activism and Access to Welfare in Lebanon," *Studies in comparative international development* 46, no. 1 (2011):70–97, https://doi.org/10.1007/s12116-010-9081-9

[140] Nisreen Salti, and Jad Chaaban, "The political economy of attracting public funds: the case of Lebanon," *International Journal of Development and Conflict* 2, no. 1 (2012), https://doi.org/10.1142/S2010269012500019

[141] Nisreen Salti, and Jad Chaaban, "THE ROLE OF SECTARIANISM IN THE ALLOCATION OF PUBLIC EXPENDITURE IN POSTWAR LEBANON," *International Journal of Middle East Studies* 42, no. 4 (2010): 637-55, doi:10.1017/S0020743810000851.

Three other features of the evidence base on the "mainstream" health sector in Lebanon are notable. First, few studies directly evaluate the impact of conflict on health policy formulation and implementation, although the effect of both current and past violence is a strong background theme. Much of what we report below about the Civil War and its legacy for the health sector, for example, comes from a cluster of sector overview articles. [142] [143] [144]

Second, and importantly, existing work overwhelmingly presents elite perspectives on the policy process. Data on public attitudes towards health in Lebanon and how these have changed over time are few, and assessing the effect of either civil society pressure, media production or other modes for popular engagement on policymaking and implementation is difficult.[145] [146] This is linked to a broader observation that the theoretical orientation of published work on Lebanon mostly adopts rationalist and institutionalist perspectives derived from policy analysis. We found no research approaching political economy questions from critical or radical perspectives.

Third, most of the evidence we have comes from qualitative work ranging from narrative literature reviews through to mixed-methods studies incorporating key informant interviews and survey work. Quantitative analyses are few and far between, with some of the most methodologically innovative work addressing the thorny topic of confessional and political affiliation as a determinant of resource allocation in the health sector by using statistical regression techniques. There are particular challenges to accessing material on the humanitarian response in Lebanon. Most rely on agency documents and reports, the vast majority of which are published in English. There are a handful of relevant peer-reviewed studies published on health in recent years (for example the work of van Lerberghe et al.),[147] with others addressing specific questions such as the implications of registration status for service access rights for displaced Syrians in Lebanon.[148] [149] [150] Studies of the relations between different actors in the humanitarian response, and the effect of this on bargaining and decision-making in health, have been limited to a few grey literature reports published in English.[151]

The bias in the literature, and the gaps in empirical evidence, have implications for what we can and cannot say on the political economy of health in Lebanon and present opportunities for future research. These questions are addressed in Section 11.

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[142] Nabil M. Kronfol, "Rebuilding of the Lebanese health care system: health sector reforms," *Eastern Mediterranean Health Journal = La Revue de Santé de la Méditerranée orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit* 12, no. 3-4 (2006): 459-473, https://applications.emro.who.int/emhj/1203_4/12_3-4_2006_459_473.pdf?ua=1

[143] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: II. Pressure for change in the Lebanese health sector," *Health Policy and Planning* 12, no. 4 (1997): 312-319, https://doi.org/10.1093/heapol/12.4.312

[144] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: I. Unregulated private care in Lebanon," *Health Policy and Planning* 12, no. 4 (1997): 296-311, https://doi.org/10.1093/heapol/12.4.296

[145] Rima Nakkash, Lina Torossian, Taghreed El Hajj, J Khalil, Rima Afifi, "The passage of tobacco control law 174 in Lebanon: reflections on the problem, policies and politics," *Health Policy and Planning* 33, no. 5 (2018): 633-644, https://doi.org/10.1093/heapol/czy023

[146] Fadi El-Jardali, Lama Bou Karroum, Lamya Bawab, Ola Kdouh, Farah El-Sayed, Hala Rachidi, and Malak Makki, "Health Reporting in Print Media in Lebanon: Evidence, Quality and Role in Informing Policymaking," *PloS one* 10, no. 8 (2015), https://doi.org/10.1371/journal.pone.0136435

[147] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: II. Pressure for change in the Lebanese health sector," *Health Policy and Planning* 12, no. 4 (1997): 312-319, https://doi.org/10.1093/heapol/12.4.312

[148] Maja Janmyr, "UNHCR and the Syrian refugee response: negotiating status and registration in Lebanon," *The International Journal of Human Rights* 22, no. 3 (2018): 393-419, DOI: 10.1080/13642987.2017.1371140

[149] Maja Janmyr, "Precarity in Exile: The Legal Status of Syrian Refugees in Lebanon," *Refugee Survey Quarterly* 35, no. 4 (2016): 58-78, https://doi.org/10.1093/rsq/hdw016

[150] Maja Janmyr, "No Country of Asylum: 'Legitimizing' Lebanon's Rejection of the 1951 Refugee Convention," *International Journal of Refugee Law* 29, no. 3 (2017): 438-465, https://doi.org/10.1093/ijrl/eex026

[151] Kholoud Mansour, "UN Humanitarian Coordination in Lebanon," *Chatham House*, 2017.

8. Contextual features of Lebanon

8.1 Periodising conflict and political instability in Lebanon

The history of Lebanon in recent decades includes both lengthy periods of internecine conflict and shorter episodes of cross-border conflict and skirmishes or localised fighting (Figure 5). It also encompasses conflicts of varying intensity. The most formative experiences have been without question the civil war of 1975-1990 (a conflict that rapidly regionalised and then internationalised, including a Syrian intervention in 1976 and an Israeli invasion beginning in 1978), the 2006 war with Israel, and spill-over effects since 2011 from the conflict in neighbouring Syria. Each of these conflicts has had a major influence on the political and fiscal space of policymaking and implementation in the health sector.

However, it is also important to recognise the profoundly disruptive influence of persistent, low-level conflict and the political instability rooted in the country's post-war consociational power-sharing arrangement. The period since the assassination of former Prime Minister Rafik Hariri in 2005 has been particularly troubled in this respect. It was followed later that year by the withdrawal of a Syrian military presence in Lebanon that had numbered up to 40,000 personnel. There have also been periods of instability since 2005 arising from, on the one hand, efforts by the Lebanese state to enforce a monopoly on the use of force within the country's borders (which led to within-border conflicts in 2007, 2008, 2013 and 2014 (see Figure 5)), and on the other, paralysis in the executive. This included a 17-month political crisis between 2006 and 2008, which pitched the sitting government at the time against a coalition of opposition groups, and which was resolved only by an internationally brokered agreement signed in Qatar.

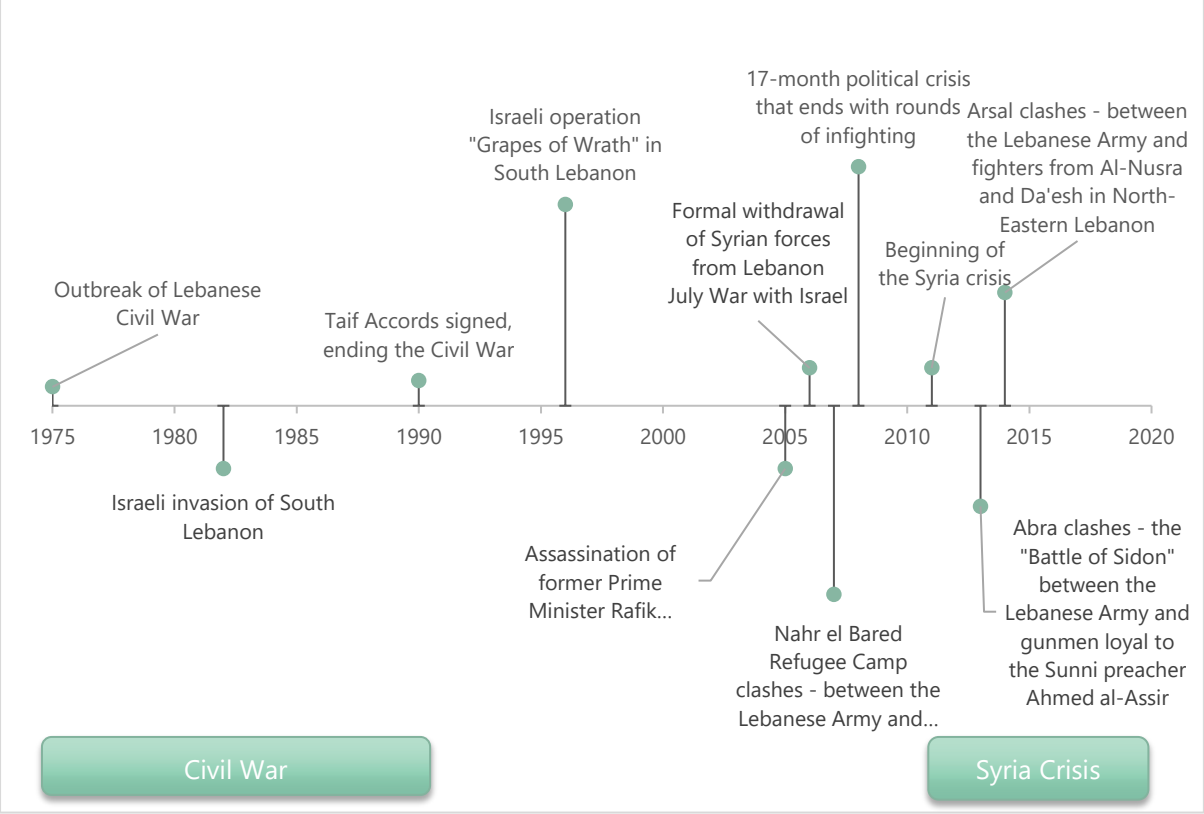


Figure 5. Timeline of key conflicts either within Lebanon or with major cross-border security implications, 1989-2018.

Any detailed assessment of the current impact of conflict on the political economy of health in Lebanon, must, however, begin by recognising the extraordinary implications of the current crisis in Syria even in the context of Lebanon's turbulent recent history. As of September 2020, there are estimated to be 880,400 registered Syrian refugees in Lebanon, with an untold additional number who are not registered – down from a peak of 1.18m in April 2015.[152] Many of those displaced are concentrated in the East (and particularly North-East) of the country, in areas where services have historically been understaffed and under-resourced.

8.2 Historical legacies and evolution of the health sector in Lebanon

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

Firstly, the managing of health service provision for migrant and displaced populations is not a new phenomenon in Lebanon. Even before the start of the Syria crisis in 2011, for example, there were some 300,000 Syrian migrant workers in Lebanon, and Syrians accounted for 55% of all unskilled workers and 30% of skilled workers in the country.[153] [154] The country also hosts some 470,000 registered Palestinian refugees, many of whom have been living in Lebanon since 1948, and for whom health services are provided directly by UNRWA among others through a network of 27 primary care facilities.[155] There have also been regular episodes of internal displacement (following incursions into Southern Lebanon for example), and latterly large-scale inward movement from neighbouring Syria. Strikingly, however, the policy response to refugee and asylum questions has been marked by persistent (and latterly growing) hostility. Successive Lebanese governments have consistently ignored issues of service access and use for refugees, preferring to leave them to international agencies, the NGO/charity or informal sectors. There has also been a tendency towards exclusionary positions across a range of social policy issues including labour market integration.[156]

A second feature is the changing power of the private and not-for-profit sectors over time. Before the beginning of the Civil War in 1975, the MOPH had provided free healthcare for the vulnerable in public hospitals and covered the costs of private care only where relevant services were not available in the public sector. In 1975, this amounted to around 10% of the Ministry's budget, but by the late 1990s, the MOPH spent more than 80% of its budget on care in the private sector.[157] A *de facto* purchaser-provider split emerged in Lebanon during the Civil War as the state contracted out health care to private providers, partly as a result of the widespread destruction of public health facilities, but also because of a progressive fragmentation of governance as the conflict developed. The few public health programs that were able to continue operating at scale during the conflict – such as vaccinations and maternal and child health care – were largely donor-supported and delivered by

[152] Operational Data Portal, *Syria Regional Refugee Response*, UNHCR, accessed on September 17, 2020, https://data2.unhcr.org/en/situations/syria/location/71

[153] John Chalcraft, *The Invisible Cage : Syrian Migrant Workers in Lebanon* (Stanford, California: Stanford University Press, 2009).

[154] Salem Ajluni, and Mary Kawar, *Towards Decent Work in Lebanon: Issues and Challenges in Light of the Syrian Refugee Crisis* (Beirut, Lebanon: International Labour Organization, ILO Regional Office for Arab States, 2015).

[155] United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), "Where we work," *UNRWA*, 2020, https://www.unrwa.org/where-we-work/lebanon

[156] Ziad Abdel Samad and Bihter Moschini, "HUMANITARIAN ASSISTANCE IN LEBANON OVERVIEW, CHALLENGES AND RECOMMENDATIONS – Revisiting the Humanitarian System: The Call for Country Ownership in the Case of Lebanon," *Lebanon Support,* 2016, https://civilsociety-centre.org/sites/default/files/resources/humanitarianassistancelebanon-overviewchallengesrecommendations-ls2016.pdf

[157] Nabil M. Kronfol, "Rebuilding of the Lebanese health care system: health sector reforms," *Eastern Mediterranean Health Journal = La Revue de Santé de la Méditerranée orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit* 12, no. 3-4 (2006):459–473, https://applications.emro.who.int/emhj/1203_4/12_3-4_2006_459_473.pdf?ua=1

NGOs (either Lebanese or international).[158] There was also an explosion in the supply of hospital services during this period at the expense of ambulatory care, which contributed to a funding crisis in the early to mid-1990s.[159]

But it was not just the shift in the balance of power between public, private and not-for-profit actors during the Civil War that mattered – what was also significant was the *nature* of the actors that emerged during this period. In particular, the Civil War saw a marked rise in the power of confessional- and politically-affiliated organisations in the health sector. Recent evidence suggests that up to 17% of medical centres and dispensaries are run by Christian charities and 11% by Muslim charities (Sunni and Shi'i), political parties respectively account for a further 7% and 8% of basic healthcare institutions).[160] Sections 9.3 and 9.5 detail in more depth the implications of this change, which accompanied a broader confessionalisation and, in the post-war era, sectarianisation of the political system in Lebanon (see section 8.3 below).

The skewing effect of rising donor activity also had an important influence on the shape of the health sector in Lebanon after the Civil War in two ways. The first of these was discontinuity in funding streams: as international funding for what had been a wartime response dwindled after 1990, NGOs that had previously relied on these funding streams moved increasingly towards fee-for-service models, and doctors (many employed on a part-time basis within this network) used centres increasingly as recruiting grounds for patients, leading to a fragmentation in care provision.[161] This transformation has proven remarkably resistant to reform, partly because incentives for health workers to change their practice are weak. The second factor was an implicit encouragement of irrational approaches to treatment. Programs for diabetes and hypertension were heavily donor funded during and immediately after the Civil War, but often without associated guidelines to ensure cost containment.[162]

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

8.3 Politics and the macroeconomic picture in Lebanon today

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

International and regional actors are influential players in Lebanon

The first is that Lebanon is significantly influenced by regional and international political and economic actors, which has important implications for the policy making process, and for who shapes policy priorities, design and implementation. These influences include: the enduring legacy of French colonial rule under a League of Nations mandate from the early 1920s through to independence in

[158] Kasturi Sen, and Abla Mehio-Sibai, "Transnational capital and confessional politics: the paradox of the health care system in Lebanon," *International Journal of Health Services: Planning, Administration, Evaluation* 34, no. 3 (2004): 527-551, https://doi.org/10.2190/6X2V-GE4T-9BQF-WYXB

[159] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: I. Unregulated private care in Lebanon," *Health Policy and Planning* 12, no. 4 (1997): 296-311, https://doi.org/10.1093/heapol/12.4.296

[160] Melani Cammett, *Compassionate Communalism: Welfare and Sectarianism in Lebanon* (Ithaca, NY: Cornell University Press, 2014), http://www.jstor.org/stable/10.7591/j.ctt5hh11g.

[161] Kasturi Sen, and Abla Mehio-Sibai, "Transnational capital and confessional politics: the paradox of the health care system in Lebanon," *International Journal of Health Services: Planning, Administration, Evaluation* 34, no. 3 (2004): 527-551, https://doi.org/10.2190/6X2V-GE4T-9BQF-WYXB

[162] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: I. Unregulated private care in Lebanon," *Health Policy and Planning* 12, no. 4 (1997): 296-311, https://doi.org/10.1093/heapol/12.4.296

1946 (and continuing European and particularly French influence over political and economic activities in Lebanon to this day);[163] the expansive role of the Syrian state (in the form of a physical, military presence until 2005, but also allied business and commercial interests both before and since that time) ;[164] and also a complex relationship with neighbouring Israel.[165]

International institutions also exert a significant influence over Lebanon in domestic affairs, partly because of the historical openness of the Lebanese economy.[166] The World Bank and International Monetary Fund have historically been major players due to the country's reliance on external aid support, and they shape domestic perceptions of policy priorities in important ways.[167] The World Bank's current Country Partnership Framework for 2017-22, for example, covers support across a range of areas from improved municipal service delivery (water, transport, environmental services and local economic development) to increased job opportunities.[168] Importantly, health does not feature among the key priority areas for support identified in the Bank's country diagnostic, although structural challenges in the health sector are recognised.[169] However, in 2017, the World Bank launched a Lebanon Health Resilience Project of US$ 120m, with the aim of supporting access to quality healthcare services for vulnerable Lebanese and Syrian refugees in Lebanon.[170] In the health sector, the WHO has an important technical presence and multilateral bodies are exercising increasing influence, especially in the context of the humanitarian response to conflict in neighbouring Syria (see below).

The confessional orientation of the political system in Lebanon

The second feature is that Lebanon is a corporate consociational democracy where the dynamics of domestic policymaking are profoundly shaped by a confessional power-sharing arrangement, fear of the potential political implications of shifts in the country's demographic and confessional balance, and a political economy in which clientelism is widespread (leading it to be described as a 'fragmented democracy').[171] The top three offices of state are, by agreement, reserved for individuals from specific confessional groups (the Presidency falls to a Maronite Christian, the premiership to a member of the Sunni Muslim community, and the role of Speaker of Parliament to a Shia based on Lebanon's National Pact).

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

[163] Kamal Salibi, *A House of Many Mansions : the History of Lebanon Reconsidered* (London, UK: I.B. Tauris, 1988).
[164] Taku Osoegawa, *Syria and Lebanon: International Relations and Diplomacy in the Middle East* (London, UK: I.B. Tauris, 2015).
[165] David Hirst, *Beware of Small States: Lebanon, Battleground of the Middle East* (New York: Nation Books, 2010).
[166] Toufic Gaspard, A *Political Economy of Lebanon, 1948-2002* (Leiden, The Netherlands: Brill, 2003).
[167] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.
[168] The World Bank, "Country Partnership Framework for the Lebanese Republic for the Period FY17-FY22," *The World Bank, International Finance Corporation, and Multilateral Investment Guarantee Agency*, June 2016, https://elibrary.worldbank.org/doi/pdf/10.1596/24678
[169] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.
[170] The World Bank, "Lebanon Health Resilience Project," *The World Bank,* June 26, 2017, https://www.worldbank.org/en/news/loans-credits/2017/06/26/lebanon-health-resilience-project
[171] Clement Moore Henry, and Robert Springborg, *Globalization and the Politics of Development in the Middle East* (Cambridge: Cambridge University Press, 2010).

population level data in Lebanon, where this information may be at risk of challenging the political status quo.[172] [173]

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

Table 2. Trends in a selection of key macroeconomic indicators for Lebanon, 2015-2020 (projected) – highlighting fiscal imbalance and the worsening debt: GDP ratio in recent years (e = estimate; f = forecast)[174]

The fragility of Lebanon's macroeconomic position

Thirdly, the macroeconomic picture in Lebanon is parlous and fiscal space for increased public investment in public services including health is very limited (see Table 2). This situation has been strongly shaped by both the near-term and longer-term legacies of armed conflict, but also by the neoliberal fiscal and monetary policies. This includes periods of intensive government spending under the guise of reconstruction following the 1975-1990 Civil War, and also the more recent (2006) war with Israel. A key aspect of the macroeconomic picture in Lebanon is the government's reliance on heavy borrowing on local and international markets to meet reconstruction and other needs. In 1990, real GDP per capita in Lebanon was less than a third of what it had been in 1974 before the beginning of the civil war. That conflict also inflicted physical infrastructure losses estimated at US$25 billion.[175] These losses compounded wider structural weaknesses in the Lebanese economy to create macroeconomic conditions – including sluggish GDP growth[176] – that have imposed profound constraints on fiscal space for investment in public health services. By the late 1990s, interest expenditure on the national debt was costing Lebanon over 60% of its revenues,[177] and this picture of indebtedness continues in moderated form today.[178] Although a number of stakeholders interviewed for this PEA cited the promise of untapped oil and natural gas reserves for improving the country's global macroeconomic position, the impact that new discoveries might have on resource allocation for health is unclear.

Policy responses to refugee movement

Fourthly, and perhaps most importantly in the current climate, the political and legal contours of the Lebanese government's response to successive waves of refugee movements have had profound implications for health policymaking and service delivery. The Syria crisis provides a case in point. Although Lebanon operated a *de facto* open-border policy towards Syrian refugees between 2011 and 2014, the government's positioning vis-à-vis the crisis has been complicated by concerns over

[172] Rania Maktabi, "The Lebanese Census of 1932 Revisited. Who Are the Lebanese?," *British Journal of Middle Eastern Studies* 26, no. 2 (1999): 219-41, http://www.jstor.org/stable/195924

[173] Muhammad A. Faour, "Religion, Demography, and Politics in Lebanon," *Middle Eastern Studies* 43, no. 6 (2007): 909-21, http://www.jstor.org/stable/40262539

[174] The Work Bank, "Lebanon's Economic Outlook – October 2018," *The Work Bank,* 2018, https://thedocs.worldbank.org/en/doc/756401538076843074-0280022018/original/mpoam18lebanonlbn2.pdf

[175] Ghassan, Dibeh, *The Political Economy of Postwar Reconstruction in Lebanon*, Research Paper 2005/044 (Helsinki: UNU-WIDER), 2005.

[176] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.

[177] Clement Moore Henry, and Robert Springborg, *Globalization and the Politics of Development in the Middle East* (Cambridge: Cambridge University Press, 2010).

[178] The Work Bank, "Lebanon's Economic Outlook - October 2018," *The Work Bank,* 2018, https://thedocs.worldbank.org/en/doc/756401538076843074-0280022018/original/mpoam18lebanonlbn2.pdf

potentially destabilising spillover effects from the conflict in Syria, as embodied in the "Dissociation Policy" introduced in 2012.[179] [180] This was intended to enforce a policy of neutrality towards the crisis by political actors in Lebanon to reduce the risk of violent spillover from Syria, but has had the effect of providing cover for limited recognition of rights for Syrians, who have no meaningful prospects of integration in Lebanon, and for whom – as an article of official government policy – no refugee camps can be established.[181]

Since 2012, this has resulted in a dualism of policy on the refugee question. On the one hand, the government has strengthened its domestic response to the crisis through the establishment of a multi-sector Crisis Response Plan (LCRP). On the other, it has adopted increasingly exclusionary rhetoric towards Syrian refugees, and in May 2015 it formally requested that UNHCR stop registering new arrivals from Syria.[182] Relations between the government and many of the major agencies involved in the response are strained.[183]

For the refugees themselves, the rights of residency for displaced Syrians are severely restricted, as are meaningful opportunities for labour market participation and other forms of social and economic integration – especially for skilled workers. The latest Vulnerability Assessment of Syrian Refugees in Lebanon for 2019 reports labour market participation rates of 38% for Syrians in Lebanon, down from 43% for the previous year (and just 11% for Syrian women, down from 16% in 2018).[184] [185] The Lebanese government also eschews the use of refugee camps: although UNRWA does operate camps for displaced Palestinians (a truly long-term refugee crisis), the million or more displaced Syrians currently living in the country are scattered across 2,100 formal and informal tented settlements, many of them in governorates such as Bekaa and Akkar that border Syria, where public service access and quality for host communities has historically been variable. Some 73% of the displaced Syrian population in Lebanon live below the poverty line.[186]

[179] Tamirace Fakhoury, "GOVERNANCE STRATEGIES AND REFUGEE RESPONSE: LEBANON IN THE FACE OF SYRIAN DISPLACEMENT," *International Journal of Middle East Studies* 49, no. 4 (2017): 681-700, doi:10.1017/S0020743817000654
[180] Maja Janmyr, "THE LEGAL STATUS OF SYRIAN REFUGEES IN LEBANON," *Issam Fares Institute for Public Policy and International Affairs*, March 2016, https://website.aub.edu.lb/ifi/publications/Documents/working_papers/20160331_Maja_Janmyr.pdf
[181] Ibid.
[182] Maja Janmyr, "Precarity in Exile: The Legal Status of Syrian Refugees in Lebanon," *Refugee Survey Quarterly* 35, no. 4 (2016): 58-78, https://doi.org/10.1093/rsq/hdw016.
[183] Maja Janmyr, "UNHCR and the Syrian refugee response: negotiating status and registration in Lebanon," *The International Journal of Human Rights* 22, no. 3 (2018):393-419, DOI: 10.1080/13642987.2017.1371140
[184] UNHCR, *VASyR 2018 Vulnerability Assessment of Syrian Refugees in Lebanon,* UNHCR, UNICEF, WFP, Inter-Agency Coordination Lebanon, 2018, https://data2.unhcr.org/en/documents/download/67380
[185] UNHCR, *VASyR 2019 Vulnerability Assessment of Syrian Refugees in Lebanon,* UNHCR, UNICEF, WFP, Inter-Agency Coordination Lebanon, 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/73118.pdf
[186] Ibid.

8.4 Broad features of the population health context in Lebanon

Along with many of its middle-income regional neighbours, Lebanon has experienced a partial epidemiological transition to a disease burden today in which non-communicable diseases (NCDs) predominate. There has also been a marked improvement in average life expectancy at birth from around 70 in 1990 to around 79 in 2018 (the last year for which complete data are available).[187] The health policy implications of rising life expectancy – in terms of both the design of care delivery models (for both health and social care) and the sustainability of financing for the health sector in Lebanon – are broadly recognised in the literature. However, policy responses to this changing picture are generally regarded as having been slow.[188]

Major causes of both death and disability in Lebanon in 2017 (the latest year for which complete estimates are available) were cardiovascular diseases, diabetes, cancers, diabetes and chronic kidney disease.[189] The distribution of major sources of disability (in DALYs) has remained remarkably similar since 1990, although the impact of maternal and neonatal causes of disability today is markedly lower than at that time. Importantly, while there was a consistent downward trend in all-cause mortality and disability (DALY) rates in Lebanon throughout the 1990s, progress against these measures appears to have stalled since 2000.

The disease distribution described above is also reflected in the risk factor profile for Lebanon, which in 2017 (again, the last year for which complete data are available) was very much that of a middle- or higher-income country. High body mass index (BMI), tobacco consumption, dietary risks and hypertension contributed the greatest share of DALYs lost to ill-health in Lebanon.[190]

The crisis in Syria has transformed the health picture of the population in Lebanon. Displaced Syrians are mainly young (53% are children) and poor, with low levels of prior educational attainment. The effects of geographical distribution are an important factor in understanding the pressures shaping demand for health services, and policy responses, across the country – especially in the context of inward movement from Syria. Historically, specialist health service provision has been concentrated in major urban centres (especially Beirut), rather than in the poorer, peri-urban and rural areas in the interior of the country where health needs are most concentrated. These areas have also seen some of the largest influxes of displaced Syrians and the most pronounced demand pressures on services at a local level.[191] [192] [193] [194]

[187] The World Bank, "Life expectancy at birth, total (years) – Lebanon," The World Bank, accessed on September 17, 2020, https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=LB

[188] Abla Mehio Sibai, Kasturi Sen, May Baydoun, and Prem Saxena, "Population ageing in Lebanon: current status, future prospects and implications for policy," *Bulletin of the World Health Organization* 82 (2004): 219-225.

[189] IHME Vizhub, GBD compare portal, IHME Vizhub, accessed September 17, 2020, https://vizhub.healthdata.org/gbd-compare/

[190] Ibid.

[191] UNHCR, *VASyR 2018 Vulnerability Assessment of Syrian Refugees in Lebanon,* UNHCR, UNICEF, WFP, Inter-Agency Coordination Lebanon, 2018, https://data2.unhcr.org/en/documents/download/67380

[192] UNHCR, *VASyR 2019 Vulnerability Assessment of Syrian Refugees in Lebanon,* UNHCR, UNICEF, WFP, Inter-Agency Coordination Lebanon, 2019, https://reliefweb.int/sites/reliefweb.int/files/resources/73118.pdf

[193] Abla Mehio Sibai, Kasturi Sen, May Baydoun, and Prem Saxena, "Population ageing in Lebanon: current status, future prospects and implications for policy," *Bulletin of the World Health Organization* 82 (2004): 219-225.

[194] Shannon Doocy, Emily Lyles, Baptiste Hanquart, LHAS Study Team, and Michael Woodman, "Prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon," *Conflict and Health* 10, no. 21 (2016), https://doi.org/10.1186/s13031-016-0088-3

9. Current form and function in the health sector

9.1 Roles and responsibilities

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

	MOSA	The Ministry of Social Affairs is the main provider of social protection and assistance in Lebanon. MOSA operates Social Development Centres where primary healthcare services are delivered.[195] Besides the importance of its work in addressing key social determinants of health, MOSA is also the nodal Ministry for oversight of the Lebanon Crisis Response Plan (LCRP) – which governs the official response to the Syria crisis (including health).
Monitoring agencies	Insurance Control Commission	The ICC is a quasi-governmental institution under the Ministry of Economy and Trade in Lebanon, in charge of maintaining an efficient and stable insurance market.
Not for Profit organisations	Amel	Amel (Amel Association International) was established in 1979 as a nominally non-confessional not-for-profit organisation providing health services. It now operates a network of hospitals, clinics and accessory support services focusing on disadvantaged populations, and is a key delivery partner for a number of international organisations operational in Lebanon, including UNHCR.
	Islamic Health Committee (Hezbollah)	The Islamic Health Committee is the health service delivery arm of Hezbollah's wider social service programme (*Jihād al-Binā*). The Committee operates a network of clinics, hospitals and other facilities providing health services, and has at times (e.g. in 2006) played a prominent humanitarian response role during conflict.[196]
International organisations and agencies	European Union	Through its Regional Trust Fund in Response to the Syrian Crisis, the European Union is now the largest single donor to the health sector in Lebanon, providing EUR 173m in funds since 2014.[197] The European Union donated an additional EUR 32.2m in humanitarian aid to support vulnerable Lebanese and Syrians impacted by the Beirut blast.[198]
	WHO	The Lebanon office of WHO has played an important role in supporting technical capacity building in the MOPH and indeed across the health sector since the end of the Civil War in 1990.
	World Bank	The World Bank has had a presence in Lebanon since the mid-1950s, and while its focus has historically been on support for long-range development work in the mainstream health sector, it has taken a proactive role in responding to the crisis in Syria, including the establishment of the Lebanon Syria Crisis Trust Fund (LSCTF) (a multi-donor trust fund designed to help mitigate the effects of the crisis). Health is one of the four emergency project focuses of the LSCTF.

[195] Republic of Lebanon - Ministry of Social Affairs, "The National Social Development Strategy of Lebanon 2011," *Republic of Lebanon - Ministry of Social Affairs,* 2011, http://www.databank.com.lb/docs/National%20Social%20Development%20Strategy%202011.pdf

[196] Joseph Daher, *Hezbollah: The Political Economy of Lebanon's Party of God* (London, UK: Pluto Press, 2016).

[197] UNICEF, "European Union renews commitment – support for the Lebanese Healthcare System reaches €173 million," *UNICEF,* December 18, 2018, https://www.unicef.org/lebanon/press-releases/european-union-renews-commitment-support-lebanese-healthcare-system-reaches-173

[198] European Civil Protection and Humanitarian Aid Operations, "Lebanon," *European Civil Protection and Humanitarian Aid Operations,* December 12, 2020, https://ec.europa.eu/echo/where/middle-east/lebanon_en

Academic institutions	Lebanese American University, AUB and others	Lebanese American University, St Joseph University, AUB, Sagesse University and Lebanese University form the quartet of major academic institutions in Lebanon that carry out research work on the health sector in the country. AUB in particular has a track record of work with policymakers and has dedicated centres (K2P and SPARK) focused on questions around evidence generation, synthesis and uptake into policy, principally in health.

Table 3. Selection of key actors in the mainstream health sector in Lebanon and a description of their roles (note that this list is not comprehensive, especially when considering not-for-profit service providers in Lebanon).

Table 3 above outlines the roles and responsibilities of key actors within the mainstream health system in Lebanon, while Table 4 below shows the equivalent for actors in the humanitarian response space. A third table (appendix 3) maps specific functions in the health sector to these actors to give a sense of the span of activities being undertaken. An important overarching observation to be gleaned from this is that MOPH has a very broad and diverse remit, spanning the full range of activities from norm-setting and guideline development, through regulatory and quality assurance, to financing and direct provision of services.

The humanitarian response space in Lebanon has developed in large measure in isolation from the wider health system, and other players come to the fore here (Table 4). This results partly from the historical evolution of the health sector – particularly the long-standing presence of multilateral agencies responding to protracted refugee problems (e.g. UNRWA for the Palestinian refugee population), and institutional legacy effects from past conflicts (notably the 2006 war). But this is also a result of the Lebanese government's calculated and long-established hostility towards refugee and asylum matters. For much of the first three years of the Syria crisis, there was no official Lebanese government policy response and UNHCR was by default the lead agency, in coordination with OCHA and UNDP under the overall supervision of a UN resident coordinator/humanitarian coordinator (UNRC/HC). The first comprehensive government policy position was not issued until October 2014. This policy positions MOSA as the central government ministry overseeing the response, and while MOPH has a line ministry function in the LCRP, it is subordinate to MOSA.[199]

Category	Actor	Description and summary of role and responsibilities in the sector
Governance, oversight and coordination	Health sector working group	Health Clusters are normally formed as short-term institutional arrangements to help manage crisis responses. An important feature of the Lebanese context is that the kind of health sector response mechanism activated has varied across conflicts. A Lebanon Crisis Health Cluster was formed in 2006 as a response to the conflict in that year, but continued to operate into the late 2000s, to support responses to ongoing instability, including fighting in Nahr el-Bared camp in 2007. The response to the crisis in Syria has been different; Lebanon is not formally part of the Whole-of-Syria cluster, and the domestic response to the crisis is instead governed by a health sector working group under the LCRP.
	UN OCHA	OCHA's mandate theoretically focuses on coordination (covering financing, policy, and information management in humanitarian

[199] Kholoud Mansour, "UN Humanitarian Coordination in Lebanon," *Chatham House*, 2017

		responses), but the scope of its role in Lebanon is vague and it sits outside the core governance structure for the LCRP. OCHA houses the Lebanon Humanitarian Fund, a Country Based Pooled Fund theoretically aligned with LCRP.
International organisations and agencies providing programs and services	UNDP	UNDP's presence in Lebanon dates back to 1960, and its work spanned the Civil War from 1975-90. While it does not provide health services, UNDP programming directly influences broader social determinants of health in Lebanon, and as joint lead UN agency in the LCRP (with UNHCR), it helps to coordinate the humanitarian response to the Syria crisis in the country.
	UNHCR	Primary provider of services to registered refugees in Lebanon. UNHCR has had a field presence in Lebanon since 1963, but its work in-country was not formalised until 2003 when an official MOU with the Lebanese government was signed (which was notably light on commitments for the Lebanese government to uphold the 1951 Refugee Convention).[200] It operates with the permission of the Lebanese government and there have been ongoing challenges in defining its operating space in-country.
	UNRWA	The UN Relief and Works Agency was established to meet the needs of Palestinians displaced in 1948. There are around 450,000 Palestinian refugees registered in Lebanon with UNRWA, living across 12 camps. A distinctive feature of UNRWA's mandate is that its activities span almost the complete spectrum from policy development and implementation through to service delivery, and it has long-established systems for health service provision in Lebanon and other countries in the MENA region. UNRWA has a dedicated health provider network for displaced Palestinians, incorporating 28 primary healthcare facilities across the country. It also has reciprocal arrangements with the Palestinian Red Crescent Society to support access to secondary care in Lebanon.
Not-for-profit organisations involved in service delivery	Lebanese Red Cross	The Lebanese branch of the International Red Cross movement, based in Beirut. The LRC is active across both the mainstream (covering services such as blood donation and transfusion support, for example) and humanitarian response sectors. It also acts as an auxiliary service to the Lebanese Army.
	Multi Aid Programs (MAPs)	MAPs were established in 2013 and operate a series of public service programs, including a health program targeted at meeting the needs of displaced Syrians in Lebanon and support for the training of Syrian health professionals. The focus of the program is on primary healthcare delivery.

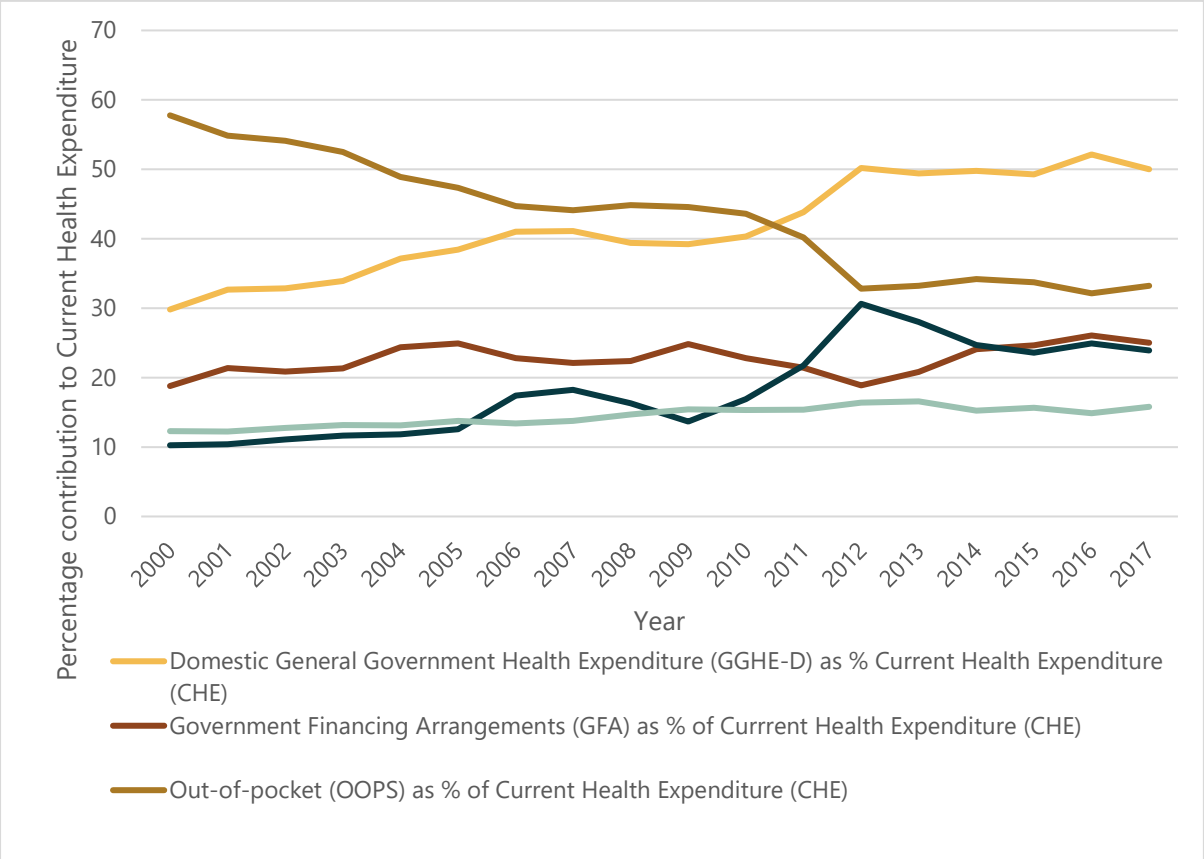
Table 4. Selection of notable actors in the humanitarian health response system in Lebanon (aside from those listed in Table 3 in the mainstream health sector).

[200] Maja Janmyr, "UNHCR and the Syrian refugee response: negotiating status and registration in Lebanon," *The International Journal of Human Rights* 22, no. 3 (2018): 393-419, DOI: 10.1080/13642987.2017.1371140

9.2 Ownership structure and financing

The distribution of ownership for health facilities in Lebanon varies according to the level of care. While health promotion and prevention activities generally fall under the umbrella of the MOPH, the provision of health services at the primary, secondary and tertiary levels looks very different. Secondary and tertiary care provision in Lebanon is almost exclusively the preserve of the private sector. Therefore, access to secondary and tertiary healthcare for refugees is challenging and relies on the support of humanitarian agencies such as the UNHCR for Syrian refugees and the UNRWA for Palestinian refugees.[201] [202] Meanwhile, primary care is provided through a network of primary healthcare centres (PHCs) that are administered with MOPH support but in which services are delivered by NGOs.

The health financing landscape in Lebanon is notoriously fragmented and difficult to navigate. In aggregate terms, the country had historically one of the highest levels of spending on health as a proportion of GDP in the MENA region, but this has reduced somewhat in the years since 2000, and stood at 8% in 2016 (the last year for which complete data are available). Importantly, financing sources are skewed heavily towards domestic private health expenditure – which contributed 49% of current health expenditure (CHE) in Lebanon in 2017 – and particularly out-of-pocket (OOP) spending. Although OOP spending has steadily declined as a proportion of CHE from 58% in 2000, in 2017 it still accounted for 33% of all funding for health service provision in the mainstream Lebanese health system.[203]



[201] UNHCR, "Health programme 2019," *UNHCR,* 2019, https://www.unhcr.org/lb/wp-content/uploads/sites/16/2019/04/Health-Factsheet.pdf
[202] UNRWA, "Health in Lebanon," *UNRWA*, https://www.unrwa.org/activity/health-lebanon
[203] WHO, *Global Health Expenditure Database,* WHO, accessed April 18, 2019, https://apps.who.int/nha/database/Select/Indicators/en

Figure 6. Trends in the contributions of different financing arrangements to CHE in Lebanon, 2000-2017, the last year for which data are available (source: WHO Global Expenditure Database)

With regard to financing schemes, payment for services incorporates a number of financing intermediaries – principally six publicly managed, employment-based social insurance funds, which have different governance mechanisms.[204] These funds are:

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

These compulsory schemes covered about 51% of the population in 2016, leaving 49% with voluntary (private) coverage or no formal coverage at all to meet catastrophic costs. Private insurers are regulated by a fourth ministry – the Ministry of Economy and Trade. For those without any coverage at all, the MOPH covers the costs of essential services (medications, hospitalisations and so forth).[205] MOPH coverage reimburses around 80% of hospital costs for the uninsured depending on the nature of the service provided.[206] Private insurance schemes naturally sit alongside all of those listed above – a proportion of the population is covered by these and selected other schemes.

Alongside the insurance system and the singular role of the MOPH as both a service provider and payer in Lebanon, perhaps the most striking feature of the financing environment is the high level of expenditure on pharmaceuticals. At 45% of total healthcare expenditure in Lebanon, spending is three times the global average (15%) and is driven by an unusually high expenditure on patented medications (around 49% of the USD 1.6bn in pharmaceutical sales in the health sector in 2015).[207] This is partly because of a failure to introduce pricing reforms, but is mainly due to enduringly weak incentives for health practitioners to prescribe generic medicines, despite the implementation of a new policy in recent years to encourage drug substitution.[208] [209]

[204] Fadi El-Jardali, Lama Bou-Karroum, Nour Ataya, Hana Addam El-Ghali, and Rawan Hammoud, "A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure," *Social Science & Medicine* 1982, no. 123 (2014): 45-54, https://doi.org/10.1016/j.socscimed.2014.10.044
[205] Ibid.
[206] Mustapha D. Ibrahim, Sahand Daneshvar, "Efficiency Analysis of Healthcare System in Lebanon Using Modified Data Envelopment Analysis," *Journal of Healthcare Engineering* 2018, no. 2 (2018), https://doi.org/10.1155/2018/2060138
[207] McKinsey, Lebanon Economic Vision, *McKinsey,* 2018, https://www.economy.gov.lb/media/11893/20181022-1228full-report-en.pdf
[208] Fadi El-Jardali, Racha Fadlallah, Rami Z Morsi, Nour Hemadi, Mounir Al-Gibbawi, Magda Haj, Suzan Khalil, Youssef Saklawi, Diana Jamal, and Elie A Akl, "Pharmacists' views and reported practices in relation to a new generic drug substitution policy in Lebanon: a mixed methods study," *Implementation Science* 12, no. 1 (2017), https://doi.org/10.1186/s13012-017-0556-1
[209] Rima Hajjar, Aya Bassatne, Mohamad Ali Cheaito, Rabie Naser El Dine, Sarah Traboulsy, Fadi Haddadin, Gladys Honein-AbouHaidar, and Elie A. Akl, "Characterizing the interaction between physicians, pharmacists and pharmaceutical representatives in a middle-income country: A qualitative study," *PloS one* 12, no. 9 (2017), https://doi.org/10.1371/journal.pone.0184662

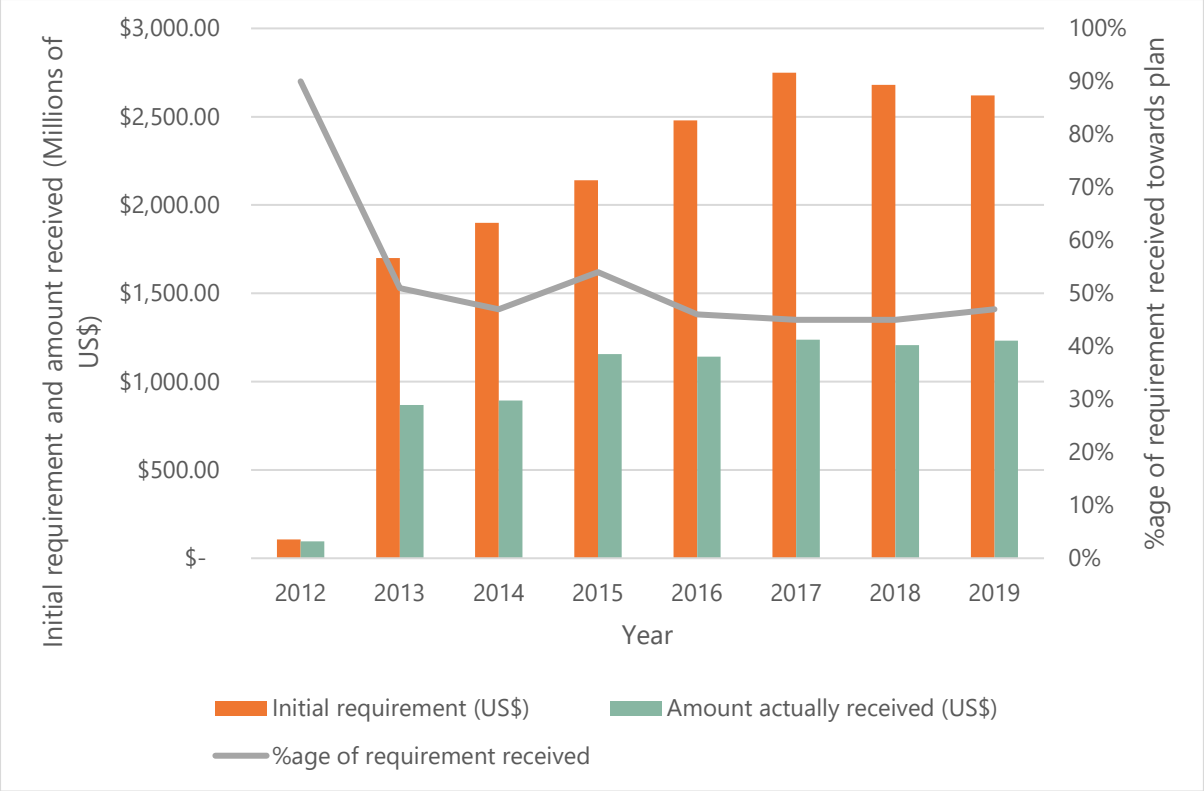


Figure 7. Trends in absolute funding receipts for humanitarian response activities in Lebanon (blue bars) mapped against requirements (red bars). The green line shows the trend over time in the proportion of funding requirements ultimately met by donors (source: LCRP Update 2018 [210]).

Data on both the volume and distribution of financing for the humanitarian response in Lebanon are sparse. We know that – as with many other humanitarian response efforts worldwide – the LCRP is chronically underfunded. For most years since its inception, receipts to the LCRP have hovered a little under 50% of stated requirements (see Figure 7).

It is also clear, however, that there are important additional funding streams for the humanitarian response in Lebanon beyond those captured by official crisis response data sources – in particular, financing from the Gulf States and Iran. Much of this money is allocated directly to partners in Lebanon or via other opaque channels rather than through the LCRP – and for this reason the scale and scope of this funding is almost impossible to verify independently.[211] Evidence from the recent historical record in Lebanon is, however, clear on the importance of regional funding streams to both near-term support and longer-term reconstruction efforts during and after the Civil War and the 2006 conflict.[212] [213] [214] [215] For example, the flash appeal for humanitarian response funding following the 2006 war requested USD 155m yet the final allocation was some USD 520m, more than 25% of which

[210] The Government of Lebanon and the United Nations, Lebanon Crisis Response 2017-2020 (2018 update), *The Government of Lebanon and the United Nations,* 2018, https://lebanon.un.org/sites/default/files/2021-02/LCRP2018_EN_Full_180122-035824.pdf

[211] Dalya Mitri, "Challenges of aid coordination in a complex crisis: An overview of funding policies and conditions regarding aid provision to Syrian refugees in Lebanon," *CSR 2014*, 2014.

[212] Hannes Baumann, *Citizen Hariri: Lebanon's Neo-Liberal Reconstruction* (Oxford, UK: Oxford University Press, 2017).

[213] Christine Sylva Hamieh, and Roger Mac Ginty, "A very political reconstruction: governance and reconstruction in Lebanon after the 2006 war," *Disasters* 34, no.1 (2009), https://doi.org/10.1111/j.1467-7717.2009.01101.x

[214] Roger Mac Ginty, "Reconstructing post-war Lebanon: A challenge to the liberal peace?," *Conflict, Security & Development* 7, no.3 (2007): 457-482, DOI: 10.1080/14678800701556552

[215] Adele Harmer, and Ellen Martin, "Diversity in donorship – Field lessons," *Overseas Development Institute*, 2010, https://reliefweb.int/sites/reliefweb.int/files/resources/65A889357367D8204925770600234185-HPG%20DAC.pdf

came from donors outside the OECD's Development Assistance Committee (DAC) – principally Saudi Arabia, the UAE, Kuwait and Turkey. The largest allocations to long-term reconstruction at a pledging conference later in 2006 also came from the Gulf States.[216]

9.3 Power relations, bargaining and rent-seeking in the health sector

The available literature shows there are significant power imbalances in the health sector, spanning both the mainstream health system and the humanitarian response architecture for refugees. A striking feature of some of the literature on the sector, and indeed on the political economy of public policymaking in Lebanon, is that the power-sharing arrangement put in place as a result of the Taif Accords at the end of the Civil War embedded clientelism in the public sector. This is particularly due to its entrenching of a confessional and sectarian-based political economy that undermines the capacity of public services in Lebanon to distribute public goods rationally.[217] [218]

9.3.1 Confessionalism and its influence on bargaining and rent-seeking in Lebanon's health sector

The redistribution of power enshrined by the Taif Accords established quota arrangements for leading government and public administration posts ("first grade" positions equivalent to senior civil service and ministerial level) across confessional groups in Lebanon. In reality, the principle of parity in the distribution of posts between groups was applied across the public sector as a whole after Taif, and has had significant implications for the speed and effectiveness of hiring to public posts. The effect of the change was that "recruitment to the public sector became part of a complex ensemble protecting the political, economic, and security prerogatives of the sectarian elite and their cronies".[219] This can be seen directly in appointments to first grade positions in the health sector. Under Taif, the position of Director-General (DG) of the MOPH is allocated to the Druze community. Other DG-level positions with direct relevance to the health sector are allocated to members of other groups (DGs of the MOF and the High Council for Privatisation to Maronite Christians, DG of the NSSF to a Shia, DG of the Ministry of Labour to a Greek Orthodox Christian, and DG for the Ministry of the Displaced to a Druze).

Such power imbalances manifest in health sector bargaining in varying ways according to the actor and the policy question concerned. The effect of the post-Taif system has been to allocate, by community, control over tenders for government contracts and access to resources, and to "confessionalise" the question of accountability for performance.[220] [221] The distorting influence of confessionalism over sector activities pervades all levels from policymaking through to ground-level service delivery.[222] [223] But as we will see in section 9.5, the implications for service access are not always as straightforward as they might appear. Nevertheless, evidence suggests that confessional and

[216] Ibid.
[217] Reinoud Leenders, *Spoils of Truce: Corruption and State-Building in Postwar Lebanon*, 1st ed. (Ithaca, NY: Cornell University Press, 2012), https://books.google.co.uk/books/about/Spoils_of_Truce.html?id=8KAiRCdzV_cC&redir_esc=y
[218] Bassel F. Salloukh, "Taif and the Lebanese State: The Political Economy of a Very Sectarian Public Sector," *Nationalism and Ethnic Politics* 25, no. 1, (2019): 43-60, DOI: 10.1080/13537113.2019.1565177
[219] Ibid.
[220] Reinoud Leenders, *Spoils of Truce: Corruption and State-Building in Postwar Lebanon*, 1st ed. (Ithaca, NY: Cornell University Press, 2012), https://books.google.co.uk/books/about/Spoils_of_Truce.html?id=8KAiRCdzV_cC&redir_esc=y
[221] Bassel F. Salloukh, "Taif and the Lebanese State: The Political Economy of a Very Sectarian Public Sector," *Nationalism and Ethnic Politics* 25, no. 1, (2019): 43-60, DOI: 10.1080/13537113.2019.1565177
[222] Melani Cammett, "Sectarianism and the Ambiguities of Welfare in Lebanon," *Current Anthropology* 56, no. S11 (2015): S76-87, https://doi.org/10.1086/682391
[223] Bradley Chen and Melani Cammett, "Informal politics and inequity of access to health care in Lebanon," *International Journal for Equity in Health* 11, no. 23 (2012), doi:10.1186/1475-9276-11-23

sectarian affiliation has a direct effect on the allocation of public spending in Lebanon, which is often tenuously linked to actual service need.[224] [225]

9.3.2 The role of MOPH

In the government-run health sector, MOPH exercises a key technical, regulatory and quality assurance role, but is also a third-party payer for primary, secondary and tertiary care, alongside public providers of insurance and the various private insurance companies. However, its authority has not yet fully recovered from its hollowing out during the 1975-90 Civil War, when much technical capacity was lost and public health service provision was scaled back greatly. Nevertheless, the Ministry can exert a decisive influence over policymaking and implementation, as demonstrated during reforms to tobacco control laws in the mid-2000s (Box 1) and more recently in the development and implementation of a National Mental Health Strategy for Lebanon. Policy change was successfully achieved in the former case despite the presence of powerful vested interests in this area – including both the international tobacco industry and the Regie, the national, parastatal state-run tobacco monopoly in Lebanon that is administered by the MOF and which provides key revenue streams for that ministry. This depended on a combination of global impetus towards change (the signing of the Framework Convention on Tobacco Control), strong technical support to the MOPH from the WHO, political commitment from leaders in Lebanon, and an activist academic and civil society lobby which effectively brought local research evidence to bear on the policy debate (see below). In the latter case, the extraordinary service pressures arising as a result of the crisis in Syria combined with the opening up of new, albeit insecure, funding lines and strong leadership appear to have created a favourable window of opportunity for change.[226] [227]

The reform of health financing, however, has been an area of persistent failure partly because power relations in this area have been skewed decisively towards a selection of actors – principally the Syndicate of Private Hospitals and the Lebanese Order of Physicians – who have a strong interest in maintaining the policy status quo. The MOPH – despite its status as a key third-party payer for services – has had limited success in pushing for a reform of health financing arrangements.[228]

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

On one level, the literature sources make clear that there are tensions between the multilateral agencies leading large parts of the response to the Syria crisis and the Lebanese government – at the behest of which the UNRC/HC operates.[229] But there have also been profound problems of coordination between these agencies themselves – including over the leadership of different aspects of the response. Although UNHCR formally leads the humanitarian response to the Syria crisis in Lebanon (including provision of health services to Syrian refugees), recent reports, including

[224] Nisreen Salti, and Jad Chaaban, "The political economy of attracting public funds: the case of Lebanon," *International Journal of Development and Conflict* 2, no. 1 (2012), https://doi.org/10.1142/S2010269012500019

[225] Nisreen Salti, and Jad Chaaban, "THE ROLE OF SECTARIANISM IN THE ALLOCATION OF PUBLIC EXPENDITURE IN POSTWAR LEBANON," *International Journal of Middle East Studies* 42, no. 4 (2010): 637-55, doi:10.1017/S0020743810000851

[226] Fiona Fleck, "Reforming mental health in Lebanon amid refugee crises," *Bulletin of the World Health Organization* 94, no. 8 (2016): 564-565, https://doi.org/10.2471/BLT.16.030816

[227] Rabih El Chammay, Elie Karam, Walid Ammar, "Mental health reform in Lebanon and the Syrian crisis," *The Lancet. Psychiatry* 3, no.3 (2016): 202-3, doi:10.1016/S2215-0366(16)00055-9

[228] Fadi El-Jardali, Lama Bou-Karroum, Nour Ataya, Hana Addam El-Ghali, and Rawan Hammoud, "A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure," *Social Science & Medicine* 1982, no. 123 (2014): 45-54, https://doi.org/10.1016/j.socscimed.2014.10.044

[229] Maja Janmyr, "UNHCR and the Syrian refugee response: negotiating status and registration in Lebanon," *The International Journal of Human Rights* 22, no. 3 (2018):393-419, DOI: 10.1080/13642987.2017.1371140

independent evaluations of the response, have identified competition between UNHCR, UN OCHA and UNDP over leadership roles as a key factor in explaining ongoing weaknesses in coordination.[230]

Evidence on the question of corruption and rent-seeking in the health sector – both mainstream and the humanitarian response space – is limited. While donor and agency reports make clear the scale of the corruption challenge in the wider economy in Lebanon,[231] [232] research explicitly addressing the scale and scope of rent-seeking in the health sector in the country was restricted to a cluster of studies on the *confessionalisation* of health service provision.[233] [234]

9.4 Ideology, norms and values

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

- An elite-level preference for laissez-faire approaches to economic management in Lebanon[235] emerges consistently from the academic literature. Combined with the destructive effects of the Civil War and support from international financial institutions,[236] this helped to create the conditions for private and not-for-profit sector expansion in health. But there are tensions in how this is practically manifested in the health sector, some of which are evident in the MOPH's current Strategic Plan for Health. This document puts health equity, universal health coverage, and addressing key determinants of health (upstream from the health sector) upfront in its vision for the future of the sector. From a strategic and operational perspective, the document highlights strengthened *public* service provision as central to this aim, particularly through support for the public primary care and hospital sectors. However, it side-steps the question of financing reform as a means to improve coverage, and instead frames the refugee population in Lebanon mainly in terms of emergency preparedness and response.[237]

- A tendency among decision-makers towards political "abstention" (in the words of interviewees) – i.e. active decisions by key actors to maintain the *status quo* in the health sector in the belief that this serves their own interests (personal, financial, mobilisation of voters) and also those of key allies in the sector.

- Elite and popular attitudes towards refugee populations in Lebanon and their civil rights. Section 8.3 highlighted the so-called "Dissociation Policy" as an important articulation of official policy towards the Syrian crisis with major implications for the health response for refugees, alongside a tacit desire by policymakers to avoid a repeat of the long-term settlement of Palestinian refugees in Lebanon. While displaced Syrians continue to be able to access primary healthcare through government-supported facilities, the uncertain status of those without formal registration acts as a significant barrier to access. But there has also been a coarsening of political discourse in Lebanon towards Syrian refugees from some quarters over the past two years – especially in the run-up to

[230] Kholoud Mansour, "UN Humanitarian Coordination in Lebanon," *Chatham House*, 2017.
[231] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.
232 The Work Bank, "Lebanon's Economic Outlook – October 2018," *The Work Bank,* 2018, https://thedocs.worldbank.org/en/doc/756401538076843074-0280022018/original/mpoam18lebanonlbn2.pdf
[233] Melani Cammett, *Compassionate Communalism: Welfare and Sectarianism in Lebanon* (Ithaca, NY: Cornell University Press, 2014), http://www.jstor.org/stable/10.7591/j.ctt5hh11g.
[234] Nisreen Salti, and Jad Chaaban, "The political economy of attracting public funds: the case of Lebanon," *International Journal of Development and Conflict* 2, no. 1 (2012), https://doi.org/10.1142/S2010269012500019
[235] Toufic Gaspard, *A Political Economy of Lebanon, 1948-2002*, (Leiden, The Netherlands: Brill, 2003)
[236] Kasturi Sen, and Abla Mehio-Sibai, "Transnational capital and confessional politics: the paradox of the health care system in Lebanon," *International Journal of Health Services: Planning, Administration, Evaluation* 34, no. 3 (2004): 527-551, https://doi.org/10.2190/6X2V-GE4T-9BQF-WYXB
[237] Ministry of Public Health, "Health Strategic Plan 2016-2020," *World Health*, 2008.

the 2018 parliamentary elections. Senior Lebanese politicians have publicly called for refugees to return to Syria, and efforts to realise this are now being pursued despite continuing insecurity over the border.[238]

- The third key theme in the literature – raised in section 9.3 – concerns the role of identity politics in shaping health sector activity in Lebanon. Section 9.5 below details in depth how this manifests in service delivery.

9.5 Service delivery

The service delivery landscape in Lebanon is diverse – and characterised by pronounced market failures and inequities in access and quality.[239] [240] [241] [242] [243] The privileging of secondary and even tertiary care services at the expense of prevention and broad-based primary care is a long-standing feature of the service delivery landscape in Lebanon. Again, this stems in part from the destabilising effects of the Civil War. Reviews published in the late 1980s and 1990s note an explosion in per capita provision during this period of what were then high-end medical technologies such as MRI and CT scanning facilities, and cardiac catheterisation laboratories – far beyond demonstrable health need – as fee-for-service provision proliferated.[244] [245] [246] As Figure 8 illustrates, technology density in the health sector in Lebanon continues to outstrip regional neighbours today. And while the MOPH and Education Ministry do provide some preventive services, NGOs continue to be mainstay providers of vaccination, maternal and child health interventions, and health education.[247]

[238] Carmen Geha, and Joumana Talhouk, "Politics and the Plight of Syrian Refugees in Lebanon: Political Brief on the Return of Syrian Refugees," *Political Studies and Public Administration Department, American University of Beirut,* August 2018, https://www.aub.edu.lb/Documents/Politics-and-the-Plight-of-Syrian-Refugees-in-Lebanon.pdf
[239] Walid Ammar, *Health System and Reform in Lebanon* (Beirut, Lebanon: Entreprise universitaire d'études et de publications, 2003).
[240] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: II. Pressure for change in the Lebanese health sector," *Health Policy and Planning* 12, no. 4 (1997): 312-319, https://doi.org/10.1093/heapol/12.4.312
[241] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: I. Unregulated private care in Lebanon," *Health Policy and Planning* 12, no. 4 (1997): 296-311, https://doi.org/10.1093/heapol/12.4.296
[242] Jade Khalife, Nadwa Rafeh, Jihad Makouk, Fadi El-Jardali, Bjorn Ekman, Nabil Kronfol, Ghassan Hamadeh, and Walid Ammar, "Hospital Contracting Reforms: The Lebanese Ministry of Public Health Experience," *Health Systems & Reform* 3, no.1 (2017): 34-41, DOI: 10.1080/23288604.2016.1272979
[243] Fadi El-Jardali, Lama Bou-Karroum, Nour Ataya, Hana Addam El-Ghali, and Rawan Hammoud, "A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure," *Social Science & Medicine* 1982, no. 123 (2014): 45-54, https://doi.org/10.1016/j.socscimed.2014.10.044
[244] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: II. Pressure for change in the Lebanese health sector," *Health Policy and Planning* 12, no. 4 (1997): 312-319, https://doi.org/10.1093/heapol/12.4.312
[245] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: I. Unregulated private care in Lebanon," *Health Policy and Planning* 12, no. 4 (1997): 296-311, https://doi.org/10.1093/heapol/12.4.296
[246] Nabil M. Kronfol, and Rashid Bashshur, "Lebanon's Health Care Policy: A Case Study in the Evolution of a Health System under Stress," *Journal of Public Health Policy* 10, no. 3 (1989): 377-96, https://doi.org/10.2307/3342798.
[247] Kasturi Sen, and Abla Mehio-Sibai, "Transnational capital and confessional politics: the paradox of the health care system in Lebanon," *International Journal of Health Services: Planning, Administration, Evaluation* 34, no. 3 (2004): 527-551, https://doi.org/10.2190/6X2V-GE4T-9BQF-WYXB

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

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

Conflict and its legacy have had important effects on efforts to reform tobacco control legislation in Lebanon. The most obvious effect has been disruptive: the outbreak of civil war in 1975 for example, drew a halt to national public information campaigns to curb tobacco use which were not revived until the late 1970s. Legislative efforts to strengthen tobacco control in the 2000s suffered from repeated cycles of political and economic instability, prompted partly by episodes of conflict.[248] However, there was also an important *geopolitical* dimension to the tobacco question; a farming subsidy system evolved over time to support Lebanese leaf growers predominantly in the previously Israeli-occupied south of the country in order to shore up territorial claims to this land.

Historically, the tobacco industry had also exerted a powerful influence over Lebanese policymakers, lobbying against marketing and advertising restrictions, and promoting voluntary codes of practice for producers instead of binding legal requirements.[249] A key player had been the Regie, the state-run tobacco monopoly in Lebanon (falling under the Ministry of Finance). In 2004, a draft bill on a comprehensive tobacco advertising ban in Lebanon had been rejected partly because of Regie concerns about the macroeconomic impact of such a ban on employment and advertising revenue to the state.

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

Incentives for change at the elite level also altered in favour of reform, partly under pressure from powerful civil society lobbying. Specifically, in the mid-to-late 2000s there was a strengthening in the position of the MOPH's National Tobacco Control Programme (with technical support from WHO following the ratification of the Framework Convention on Tobacco Control in 2005) and the emergence of a powerful, advocacy coalition, including civil society organisations, parts of the media and importantly academics, who were able to use their position of credibility and trust to boost support for tightened tobacco control. Researchers at the AUB consistently highlighted spiralling tobacco use in Lebanon from 1999 onwards, and formed the Tobacco Control Research Group (TCRG), a multidisciplinary group of researchers committed to advancing evidence for the prevention and control of tobacco use and its consequences, specifically to address it. Research by the TCRG provided the evidence-base for framing tobacco use as a major public health problem, and for the relevance and applicability of local solutions.[250]

[248] Rima Nakkash, Lina Torossian, Taghreed El Hajj, J Khalil, Rima Afifi, "The passage of tobacco control law 174 in Lebanon: reflections on the problem, policies and politics," *Health Policy and Planning* 33, no. 5 (2018): 633-644, https://doi.org/10.1093/heapol/czy023

[249] Rima Nakkash, and Kelley Lee, "The tobacco industry's thwarting of marketing restrictions and health warnings in Lebanon," *Tobacco Control* 18 (2009): 310-316, https://doi.org/10.1136/tc.2008.029405

[250] Rima Nakkash, Lina Torossian, Taghreed El Hajj, J Khalil, Rima Afifi, "The passage of tobacco control law 174 in Lebanon: reflections on the problem, policies and politics," *Health Policy and Planning* 33, no. 5 (2018): 633-644, https://doi.org/10.1093/heapol/czy023

9.5.1 Primary health care provision

For Lebanese residents, primary care is available through a nationwide network of PHCs (a majority of which are run by private or not-for-profit organisations, although the MOPH's own network is gradually expanding) and pharmacies, which provide a combination of curative and preventive services including vaccination. In practice, population coverage through the primary care network is limited – some studies indicate that as little as 20% of the Lebanese population have regular access to a family physician for their health needs.[251] By contrast, the post-Civil War period saw rapid expansion in the secondary and tertiary care sectors, which remain primarily the preserve of private providers, although the number of beds in the public health sector has grown since the early 1990s.[252] [253]

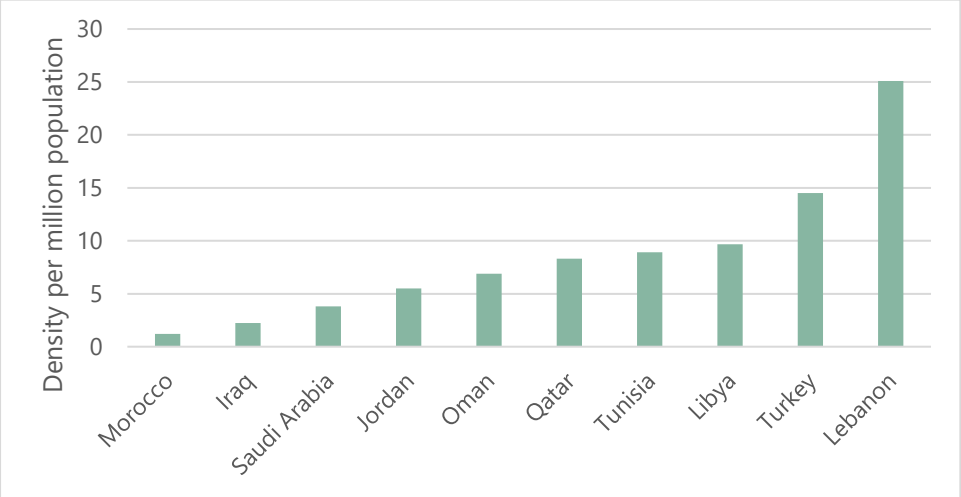


Figure 8. Density per million population of CT scanning units for Lebanon and a selection of other MENA countries in 2013 – the last year for which comprehensive data are available (source: WHO Global Health Observatory)

9.5.2 Confessional providers

A key feature of the health service delivery landscape in recent years – with important implications for bargaining processes within the sector as a whole – has been the emergence of confessionally-based providers. As we saw in Section 8.2, it is estimated that around 28% of medical centres and dispensaries are run by Christian and Muslim charities, with a further 15% of basic healthcare being provided by services affiliated to Sunni and Shi'i political parties in Lebanon.[254] The relationship between the confessional and political turn in service provision and access across communities is complex. On one hand, the rise of this new class of providers has been important in expanding the provision of key social services to vulnerable groups in society (including health services but also education and welfare support). There is evidence that confessionally- or politically-affiliated providers often open their doors to people from other communities.[255] [256] However, the extent to which different providers do so varies according to service pressures, the local politics of resource allocation

[251] Nabil M. Kronfol, "Rebuilding of the Lebanese health care system: health sector reforms," *Eastern Mediterranean Health Journal = La Revue de Santé de la Méditerranée orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit* 12, no. 3-4 (2006):459–473, https://applications.emro.who.int/emhj/1203_4/12_3-4_2006_459_473.pdf?ua=1

[252] Ibid.

[253] Walid Ammar, *Health System and Reform in Lebanon* (Beirut, Lebanon: Entreprise universitaire d'études et de publications, 2003).

[254] Melani Claire Cammett, "Partisan Activism and Access to Welfare in Lebanon," *Studies in Comparative International Development* 46, no. 1 (2011): 70-97, https://doi.org/10.1007/s12116-010-9081-9

[255] Melani Cammett, *Compassionate Communalism: Welfare and Sectarianism in Lebanon* (Ithaca, NY: Cornell University Press, 2014), http://www.jstor.org/stable/10.7591/j.ctt5hh11g.

[256] Melani Cammett, "Sectarianism and the Ambiguities of Welfare in Lebanon," *Current Anthropology* 56, no. S11 (2015): S76-87, https://doi.org/10.1086/682391

for welfare services, and the potential for accrual of rents – especially given the relationship between electoral representation and the targeting of service provision.[257] [258] This is linked to a wider pattern of the instrumentalization of institutions and service access for political and economics ends.

9.5.3 Service provision for refugees

As in other areas, a central fault-line in the service delivery landscape runs between provision for Lebanese citizens and residents, and refugee populations. Access to services through the mainstream Lebanese health system is practically constrained by limitations on residency rights for displaced Syrians, and also increasingly by the framing of health and welfare policy in Lebanon. This partly reflects the extraordinary pressure on services exerted by the influx from Syria. Data from December 2012, in the early phases of the crisis, show that some 40% of all recorded visits to MOPH-supported PHCs were by Syrian refugees.[259]

Refugees can nevertheless access subsidized care through the MOPH's PHC network, at some MOSA-affiliated clinics, and of course through the wider network of privately owned and operated PHCs which form the bulk of the primary care system in Lebanon.[260] UNHCR is a key provider of services for Syrian refugees, doing so primarily through a network of UNHCR sponsored PHCs nationwide. It provides direct support to around 30 such facilities, and is in partnerships with providers in another 100 where subsidised care for refugees is available, with collaborations with NGOs such as the International Medical Corps and Caritas, and Lebanese NGOs such as Amel.[261] UNHCR supports deliveries and life-saving emergency care by paying 75–90% of hospital fees, depending on admission costs and an assessment of the socio-economic status of the recipient.[262] For registered Palestinian refugees – many of whom have been in Lebanon for far longer than their Syrian counterparts – UNRWA's parallel system of 27 PHCs provides a key primary care access point, especially for the 50% of the displaced population that live in the 12 UNRWA-run camps in Lebanon.[263] [264] [265]

The picture is different, however, in terms of access to specialised (or referral) services for refugees. MOPH-funded providers offer subsidised care, though refugees have been obliged to meet an increasing proportion of the cost of services through co-payments. UNHCR covers 75% of the cost of emergency procedures, obstetric and neonatal care,[266] though its ability to cover part or all of the costs of highly specialised care such as kidney dialysis or oncology services is increasingly constrained by limited budgets and pressure of demand.[267] There is good evidence that this is having a

[257] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.
[258] Bradley Chen and Melani Cammett, "Informal politics and inequity of access to health care in Lebanon," *International Journal for Equity in Health* 11, no. 23 (2012), doi:10.1186/1475-9276-11-23
[259] Poverty Reduction and Economic Management Unit, Middle East and North African Region, "LEBANON ECONOMIC MONITOR – THE BRUNT OF THE SYRIAN CONFLICT," *The World Bank,* 2013, https://openknowledge.worldbank.org/bitstream/handle/10986/21971/Lebanon0econom0conflict000Fall02013.pdf?sequence=1&isAllowed=y
[260] Kelsey Vaughan, "Seeking Sustainability for Refugee Health Care in Lebanon: Review and Recommendations," *United Nations,* 2016.
[261] Ibid.
[262] UNHCR, "Health Access and Utilization Survey: Access to Health Services in Jordan Among Syrian Refugees," *UNHCR,* 2016, https://reliefweb.int/report/jordan/health-access-and-utilization-survey-access-health-services-jordan-among-syrian-0
[263] Walid Ammar, Ola Kdouh, Rawan Hammoud, Randa Hamadeh, Hilda Harb, Zeina Ammar, Rifat Atun, David Christiani, Pierre A Zalloua, "Health system resilience: Lebanon and the Syrian refugee crisis," *Journal of Global Health* 6, no. 2 (2016), https://doi.org/10.7189/jogh.06.020704
[264] Sarah E. Parkinson, and Orkideh Behrouzan, "Negotiating health and life: Syrian refugees and the politics of access in Lebanon," *Social Science & Medicine* 146 (2015): 324-331, https://doi.org/10.1016/j.socscimed.2015.10.008
[265] Karl Blanchet, Fouad M. Fouad, F.M. Tejendra Pherali, "Syrian refugees in Lebanon: the search for universal health coverage," *Conflict and Health* 10, no. 12 (2016), https://doi.org/10.1186/s13031-016-0079-4
[266] Kelsey Vaughan, "Seeking Sustainability for Refugee Health Care in Lebanon: Review and Recommendations," *United Nations,* 2016.
[267] Nagi S. El Saghir, Enrique Soto Pérez de Celis, Johny E. Fares, and Richard Sullivan, "Cancer Care for Refugees and Displaced

deleterious effect on health service engagement, especially for patients with chronic conditions for whom the cost of medications is a significant barrier to access.[268] [269] Therefore, MOPH should allocate a budget or partner with funding agencies to support refugees' access to secondary healthcare, and organise a triage and referencing system to limit the costs and facilitate the process.

9.5.4 Informal health care provision

A striking phenomenon since the start of the Syrian crisis has been the growth in *informal* service provision in Lebanon – especially in areas of the country where large concentrations of displaced Syrians are now living – to help meet perceived shortfalls in the services offered to these populations. This includes emerging service provision by displaced Syrian health professionals, working without formal registration and regulatory oversight, primarily in primary care settings. These services offer a valuable and low-cost alternative to the private sector for Syrian refugees, but there are obvious concerns both about service quality and protection for Syrian health workers working in settings which effectively operate in a governance vacuum. From a political economy perspective, the existence of informal providers depends on accommodations with local authorities (who turn a blind eye to these activities) and Lebanese health professionals (to whom onward referrals may be made) – both of which are insecure. Financing for these providers is opaque but appears to depend on a combination of charitable contributions and a willingness by many health workers to work on a voluntary basis, supporting service fees that are much lower than those charged in the mainstream health system.[270]

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

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

Section 9.5 on power relations and bargaining in the sector made it clear that the power to influence decision-making processes in health is skewed, with some actors exercising considerably more power than others (although the exact balance varies by policy issue). In general terms, policymaking processes in health are fairly closed, driven primarily at a Ministerial level (i.e. elite-driven) and with limited consultation with broader system stakeholders – *except* where these stakeholders have direct lines of influence over Lebanese politicians. There have been instances of policy change where civil society actors have shaped the policy agenda in more meaningful ways (tobacco control reform in the mid-2000s stands out as one example of this), but this is the exception rather than the rule.

9.6.2 The political economy of evidence generation, synthesis and use

There are varying perspectives in the literature on the efficacy of evidence generation, synthesis and integration into health policymaking and implementation in Lebanon. Research indicates some consensus among decision-makers in the health sector in Lebanon that there are recognised sources

Populations: Middle East Conflicts and Global Natural Disasters," *American Society of Clinical Oncology Educational Book* 38 (2018): 433-440, doi: 10.1200/EDBK_201365

[268] Shannon Doocy, Emily Lyles, Baptiste Hanquart, LHAS Study Team, and Michael Woodman, "Prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon," *Conflict and Health* 10, no. 21 (2016), https://doi.org/10.1186/s13031-016-0088-3

[269] Amreesha Jagarnathsingh, Mohammad Blakah, Charlotte Peltre, Rola Saleh, and Maria Sebas, "Access to Healthcare for Syrian Refugees. The Impact of Fragmented Service Provision on Syrians' Daily Lives," *Lebanon Support,* 2016, https://civilsociety-centre.org/sites/default/files/resources/accesshealthcaresyrianrefugees-ls2016.pdf

[270] Sharif A. Ismail, Adam P. Coutts, Diana Rayes, Sophie Roborgh, Aula Abbara, Miriam Orcutt, Fouad M Fouad, Gladys Honein, Nour El Arnaout, Aya Noubani, Hana Nimer and Spencer Rutherford, "Refugees, healthcare and crises: informal Syrian health workers in Lebanon," *International Institute for Environment and Development,* 2018, http://pubs.iied.org10856IIED

and institutions in the country from which to seek health evidence.[271] [272] Productivity in research domains relevant to health policymakers in Lebanon continues, however, to be relatively weak, with a low output of research addressing policy-relevant questions (e.g. systematic reviews)[273] and knowledge translation activities.[274] We were unable to identify data on the scale, source or distribution of research funding for health in Lebanon**.**

The degree to which available evidence actually influences policymaking in health varies. On the one hand, there is agreement across a number of studies on a commitment at Ministry level to strengthen technical expertise and improve the use of evidence in the post-Civil War period, partly as a result of what was perceived to be an irrational growth of health expenditure and poorly-evidenced practice between 1975 and 1990. One study points out that this was part of a deliberate strategy by the Lebanese MOPH, with WHO support, to restate its importance in policy development and implementation in the health sector after the end of the Civil War, by emphasising its role as a procurer and user of evidence (in a way that other actors in the sector could not). These efforts were underpinned by new research evidence commissioned from the WHO, academics in Lebanon, and elsewhere.[275]

It is also clear that evidence has been used effectively by various actors across the system in sometimes politically contentious areas to help bring about reform. As we have seen, the reform of tobacco control law in Lebanon provides a case in point (see Box 1). On the other hand, studies of other reform efforts – notably recent attempts to reform public health insurance provision in Lebanon – suggest that research evidence often plays a limited role, or at least one subordinate to political (including confessional) and personal factors in decision-making. Some of these criticisms are linked to a wider critique of the decision-making style in the health sector in Lebanon, which has been described as closed and driven primarily by the interests of Ministers.[276] This has hindered effective policy change in some areas, where studies note insufficient efforts to involve local stakeholders in policy design and a tendency to transplant international evidence into the health system without adequate consideration of contextual specificities in Lebanon.[277]

[271] Fadi El-Jardali, Diana Jamal, Nour F Ataya, Maha Jaafar, Saned Raouf, Claudia Interiano Matta, Saja Michael and Colette Smith, "Health Policy and Systems Research in Twelve Eastern Mediterranean Countries: a Stocktaking of Production and Gaps (2000-2008)," *Health Research Policy and Systems* 9, no. 39 (2011), https://doi.org/10.1186/1478-4505-9-39

[272] Fadi El-Jardali, John N Lavis, Nour Ataya, Diana Jamal, Walid Ammar and Saned Raouf, "Use of health systems evidence by policymakers in Eastern Mediterranean countries: views, practices, and contextual influences," *BMC Health Services Research* 12, no. 200 (2012), https://doi.org/10.1186/1472-6963-12-200

[273] Fadi El-Jardali, Elie A. Akl, Lama Bou Karroum, Ola Kdouh, Chaza Akik, Racha Fadlallah, and Rawan Hammoud, "Systematic reviews addressing identified health policy priorities in Eastern Mediterranean countries: a situational analysis," *Health Research Policy and Systems* 12, no. 1 (2014): 1-11, https://doi.org/10.1186/1478-4505-12-48

[274] Farah Yehia, and Fadi El-Jardali, "Applying knowledge translation tools to inform policy: the case of mental health in Lebanon," *Health Research Policy and Systems* 13, no. 29 (2015), https://doi.org/10.1186/s12961-015-0018-7

[275] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: II. Pressure for change in the Lebanese health sector," *Health Policy and Planning* 12, no. 4 (1997): 312-319, https://doi.org/10.1093/heapol/12.4.312

[276] Fadi El-Jardali, Lama Bou-Karroum, Nour Ataya, Hana Addam El-Ghali, and Rawan Hammoud, "A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure," *Social Science & Medicine* 1982, no. 123 (2014): 45-54, https://doi.org/10.1016/j.socscimed.2014.10.044

[277] Fadi El-Jardali, Rawan Hammoud, Lina Younan, Helen Samaha Nuwayhid, Nadine Abdallah, Mohammad Alameddine, Lama Bou-Karroum, and Lana Salman, "The making of nursing practice law in Lebanon: a policy analysis case study," *Health Research Policy and Systems* 12, no. 52 (2014), https://doi.org/10.1186/1478-4505-12-52

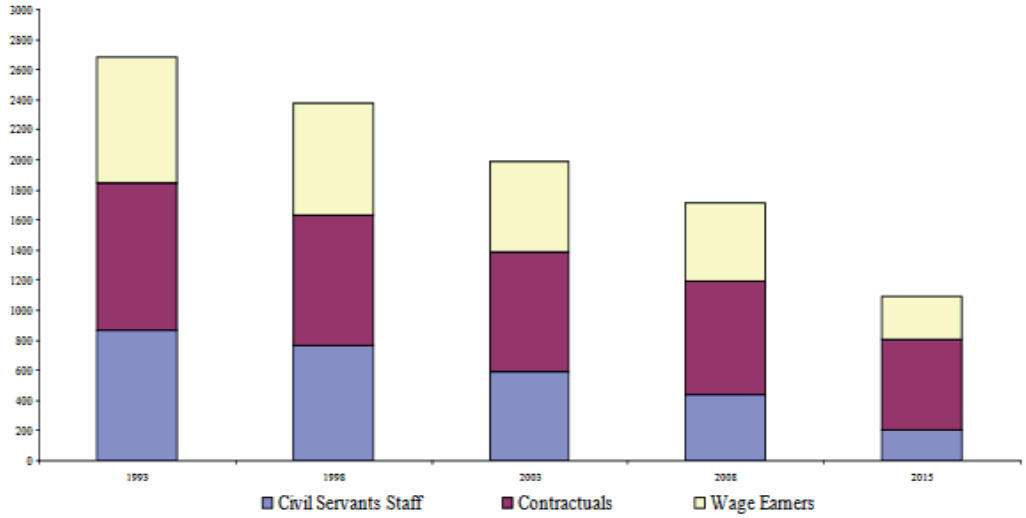


Figure 9. Employee numbers by category for the Lebanese MOPH, 1993-2015

There is also a consistent recognition in the literature on Lebanon that information asymmetries (between patients and providers) in the health sector are highly problematic. As noted earlier (Section 9.3), technical capacity in the MOPH was badly hollowed out during the 1975-90 Civil War, and while there was a degree of recovery after that conflict, manpower in the Ministry has more than halved since the early 1990s – with significant implications for the institution's capacity to perform its regulatory, evidence-brokering and quality assurance functions.

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

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

The allocation of resources for cancer care – and indeed the level of priority given to prevention and management of cancer more broadly – illustrates in microcosm many of the wider dynamics in the political economy of health in Lebanon. The degree of need for such care is well-established: after a prolonged period of stable incidence rates for new cancers,[278] [279] there has been a steady upward trend in reports, in line with broader demographic and epidemiological changes in the country.[280] National cancer treatment guidelines – drawn up in partnership with the MOPH and other system stakeholders including UNDP – are available in Lebanon to help guide treatment and support cost-containment efforts.[281] But cancer care remains prohibitively expensive.

Despite the strong evidence of rising incidence rates for cancers amenable to "lifestyle improvement" (for smoking and dietary risk),[282] and the availability of tried-and-tested screening approaches for breast and cervical cancers among others, action on prevention in Lebanon has been slow to take root.[283] The trials of tobacco control in Lebanon are outlined in Box 1, and key dietary regulation measures have not been put in place (addressing food, salt and fat content, and restrictions in marketing to children).[284] Breast cancer screening is offered during short run public health campaigns, and uptake among vulnerable age groups is generally low (especially for re-uptake or follow-on screening).[285] A similar picture is seen for cervical cancer screening.[286] These trends are linked partly to awareness issues but also to the centralisation of services in Beirut and the stated cost of screening (90,92).[287] [288]

The major focus in the health sector as a whole continues to be curative care. Here, the allocation of resources is complex, as we might expect given the labyrinthine nature of the financing system for the health sector. Lebanese residents with health insurance can expect support for costs of treatment through their programs in varying degrees. For Lebanese residents without formal coverage, the

[278] Salim M. Adib, Amjad A. Mufarrij, Ali I. Shamseddine, Spiridon G. Kahwaji, Philippe Issa, and Naji S. El-Saghir, "Cancer in Lebanon: An Epidemiological Review of the American University of Beirut Medical Center Tumor Registry (1983–1994)," *Annals of Epidemiology* 8, no. 1 (1998): 46-51, https://doi.org/10.1016/S1047-2797(97)00109-9

[279] Ali Shamseddine, Abla-Mehio Sibai, Nageeb Gehchan, Boushra Rahal, Nagi El-Saghir, Marwan Ghosn, Georges Aftimos, Nabil Chamsuddine, Muhieddine Seoud, Lebanese Cancer Epidemiology Group, "Cancer incidence in postwar Lebanon: findings from the first national population-based registry, 1998," *Annals of Epidemiology* 14, no. 9 (2004):663-668, DOI: 10.1016/j.annepidem.2003.12.002

[280] Ali Shamseddine, Ahmad Saleh, Maya Charafeddine, Muhieddine Seoud, Deborah Mukherji, Sally Temraz and Abla Mehio Sibai, "Cancer trends in Lebanon: a review of incidence rates for the period of 2003–2008 and projections until 2018," *Population Health Metrics* 12, no. 4 (2014), https://doi.org/10.1186/1478-7954-12-4

[281] UNDP, MOPH, "National Cancer Treatment Guidelines (3rd Ed.)," *UNDP, MOPH*, 2018, https://www.moph.gov.lb/userfiles/files/Quality%26Safety/NationalGuidelines/UNDP_cancerbook.pdf

[282] Alex P. Schmid, "Thesaurus and glossary of early warning and conflict prevention terms," *Fewer Forum on Early Warning and Early Response,* May 1998.

[283] International Committee of the Red Cross, "How is the Term 'Armed Conflict' Defined in International Humanitarian Law?," *International Committee of the Red Cross,* 2008, https://www.icrc.org/eng/assets/files/other/opinion-paper-armed-conflict.pdf

[284] WHO, "Noncommunicable Diseases Progress Monitor, 2017," *WHO,* 2017, http://apps.who.int/iris/bitstream/handle/10665/258940/9789241513029-eng.pdf;jsessionid=F2C5E69F5C493317EB77FD9B69996AF1?sequence=

[285] Fady G. Haddad, Hampig Raphael Kourie, and Salim M. Adib, "Trends in mammography utilization for breast cancer screening in a Middle-Eastern country: Lebanon 2005-2013," *Cancer Epidemiology* 39, no.6 (2015): 819-824, https://doi.org/10.1016/j.canep.2015.09.015

[286] I. R. Bou-Orm, R. E. Sakr, and S. M. Adib, "Cervical cancer screening among Lebanese women," *Revue d'Epidémiologie et de Santé Publique* 66, no. 1 (2018): 1-6, https://doi.org/10.1016/j.respe.2017.10.004.

[287] Fady G. Haddad, Hampig Raphael Kourie, and Salim M. Adib, "Trends in mammography utilization for breast cancer screening in a Middle-Eastern country: Lebanon 2005-2013," *Cancer Epidemiology* 39, no.6 (2015): 819-824, https://doi.org/10.1016/j.canep.2015.09.015

[288] Margueritta El Asmar, Amer Bechnak, Johny Fares, Dana Al Oweini, Ahmad Alrazim, Adnan El Achkar, and Hani Tamim, "Knowledge, attitudes and practices regarding breast cancer amongst Lebanese females in Beirut," *Asian Pacific Journal of Cancer Prevention: APJCP* 19, no. 3 (2018): 625-631, https://doi.org/10.22034/APJCP.2018.19.3.625

MOPH has been running a program since 1999 to cover the costs of cancer medications and to reduce catastrophic OOP expenditure. But the sustainability of this drug cost-coverage scheme is questionable. Spending on medications was estimated at an average USD 6,475 per patient each year in 2013, and up to around USD 31,000 for treatment-intensive conditions such as chronic myeloid leukaemia,[289] but doubled over the five years to 2016 following the introduction of anti-TNF medications to the domestic market.[290] The cost pressures have been accentuated by a low uptake of generic medications in a sector where incentives for health professionals to prescribe generics remain weak.[291]

The situation is different with displaced populations and as elsewhere is dependent on whether they are registered or undocumented displaced persons. For Palestinian refugees registered under UNRWA's umbrella, the UN programme provides financial support through an initiative called CARE that covers 50% of the costs of cancer medications up to an annual ceiling of USD 8,000. UNRWA will also cover the costs of radiotherapy sessions and provides limited funding to support hospital admission costs (a ceiling of USD 5,000 per year, given estimated annual admission costs of around USD 25,000 per patient).[292] [293]

For Syrian refugees, access issues are acute. The degree of support offered by UNHCR to registered refugees in accessing secondary and tertiary care oncology services, and in covering the costs of medications, is variable. For some populations (notably children, for whom treatment costs in Lebanon may range up to USD 200,000), such support is thought to be virtually non-existent.[294] In the context of the Syria response, eligibility is adjudicated by the UNHCR Exceptional Care Committee.[295] This picture, however, only includes registered refugees, which we know account for only a proportion of all displaced Syrians in Lebanon. For those who are unregistered, access to care depends on personal or family resources to pay for private sector care, and *ad hoc* provision by charitable organisations.

9.7 Implementation of health policy

The focus of much of this report has been on health policy development. There is strikingly little evidence from Lebanon on factors influencing policy *implementation*. Much of what we do know comes from meso- or micro-level studies of regulatory change at the providers level (e.g. the implementation of hospital accreditation).[296] [297] Although these studies provide only a partial picture,

[289] Fadia Elias, "Financial Burden of Cancer Drug Treatment in Lebanon," *European Journal of Cancer* 72 (2017), https://doi.org/10.1016/S0959-8049(17)30465-3

[290] Fadia Elias, Ibrahim R. Bou-Orm, Salim M. Adib, Selim Gebran, Anthony Gebran and Walid Ammar, "Cost of Oncology Drugs in the Middle-Eastern Country of Lebanon: An Update (2014-2016)," *Journal of Global Oncology* 4 (2018): 1-7, http://ascopubs.org/doi/10.1200/JGO.17.00179

[291] McKinsey, Lebanon Economic Vision, *McKinsey,* 2018, https://www.economy.gov.lb/media/11893/20181022-1228full-report-en.pdf

[292] UNRWA, "CARE: Catastrophic Ailment Relief Program," *UNRWA LEBANON,* 2011, https://www.unrwa.org/sites/default/files/201108196816.pdf

[293] UNRWA, "Reform of UNRWA Health Programme: A Three Year Journey 2010-2012," *UNRWA,* 2012, https://reliefweb.int/sites/reliefweb.int/files/resources/Reform%20of%20UNRWA%20Health%20Programme_0.pdf

[294] Raya Saab, Sima Jeha, Haifaa Khalifeh, Lama Zahreddine, Layal Bayram, Zeina Merabi, Miguel R. Abboud, Samar A Muwakkit, Nidale Tarek, Carlos Rodriguez-Galindo and Hassan El Solh, "Displaced children with cancer in Lebanon: A sustained response to an unprecedented crisis," *Cancer* 124 (2018): 1464-72, https://doi.org/10.1002/cncr.31273

[295] Nagi S. El Saghir, Enrique Soto Pérez de Celis, Johny E. Fares, and Richard Sullivan, "Cancer Care for Refugees and Displaced Populations: Middle East Conflicts and Global Natural Disasters," *American Society of Clinical Oncology Educational Book* 38 (2018): 433-440, doi: 10.1200/EDBK_201365

[296] Jade Khalife, Nadwa Rafeh, Jihad Makouk, Fadi El-Jardali, Bjorn Ekman, Nabil Kronfol, Ghassan Hamadeh, and Walid Ammar, "Hospital Contracting Reforms: The Lebanese Ministry of Public Health Experience," *Health Systems & Reform* 3, no.1 (2017): 34-41, DOI: 10.1080/23288604.2016.1272979

[297] Fadi El-Jardali, and Racha Fadlallah, "A review of national policies and strategies to improve quality of health care and patient safety: a case study from Lebanon and Jordan," *BMC Health Services Research* 17, no. 1 (2017), https://doi.org/10.1186/s12913-017-2528-1

the evidence indicates that there are significant deficits in the capacity of MOPH and other actors in the system to support implementation.[298] [299]

Studies addressing topics as diverse as improving care quality, the implementation of generic drug substitution policies and secondary care contracting reform, have all noted common implementation challenges. These include: difficulties in cascading guidance on changes through the system (partly as a result of the fragmentation in financing and delivery noted above), resulting in poor adherence to them; misaligned incentives at different levels, contributing to a resistance to the uptake of reformed or revised policies, including vested interests operating at the micro-level; issues of trust between actors at both the political centre and periphery in Lebanon; and lastly, the inability of authorities at the political centre to monitor implementation effectively and to make incremental changes to policy in response to feedback.[300] [301] Nevertheless, the use of participatory approaches to policy change has helped to improve engagement at both the policy formulation and implementation stages.[302]

[298] Fadi El-Jardali, Racha Fadlallah, Rami Z. Morsi, Nour Hemadi, Mounir Al-Gibbawi, Magda Haj, Suzan Khalil, Youssef Saklawi, Diana Jamal, and Elie A. Akl, "Pharmacists' views and reported practices in relation to a new generic drug substitution policy in Lebanon: a mixed methods study," *Implementation Science* 12, no. 1 (2017), https://doi.org/10.1186/s13012-017-0556-1

[299] Jade Khalife, Nadwa Rafeh, Jihad Makouk, Fadi El-Jardali, Bjorn Ekman, Nabil Kronfol, Ghassan Hamadeh, and Walid Ammar, "Hospital Contracting Reforms: The Lebanese Ministry of Public Health Experience," *Health Systems & Reform* 3, no.1 (2017): 34-41, DOI: 10.1080/23288604.2016.1272979

[300] Fadi El-Jardali, Racha Fadlallah, Rami Z. Morsi, Nour Hemadi, Mounir Al-Gibbawi, Magda Haj, Suzan Khalil, Youssef Saklawi, Diana Jamal, and Elie A. Akl, "Pharmacists' views and reported practices in relation to a new generic drug substitution policy in Lebanon: a mixed methods study," *Implementation Science* 12, no. 1 (2017), https://doi.org/10.1186/s13012-017-0556-1

[301] Fadi El-Jardali, and Racha Fadlallah, "A review of national policies and strategies to improve quality of health care and patient safety: a case study from Lebanon and Jordan," *BMC Health Services Research* 17, no. 1 (2017), https://doi.org/10.1186/s12913-017-2528-1

[302] Jade Khalife, Nadwa Rafeh, Jihad Makouk, Fadi El-Jardali, Bjorn Ekman, Nabil Kronfol, Ghassan Hamadeh, and Walid Ammar, "Hospital Contracting Reforms: The Lebanese Ministry of Public Health Experience," *Health Systems & Reform* 3, no.1 (2017): 34-41, DOI: 10.1080/23288604.2016.1272979

10. Reform priorities and the potential for change

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

- Cost-containment and financial sustainability across the sector
- Rationalising capacity, especially in the secondary care sector where there is felt to be a significant oversupply
- Shifting the focus of care from curative to preventive
- Ensuring equitable access and quality of care.[303] [304] [305] [306]

A striking feature of the literature on this topic is its tendency to describe reform options in *technical* terms only. A discussion of politics is largely absent. Additionally, there is no clear sense in the literature of public attitudes to reform in the sector or issues that are regarded as priorities for change. What little we know about public attitudes comes from a handful of public opinion surveys carried out in Lebanon, usually with small (if theoretically representative) population samples. The Arab Barometer Survey 2017, for example, showed generally low levels of satisfaction with the public health system, and low confidence in the government to improve the quality of basic health services.[307] A similar survey among Syrian refugees in Lebanon also showed low levels of satisfaction with health service provision in comparison with refugee compatriots living in Jordan.[308]

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

Arguably the key theme in the literature addressing the long-term potential for health sector reform in Lebanon is fragmentation. The health system reflects the broader economic and political situation of the country in that different health payers and providers (Ministry of Public Health, the NSSF, and the various specialty fund holders) fall under different ministries and have complex lines of accountability. This has historically undermined efforts at national, comprehensive health sector reform.[309]

10.1 Mental health policy recommendations

[303] Nabil M. Kronfol, "Rebuilding of the Lebanese health care system: health sector reforms," *Eastern Mediterranean Health Journal = La Revue de Santé de la Méditerranée orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit* 12, no. 3-4 (2006): 459-473, https://applications.emro.who.int/emhj/1203_4/12_3-4_2006_459_473.pdf?ua=1

[304] Walid Ammar, *Health System and Reform in Lebanon* (Beirut, Lebanon: Entreprise universitaire d'études et de publications, 2003).

[305] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: II. Pressure for change in the Lebanese health sector," *Health Policy and Planning* 12, no. 4 (1997): 312-319, https://doi.org/10.1093/heapol/12.4.312

[306] Wim van Lerberghe, Walid Ammar, Razie el Rashidi, May Awar, Albert Sales, and Abdelhay Mechbal, "Reform follows failure: I. Unregulated private care in Lebanon," *Health Policy and Planning* 12, no. 4 (1997): 296-311, https://doi.org/10.1093/heapol/12.4.296

[307] Huseyin Emre Ceyhun, "Refugees in Jordan and Lebanon: Life on the Margins," *Arab Barometer,* 2017, https://www.arabbarometer.org/wp-content/uploads/Syrian-Refugees_Lebanon_Jordan_Public_Opinion_Survey_2016.pdf

[308] Ibid.

[309] Eric Le Borgne, and Thomas J. Jacobs, *Lebanon: Promoting Poverty Reduction and Shared Prosperity*, The World Bank, 2016.

The Lebanese population has a long history of psychological distress due to both chronic structural societal and political factors, and more acute ones stemming from events (such as the Covid-19 pandemic and the Beirut Blast). This has created a "perfect storm" that is placing society under severe mental health pressure at a time when its ability to cope through social support has been severely disrupted by Covid-19 and lockdowns. At the same time, the lack of government or private health insurance support for mental health services, and the poor availability of psychiatric medications and inpatient psychiatric hospital beds, have constituted significant barriers to access.

Policy options might include:

1) Expanding and supporting access to the national hotline with public campaigns to increase awareness and fight stigma, including the NMHP program of guided self-help interventions that could be accessed through mobile phones (to help with access issues).
2) Continuing programs to expand government support to community mental health services in collaboration with NGOs (who are providing a large share of the services) to ensure coordination, access, quality, and sustainability, and the provision of evidence-based psychological treatment by qualified staff.
3) Ensuring the availability of essential psychiatric medications and centrally coordinating inpatient psychiatry admissions to provide equitable access to inpatient admission when needed. These efforts will need to be expanded beyond a focus on the individual to include a community-focused approach that addresses the role of structural socio-political factors in their distress and advocates for justice as essential features of mental health response.

11. Concluding remarks

11.1 Headline findings from the PEA

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

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

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

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

11.2 Summary assessment of evidence and quality

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

PEA domain	*Evidence strength and clarity*	*(Some) enduring areas of uncertainty*
Historical Legacies		Explaining the circumstances, incentives and funding conditions that precipitated growth in private and not-for-profit sector provision during the Civil War.
Roles and Responsibilities		Avenues for individual, community and civil societal voices in the policymaking process and whether/how space for contestation is modulated by conflict; the role of other actors including mass media organisations, multinational corporations and domestic business interests, and labour unions in influencing health policymaking and implementation.
Ownership Structure and Financing		Funding volume from international (particularly non-DAC) donors and the mechanisms used to channel these funds into the health sector, and modulating effect of conflict on these.
Power Relations, Bargaining and Rent-Seeking		Relations between MOPH and other government ministries (notably the Ministry of Finance); the influence MOPH has over the design and implementation of policies with the potential to affect health outcomes; how relations have changed during conflict and in transition from conflict; and the inclusion (or otherwise) of gender perspectives and marginalised voices in policymaking.
Ideologies and Values		Public attitudes towards health service provision and financing, and prioritisation of health issues in the mainstream health sector, and with respect to refugee populations; differences in ideological orientation towards redistribution in the mainstream health sector and for refugees between political and confessional groups.
Service Delivery		The effect of service delivery fragmentation on access for different population groups – in particular: gendering of service access; accessibility for older people (both settled and displaced).
Decision-Making, Including Priority-Setting		Processes for prioritising health resource allocation in MOPH and in the humanitarian sector: the inclusivity of these processes; the role of the evidence and criteria used to determine what to prioritise; the role of evidence in decision-making more generally.
Implementation Issues		Relations between centre and periphery in Lebanon in both the mainstream health sector and humanitarian responses; the technical and administrative capacity to implement policy at the local level; the dynamics of political contestation, and the role of vested interests at a local level in determining the success of implementation.

Table 5. Overall assessment of evidence strength against key PEA domains for Lebanon, and a list of some areas of uncertainty (note this list is indicative rather than comprehensive, and based on literature assessment only)

11.3 Future research and policy areas

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

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

Mental health	• Given the historically low priority given to mental health services in Lebanon and the region, as well as the dominance of specialist service delivery, how and why did incentives for action among different stakeholders change in 2012 to provide a window of opportunity for the development and implementation of the National Mental Health Strategy for Lebanon? What influence did donor and multilateral agency priorities and funding have on this? What role did domestic actors play in shaping the content of the ensuring Strategy? What lessons can be learned for change in other areas? • What challenges to implementation of the Mental Health Strategy have been experienced nationwide, and why? From a coordination perspective, what are the continuing practical incentives/disincentives to participation in implementation by the multitude of actors involved in the mainstream and humanitarian response sectors (and how can barriers be addressed)?
Cancer	• What factors explain the historically low priority given to the prevention of upstream determinants of cancer (including, for example, dietary risks and obesity) in Lebanon? How have vested interests shaped the political space for action in these upstream determinants? • What does the differential distribution of resources for diagnosis and management of cancers in specific vulnerable groups – notably children (across both settled and displaced populations) – tell us about the political economy of cancer care in conflict? What factors determine differential resource allocation? • What global and domestic factors explain the exceptionally high expenditure on patented medications (including for cancer) in Lebanon? What are the key incentives/disincentives to change, and what do these imply for approaches to financial protection for cancer patients in Lebanon – across both settled and displaced populations? • How are decisions made by the UNHCR's Exceptional Care Committee in Lebanon regarding eligibility for financial support for cancer care for registered refugees, and what factors influence these decision-making processes? Has the nature of decisions made by the ECC changed over time and if so, in what way(s)?

Table 6. Domain-focused research questions for mental health and cancer (indicative, not exhaustive)

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

Theme	*Research need*	*Sample question(s)*
Historical legacies	Historical determinants of power relations in the health sector	• Why did private and not-for-profit providers emerge as such powerful players in Lebanon during the Civil War? What funding sources facilitated this? How did they negotiate political space for action?
Actors, roles and responsibilities	Understanding the role of domestic private and not-for-profit actors and associations in the sector	• We know that private and not-for-profit providers have an important role in health service delivery in Lebanon, but who are they precisely and how has conflict shaped (or not shaped) the evolution of their service approaches? • What role, if any, has organised labour played in shaping health policy in Lebanon?
	Understanding the role of mass media in shaping health policy formulation and implementation	• How has the influence of mass media outlets and new social media outlets shaped the prioritisation of health policy issues and influenced policy implementation in Lebanon? • How – if at all – have mass media and in particular social media outputs influenced the domestic humanitarian response to the Syria crisis?
	Understanding the role of multinationals and corporate interests	• What influence do corporate interests have in determining health policy and decision-making in Lebanon, for example in relation to dietary risks? Do periods of stability/conflict modulate (or even amplify) this influence?
	Understanding the role of donors and other international actors	• What role have regional actors (in particular the Gulf States and Iran) played as donors for humanitarian response and health sector reconstruction and recovery in Lebanon during and after conflict? Proportionately how much aid have they provided? What are the channels by which this has been distributed in Lebanon, and to whom? • What role have international financial institutions played in determining policy priorities in the health sector? How – if at all – has this changed in response to conflict?
Power relations, bargaining, and rent-seeking	Determinants of the distribution of health spending	• How are decisions in the Ministry of Finance made on the allocation of funds across public spending areas in Lebanon? What role does MOPH (and indeed other health actors) have in this process? • What approaches or considerations govern the allocation of financial resources at the local level in the health sector?

		• What is the relation between confessionalism and clientelism, and the allocation of financial resources at the local level in the health sector?
	Incentives and disincentives for policy change	• How and why did incentives for key actors in mental health change to open a window for the development and implementation of the Mental Health Strategy in 2014/15? • How and why did incentives for key actors change to give rise to the LCRP? What factors explain the delay in developing an official response to the humanitarian crisis?
	Voice and marginalisation	• How do people in Lebanon perceive the health financing system and its role? Do attitudes differ between population groups (in particular among those displaced by conflict) and if so, how? • What can we say about public perceptions of priorities for change in the health domain, and how these differ between population groups?
	Incentives and disincentives to collective action	• What can we say about power relations between government ministries involved in decision-making on matters affecting health? Has this changed in discernible ways during times of conflict? • How effectively do current governance arrangements within the humanitarian response manage health service provision, and what are the key disincentives to collective action in Lebanon?
Decision-making	Priority-setting, procurement and use of evidence	• How are decisions made (in MOPH and elsewhere) on how to prioritise spending on health? • What role does evidence play in this process, and at what stage(s)? Who provides this evidence and in what form? • What are the links between MOPH, MOSA and the Treasury? • What influence do Treasury officials have on health policy?
	Relations between centre and the periphery	• How have informal health providers serving Syrian refugees in Lebanon created an operating space for themselves since 2011? By what local bargaining processes has this occurred, and through access to which funding streams?
Implementation	Better understanding barriers to effective implementation	• What strategies do policy implementation bodies use to mitigate the political and economic costs associated with policy transitions (i.e. dealing with "losers" from the policymaking process)?

Table 7. List of research questions by theme for potential onward investigation (again indicative rather than comprehensive)

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Appendices

Appendix 1: subsidiary PEA questions

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

Appendix 2: literature search approach

Literature types and sources:

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

Languages:

English, Arabic, French

Inclusions and exclusions:

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

Key concepts and keywords used for peer-reviewed literature searches

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

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

1. Cluster 1
2. Cluster 2
3. Cluster 3
4. Cluster 4
5. 1 AND 2
6. 5 AND 3 AND 4
7. Limit 6 to 2000-current, English or Arabic, full text availability only

Appendix 3: list of stakeholder organisations for interviews

Category	Informant	
International Organizations and UN agencies	**UN-ESCWA, Beirut.** Mandated to advance regional integration and providing advocacy for the region's needs and concerns on the global stage (sectoral policies). I recommend the Economic Development and Integration, Social Development, and Conflict and Governance divisions	
	World Bank, Beirut	Both organizations were the most involved international actors in financing reform movements and providing support to the GoL
	WHO, Beirut	
Universities Faculties of Economy, Political Sciences and Health	**The Lebanese University**	All of the institutions have engaged in knowledge production on relevant subject matters at specific times, in addition to the provision of support to the GoL
	Saint Joseph University	
	the American University of Beirut	
	the Lebanese American University	
Public Institutions	**Line Ministries.** Ministry of Labor, Ministry of Public Health, Ministry of Finance, Ministry of Social Affairs (political/minister, and executive/DG levels)	
	the Higher Council for Privatization	
	National Social Security Fund	
	the Central Inspection Department (regulatory body)	
Monitoring agencies	**The Insurance Control Commission.** An independent institution, in charge of maintaining an efficient and stable Insurance market and protecting the interest of policyholders and other stakeholders against eventual unfair market practices emanating from entities and persons that fall under its supervisory mandate	
	The Lebanese Transparency Association. LTA, which was established in May 1999, is Transparency International (TI)'s Lebanese chapter. It is the first Lebanese NGO that focuses on curbing corruption and promoting the principles of good governance.	
Orders/Syndicates	Physicians, Pharmacists, Pharmaceutical Manufacturers, Hospitals, insurance brokers	

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