Understanding the private health sector
in Lebanon

World Health Organization
Eastern Mediterranean Region

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1
Country context

The population of Lebanon is estimated to be approximately

6.1 million

inhabitants

The total area of the country is

10 452 km²

with a

225 km

coastline on the Mediterranean Sea

Lebanon is a democratic, parliamentary state located in the Eastern Mediterranean Region of the World Health Organization (WHO). The country is founded on respect for individual freedoms, in particular freedom of opinion and belief, respect for social justice, and equality of rights and duties among all citizens, without discrimination. The Constitution of Lebanon guarantees a free-market economy based on individual enterprise and the right to private property, which cannot be expropriated except for reasons of public utility, in cases established by law, and in exchange for fair compensation *(1)*.

Lebanon is characterized by the presence of different religious communities living side by side. The official language is Arabic, but most of the population is trilingual (Arabic, English and French). The population of Lebanon is estimated to be approximately 6.1 million inhabitants *(2)*.[1] The total area of the country is 10 452 km^2, with a 225 km coastline on the Mediterranean Sea, and it is located at the intersection of three continents: Europe, Asia and Africa. Lebanon is composed of eight administrative provinces (or muhafazah) divided into 26 districts (or qada), including the district of Beirut. Central administrative authority is granted to the governor of each province. Lebanon is led by the President of the Republic, who is the Head of State. The president is elected by the parliament for a 6-year term.

The Lebanese economy is service-oriented. Lebanon has a strong tradition of laissez-faire, with the Constitution stating that "the economic system is free and ensures private initiative and the right to private property" *(1)*. The major economic sectors include metal products, banking, agriculture, chemicals and transport equipment. The main growth sectors include banking and tourism. There are no restrictions on foreign exchange or capital movement.

In 2018, Lebanon's nominal gross domestic product (GDP) was estimated at US$ 54.1 billion, with a per capita GDP amounting to US$ 12 000 *(3)*. Government spending in 2018 amounted to US$ 15.9 billion, 23% of GDP *(4)*. The real GDP in 2018 was estimated to have grown by just 0.2%, reflecting a deceleration in economic activity linked to policy-based tightening of liquidity *(5)*. The Lebanese economy is generally classified as developing.

The civil war of 1975–1991 negatively affected the Lebanese economy, which had previously been strong due to the country's position in the Arab region, where 85% of Lebanese exports were absorbed. During the war, Lebanon lost its intermediary role in the region and faced inflation and the degradation of public services. The Lebanese economy significantly expanded after the war of 2006, with growth averaging 9.1% between 2007 and 2010 *(2)*. The 2008 Doha Agreement contributed to the improvement of the country's economic situation. The growth rate remained at around 8% per year between 2007 and 2011, despite the global financial crisis of 2008 *(6)*. After 2011, the local economy was affected by the Syrian civil war, growing by a yearly average of just 1.7% in the 2011–2016 period and 1.5% in 2017 *(2)*. In 2018, GDP was estimated to be US$ 54.1 billion *(3)*. Lebanon is the third most indebted

1 The last census dates back to 1932. Currently available data are only estimates. A figure of 4 million is estimated by various international sources and has been used in numerous studies. The figure of 6.1 million given in this text includes the refugee population.

In 2018

26%

of the population was under 15 years of age and

7%

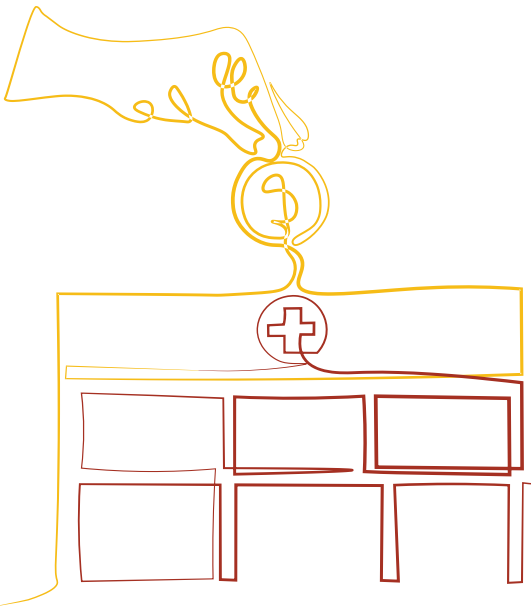
was above 65 years of age

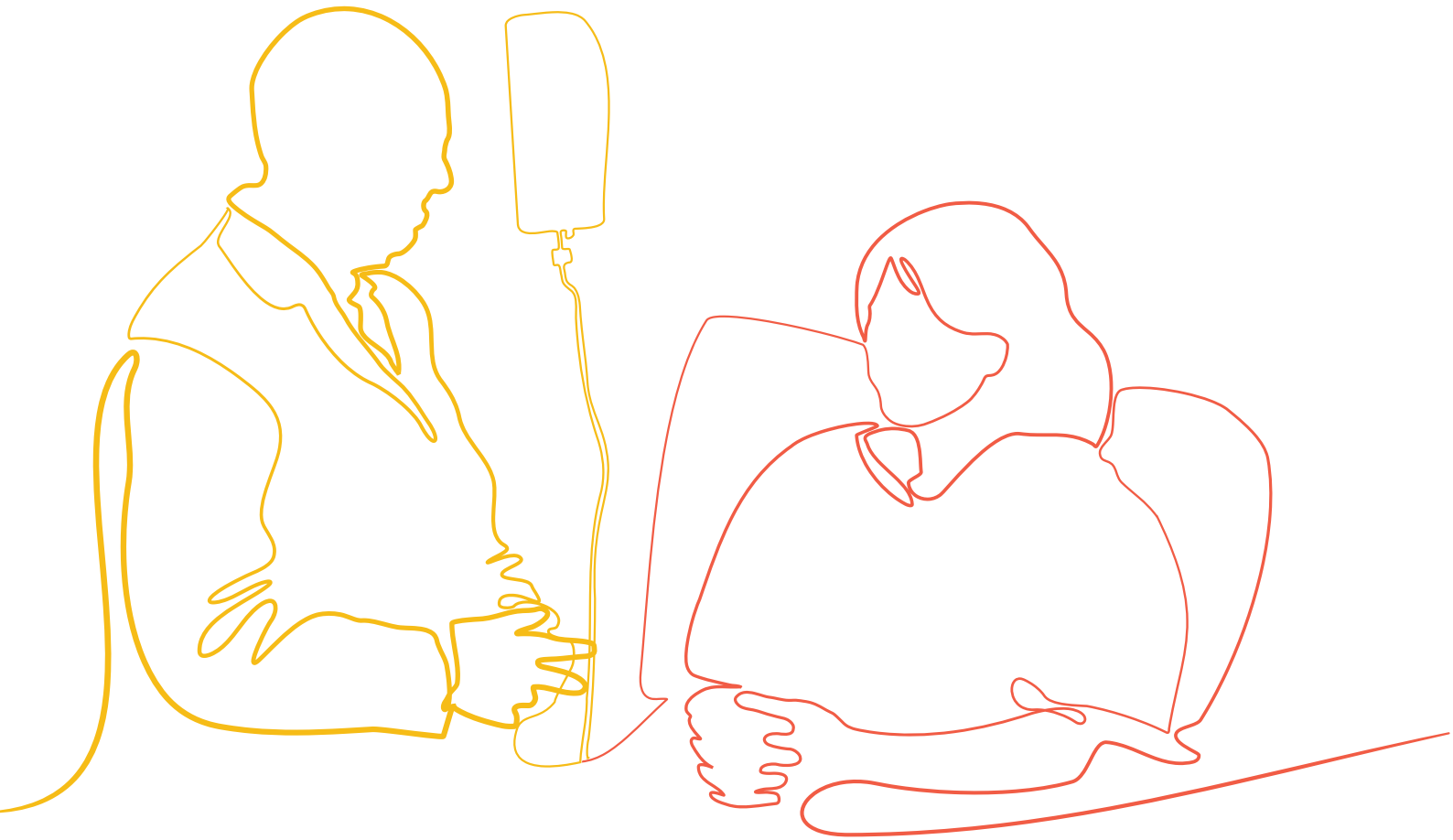
The literacy rate for the age category 15 years and older was

95%

country in the world in terms of debt-to-GDP ratio; consequently, interest payments consumed 48% of domestic government revenues in 2016, limiting the Government's ability to make needed investments in infrastructure and other public goods *(7)*.

According to recent estimates, 88.6% of around 6.85 million inhabitants live in urban areas and the population density is 671 per km^2 *(2)*. In 2015, more than 1 million Syrian refugees were registered with the United Nations High Commissioner for Refugees in Lebanon. The Government estimated the true number of Syrians in the country to be 1.5 million *(2)*. The population growth rate was estimated at 0.6% in 2018, and 26% of the population was under 15 years of age and 7% was above 65 years of age *(2)*. The total fertility rate was 2.1. The literacy rate for the age category 15 years and older was 95% *(2)*. The Gini index for the country, as estimated by the World Bank for 2011, was 31.8. The Human Development Index for 2017 was 0.757, placing the country in the high human development category, ranked 80 out of 189 countries *(8)*.





2

Health status and selected health indicators

The new health strategy adopts a patient-centred approach and considers several key factors to develop a comprehensive understanding of the existing situation and set plans for improvement

Since 2017, in its commitment to achieving universal health coverage (UHC) and leaving no one behind, the Ministry of Public Health (MoPH) in Lebanon has taken the lead in coordinating incremental reforms of the health sector, based on collaborative governance strategies to improve equity and efficiency. These reforms have led to continuous improvement in health indicators and the country's health system. Despite all the crises and pressures on the health system, it has shown high resilience. In an Economist Intelligence Unit comparison of health outcomes in 166 countries in 2014, Lebanon's position at the international level was 31 out of 166, just after Denmark and just before the United States of America *(9)*. The Bloomberg 2017 Global Health Index described Lebanon as the healthiest Arab country, ranking between Czechia and the United States of America overall *(10)*. According to the World Economic Forum's Global competitiveness report 2016–2017, Lebanon ranks 34 out of 137 countries for the health subindex *(11)*. Moreover, in the Healthcare Access and Quality Index, Lebanon ranks 31 out of 195 countries and regions, putting it at the same level as Estonia and Portugal *(12)*.

These positive improvements in the health system are considered a good basis for future opportunities and partnerships towards improved access to quality health care services *(13)*. In March 2018, the MoPH established a new health strategy, which is expected to tackle existing challenges while affirming the MoPH 's role in the health sector. The new health strategy adopts a patient-centred approach and considers several key factors to develop a comprehensive understanding of the existing situation and set plans for improvement *(13)*.

The main health indicators are summarized in Table 1. They cover health determinants and risks, health status, and health system response for 2015–2017. These data were retrieved from the MoPH statistical health bulletin for 2017.

Table 1. Main health performance indicators

	Unit	2015	2016	2017
Health determinants and risks				
Demographic and socioeconomic determinants				
Population estimate*	1000 citizens	4292	4356	4421
Number of registered births		85 453	88 996	90 647
Number of registered deaths		25 275	24 617	25 847
Crude birth rate	per 1000 population	19.9	20.4	20.5
Crude death rate	per 1000 population	5.9	5.7	5.9
Population growth rate		1.4	1.5	1.5
Population by age (%)				
	< 15	24.6	24.6	24.6
	65+	9.7	9.7	9.7
Risk factors				
Low birth weight (less than 2500 g) (%)		8.Aug	9.4	9.5
Caesarian delivery rate (%)		46.7	47	47
Health status				
Life expectancy and mortality				
Life expectancy at birth, total population				81.24 (2012)
Life expectancy at birth, male				80.27 (2012)
Life expectancy at birth, female				82.11 (2012)
Infant mortality rate	per 1000 live births		6.4	6.7
Under-5 mortality rate	per 1000 live births		8.5	9
Maternal mortality ratio	per 100 000 live births	13.6	21	16.9
Morbidity				
Measles		39	44	126
Tetanus		3	2	0
Neonatal tetanus		0	0	1
Acute flaccid paralysis		76	123	77
Hepatitis A		985	519	776
Hepatitis B		390	367	321
Hepatitis C		136	116	130
AIDS		22	21	56
Health system response				
Health financing				
Total GDP	in Lebanese pounds	75 336	77 243	80 491
Allocated to MOPH from total government budget (%)		2.50	2.64	2.96
Annual budget of MOPH	in Lebanese pounds	516	643	709
Annual budget of MOPH per capita ($US)		77	98	110
Total health expenditure (THE) per capita $US		863		
THE as percentage of GDP		7.41		
Out-of-pocket expenditure as percentage of THE		32.70		

Health workforce	per 10 000 population		
Physicians	32.0	31.0	31.3
Dentists	12.9	15.1	15.2
Pharmacists	17.7	18.2	18.9
Nursing and midwifery personnel	33.4	34.2	36.4
Hospital beds	33.7	27.3	–
Medicines and medical devices	**per million population**		
Density of high tech equipment			260 (2012)
Service coverage			
Infants fully immunized-DPT (%)	91	90	93.12
Infants fully immunized-OPV (%)	90	90.39	93.10
Infants fully immunized-measles (%)	91	90	91
Infants fully immunized-hepatitis B (%)	91	90	93.12
Married women using contraceptives (%)			54 (2009)

Department of Projects & Programmes,MOPH
Vital Data Observatory, MOPH
National Health Accounts, 2015, MOPH
National AIDS Programme, MOPH
Department of Vital and Health Statistics, MoPH
Syndicate figures calculated for the given population
Economic Accounts of Lebanon
Epidemiological Surveilance Unit, MOPH
Expanded Programme on Immunization, MOPH
MICS3,2009, CAS/UNICEF
Government budget
Estimated population from the 2004 and 2007 household surveys (CAS) in addition to registered births and deaths at Dept of Statistics

Source: MoPH , 2017 *(14)*.

The Lebanese health care system is organized around two interrelated entities – a public sector and a private sector – the latter divided into for-profit and not-for-profit systems. The private for-profit sector includes private hospitals, private clinics and outpatient diagnostic centres (radiology, laboratory, etc.), while the not-for-profit system is primarily run by nongovernmental organizations and offers preventive services through primary health care centres (PHCCs) and some nursing and rehabilitation homes and institutions.

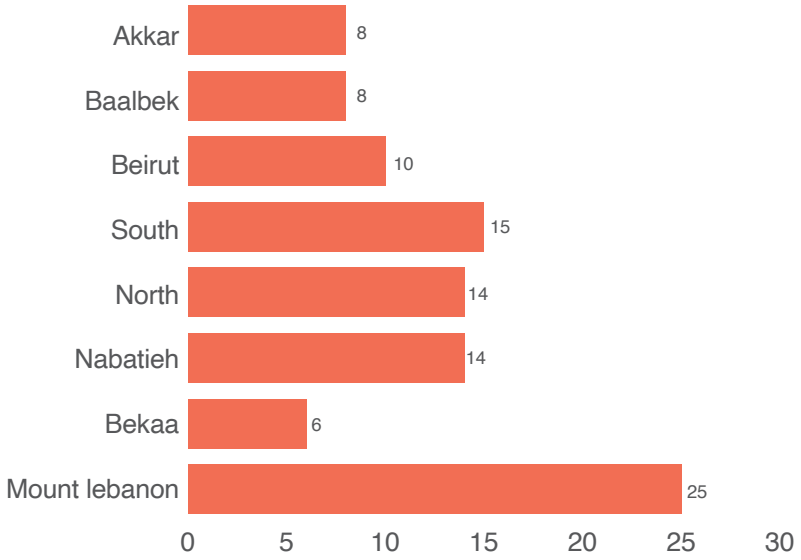
2.1 Public sector

The organization and delivery of the public health sector is under the administrative responsibility of the General Directorate of the MoPH. All health divisions and departments, except those in Beirut, are under its direct responsibility. The General Directorate encompasses two main health care directorates: the Directorate of Medical Care and the Directorate of Preventive Health Care.

To help to achieve sustainable social and economic development, the MoPH is committed to maintaining population health and providing high-quality prevention and treatment services at the possible lowest cost. Despite a decrease in the MoPH's budget in the total public expenditure, the Ministry continues to provide health services in addition to hospital services. The history of hospitals in Lebanon dates back more than a century. In 2018, the hospital network included 162 public and private

institutions, distributed across the country and covering all medical and surgical specializations. The public health sector in Lebanon includes public hospitals and PHCCs. The MoPH is responsible for 29 public hospitals across the country (Fig. 1) and a network of 229 PHCCs *(13)* distributed across different Lebanese regions, with the highest concentration in Mount Lebanon (25%) and the lowest in Beqaa (6%) *(15)*. These are mostly run by private sector institutions (nongovernmental organizations own 67% of PHCCs) on a contractual basis. The services covered by the MoPH are mainly secondary and tertiary.

Fig. 1. PHCC distribution among provinces in Lebanon, 2017



Source: El-Jardali, 2017 *(15)*.

Lebanon's public hospitals were until recently underequipped, offered poor quality services and lacked qualified professionals. These hospitals provided free general care, were managed like administrative units of the MoPH and did not benefit from financial autonomy. Their management was centralized, and their budget allocation was based on estimates rather than on studies of actual need.

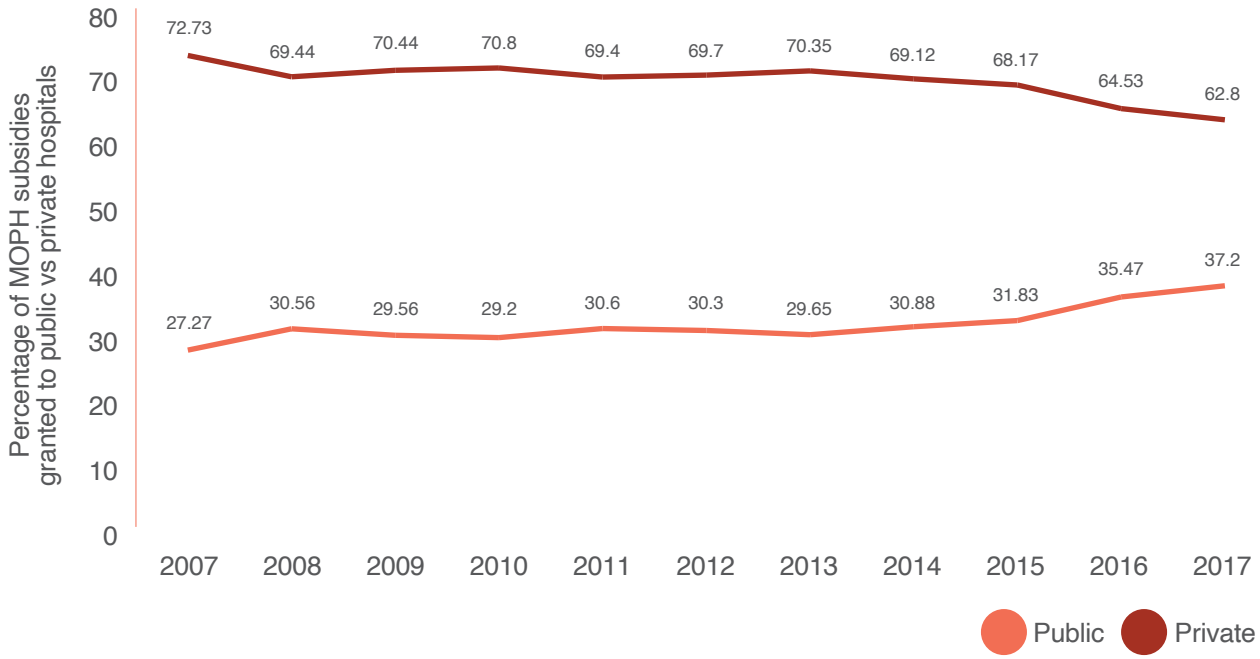
In 1996–1997, the Government tried to address these problems by several means, namely, refurbishing public hospitals, building new ones and enacting the law of autonomy of public hospitals (Law No. 544 of 24 July 1996) *(16)*. The aim of this law was to grant public hospitals more flexibility by allowing them to operate as semi-autonomous entities accountable to a board of administration appointed by the Council of Ministers. The hospitals were financed for services rendered, like private hospitals. The law of autonomy led to improvements in efficiency in these hospitals by encouraging competition between the private and public sectors, thus improving the quality of services rendered. This resulted in an improved image of public hospitals.

In 2019, there were 29 public hospitals, one of which is a university hospital, with a total of 2500 beds. This is equivalent to 17.25% of the total capacity of private and public functional beds *(17)*. Most public hospitals have fewer than 100 beds.

The MoPH has also developed its hospital services through the hospital accreditation programme based on quality of services, the introduction of new mechanisms for the purchase of hospital services and the enforcement of the law of autonomy to improve public hospital services. In 2016, the MoPH developed the health strategic plan for the medium term (2016–2020), based on the achievements of its previous strategy, which considered the increasing impact of social and economic determinants of health and the crises faced by the health sector *(18).* The Ministry considers that strengthening its capacity to manage the health sector, improving levels of health and providing comprehensive health coverage and stability are strategic issues that must be addressed in an environment with multiple risks and uncertainties.

Currently, access to, use of and subsidies to private hospitals are considerably higher than is the case for public hospitals. The difference in subsidies is depicted in Fig. 2.

Fig. 2. MoPH subsidies granted to public and private hospitals, 2007–2017

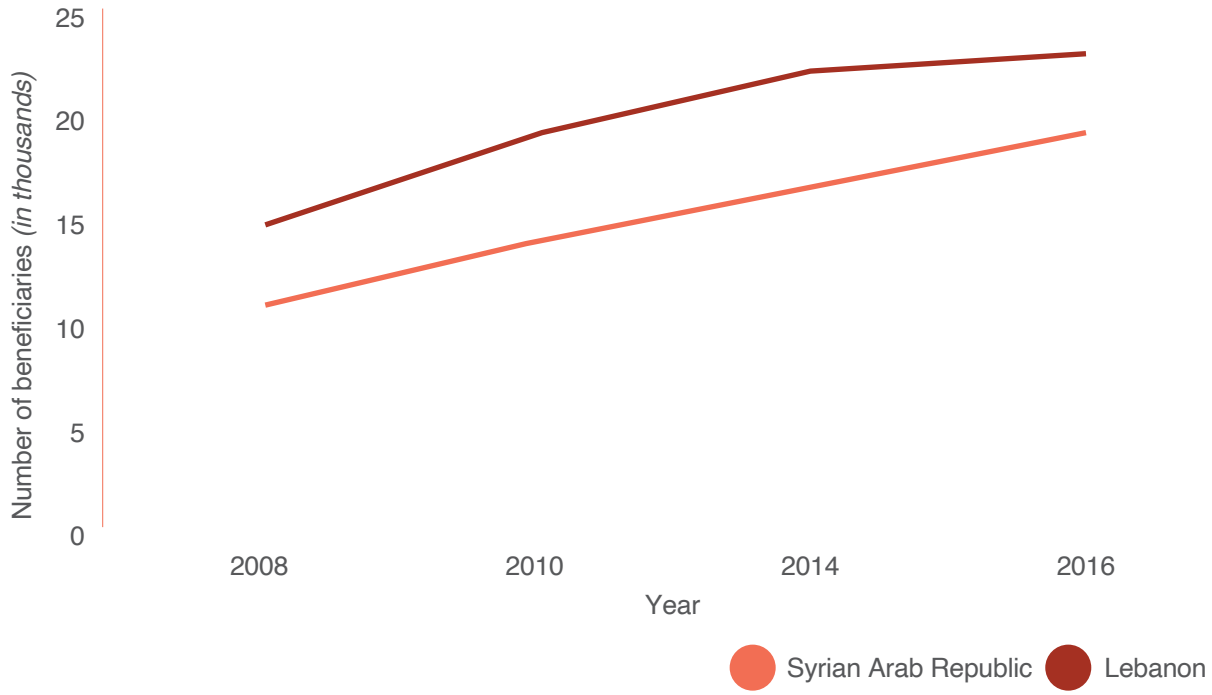


The public sector PHCCs provide a package of basic health care services, while the MoPH provides specific subsidized services such as reduced cost consultations, free medicines for chronic diseases (cancer, HIV and some psychiatric conditions), essential medicines and immunization. The PHCCs are distributed according to the population density of catchment areas *(3,19)*, with each area intended to cover a population of 15 000–20 000. In addition to PHCCs, approximately 600 dispensaries are distributed across Lebanon, which provide vaccines, particularly polio, pentavalent and measles vaccines *(15).*

The accreditation programme, founded in 2008 in collaboration with Accreditation Canada, aims to improve adherence to quality standards in the national primary health care network. The Emergency Primary Healthcare Restoration Project supports the scale-up of the accreditation programme to the entire network (229 PHCCs). As of 2018, 104 PHCCs

were enrolled in the accreditation process, 52 had been through a mock survey and 52 were already accredited *(20).* The beneficiaries of the primary health care network include Lebanese (52%), Syrians (46%) and others (2%) (Fig. 3). Based on data available from 101 PHCCs within the network, the number of Lebanese citizens accessing PHCCs increased by 56% between 2015 and 2018 *(20).*

Fig. 3. Beneficiaries of the primary health care network



Source: MoPH, 2019 (21).

2.2 Private sector

The private hospital sector is the main component and backbone of the Lebanese health care system. Highly developed both in number and capacity, it includes 133 long- and short-stay hospitals with a total of 12 000 beds *(17)*, which accounts for 83% of the country's total capacity. The hospitals are mainly general multidisciplinary facilities with 80–450 beds per hospital; fewer than 10 are university hospitals.

Private sector involvement in health service delivery plays an important role in alleviating some of the burdens of the MoPH: faith-based and sectarian organizations account for 43% of the primary health care services (28% and 15%, respectively) *(20).* The sector has, in addition, around 2700 pharmacies and 1200 diagnostic facilities *(17).*

Established in 2001–2002, the accreditation process for hospitals is implemented by the MoPH, with a strong belief that improving the quality of services is crucial to the continual improvement of the hospital sector in Lebanon. Providers and professionals are considered as the driving force behind improvements in quality. In January 2019, the MoPH revised and developed new hospital accreditation standards in accordance with the latest evidence and international best practices,

thus complying with the requirements of the International Society for Quality in Health Care. The main purpose of the updated system is to determine the level of compliance with the new standards by all aspects of the health care system and to assure the functional documented existence of the structures and processes in order to achieve optimum, measurable clinical outcomes for the patient *(22).*

In addition to private hospitals, the private not-for-profit sector – which is mainly composed of nongovernmental organizations – has expanded significantly. The number of nongovernmental organizations working in the health sector is unknown. They have, however, played an important role in service provision, including in core programmes and initiatives such as vaccination programmes.

3

Health sector resources

Despite the lack of data on its overall impact on quality of care and health care systems, the private health sector is considered vital for Lebanon's economic growth. In Lebanon, the private sector rather than the public sector is the main provider of health care services (Table 2).

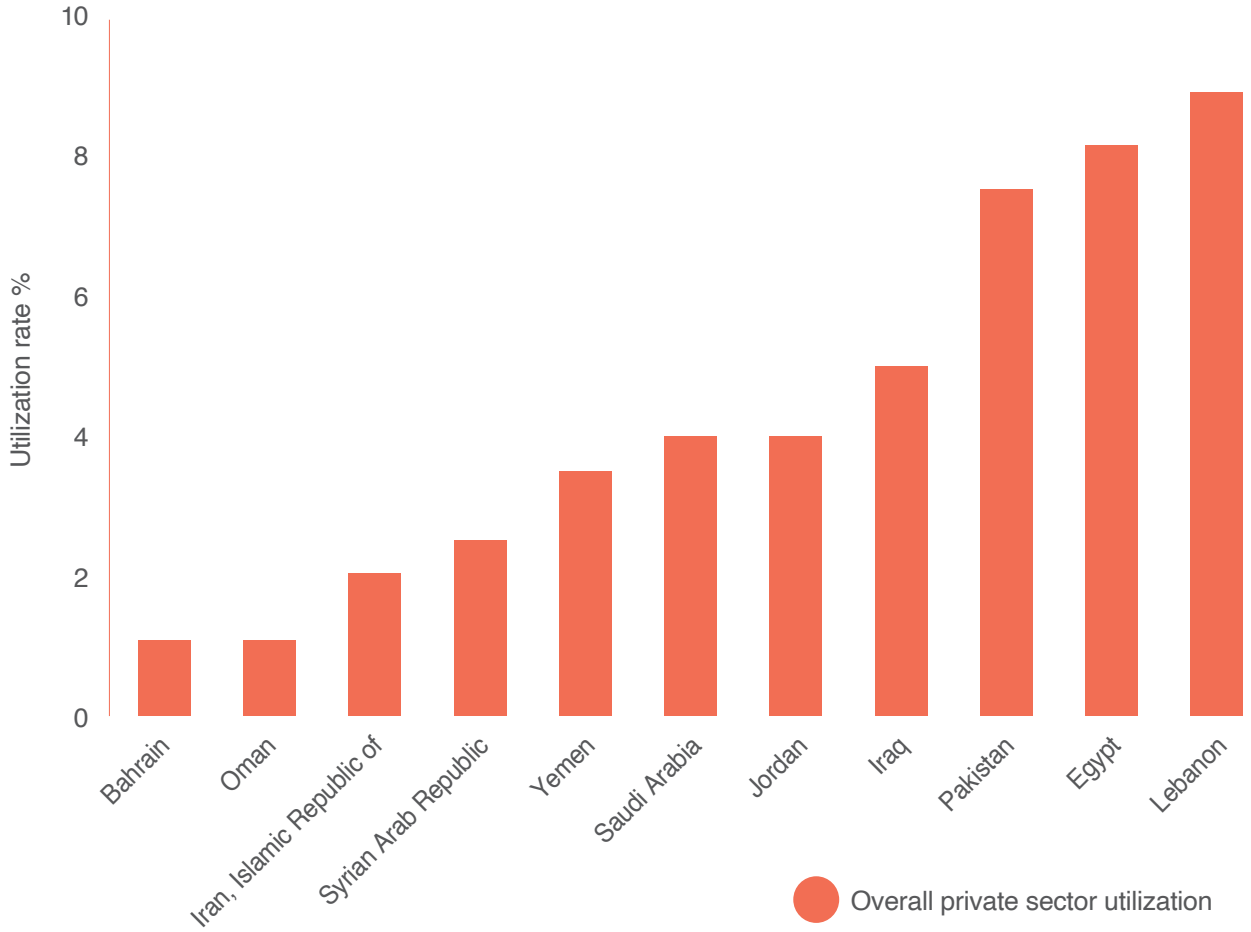
Table 2. Number of PHCCs, hospital beds, pharmacies and diagnostic facilities

PHCCs		Hospital beds		Pharmacies		Diagnostic facilities	
Private	Public	Private	Public	Private	Public	Private	Public
768	170	12 000	2500	2679	28	1114	90

Source: WHO Regional Office for the Eastern Mediterranean, 2016 *(17)*.

The private health sector is a crucial player in all countries of the Eastern Mediterranean Region, particularly in terms of achieving UHC. Lebanon has the Region's highest utilization of private sector outpatient clinics; the clinics achieve a 90% utilization rate *(17)* (Fig. 4).

Fig. 4. Utilization of private sector outpatient clinics in countries of the Region



Source: WHO Regional Office for the Eastern Mediterranean, 2016 *(17)*.

The high utilization rate of private outpatient clinics implies that the public sector in Lebanon does not deliver the required health services for patients. In addition, it implies that the private sector is a powerful player in the Lebanese health market. Improvements, regulations and reforms by the MoPH are needed to guide private sector performance, particularly in health information management, as there is a gap in data- and information-sharing across the two sectors. The establishment of a clearer strategy towards effective collaboration is crucial *(17)*.

Most private sector hospitals can accommodate a high number of patient admissions and use the latest medical equipment, making Lebanon comparable to high-income countries in terms of technology *(23)*.

In 2011, the number of short- and average-stay beds in public hospitals was 2550, while the private sector accounted for 12 648 beds for short- and long-term stays (Table 3). Furthermore, there were 116 private hospitals, compared with 28 public hospitals *(23)*.

Table 3. Distribution of hospitals (public, private and military) and number of beds per region (2011)

Region	Private hospitals*				Public hospitals*		Military hospitals***	
	Short and average stay		Long stay		Short and average stay		Short stay	24h stay
	Number of hospitals	Number of beds	Number of hospitals	Number of beds	Number of hospitals	Number of beds	Number of beds	
Beirut	17	1857	2	754	2	595	50	94
Metn	28	2359	10	1 897	6	430		
Kesrouan/Jbeil	8	635	1	30				
Chouf/Aley	9	382	3	400				
Bekaa	19	1231	0	0	5	470		
North	19	1397	2	175	7	455		
South	16	1331	1	200	3	235		
Nabatieh					5	365		
Total	116	9192	19	3456	28	2550	50	94

Source: Institute of Health Management and Social Protection, 2012 *(23)*.

Since 2011, the geographical distribution of private hospitals has changed (see Table 4). The distribution of the private sector is more concentrated in certain areas, with the highest number of private hospitals in Beirut and the Metn governorates and the lowest in Kesrouan/Jbeil *(24)*.

Table 4. Distribution of private hospitals by region (2019)

Region	Number of private hospitals
Beirut	27
Metn/Baabda	27
Bekaa	21
Kesrouan/Jbeil	8
Chouf/Aley	12
North	21
South	17

Source: Syndicat des Hôpitaux du Liban, 2019 *(24)*.

The expansion of private hospitals all over the country has had an impact on the number of admissions; private hospitals attract more than twice as many admissions as those in the public sector (162 513 and 67 016 admissions, respectively). This massive uptake of inpatient care in the private sector reflects its technological power and capacity, as well as supply-induced demand, all of which surpass the public sector's capacity. The private sector therefore requires a greater degree of control from the MoPH as an authoritative regulatory body *(23)*.

4
Health expenditure

In 2015

per capita health expenditure in Lebanon was

US$ 567

constituting

7% of GDP

In 2015 per capita health expenditure in Lebanon was US$ 567, constituting 7% of GDP *(25)*. Based on the 2017 GDP estimate of US$ 53.4 billion, the health bill was expected to be about US$ 4 billion and be paid for by three main streams of financing in roughly equal measure: (a) government expenditure from tax revenue; (b) private insurance as well as contribution-based schemes, such as the National Social Security Fund and cooperative funds; and (c) direct private expenditure by patients, as out-of-pocket payments.

The National Survey of Household Living Conditions 2004 showed that 6.5% of the population was covered by private insurance: 2.6% declared paying the whole premium directly, while 3.9% declared having their premiums paid by an employer, a syndicate or an institution. Therefore, 60% of the insured did not bear the entire premium *(26)*. Analysed data of selected private insurance schemes highlight two types of insured individual, as shown in Table 5.

- **Type 1: covered by the National Social Security Fund and has complementary private insurance; has access to hospitalization only or to additional ambulatory care (9.7% and 26.1%, respectively), with an average premium of US$ 228.**
- **Type 2: covered solely by private insurance; has access to hospital care and a variety of outpatient care, with an average premium of US$ 464** *(26)*.

Table 5. Private insurance premiums and claims, 2005 (US$)

	Private insurance				Private insurance complementary to National Social Security Fund				
	Premiums	%	Claims	%	Premiums	%	Claims	%	Total (%)
Hospitalization only	18 066 972	9.7	6 689 648	5.8	13 783 051	7.4	5 766 938	5	100
Hospitalization and ambulatory care	128 145 121	68.8	85 927 368	74.5	26 262 299	14.1	16 954 710	14.7	100

Source: Institute of Health Management and Social Protection, 2012 *(23)*.

In 2005, as published by the Association des Compagnies d'Assurances au Liban, the total premiums reached US$ 186 257 443 while claims amounted to US$ 115 338 664 (62% of the premiums) *(23)*.

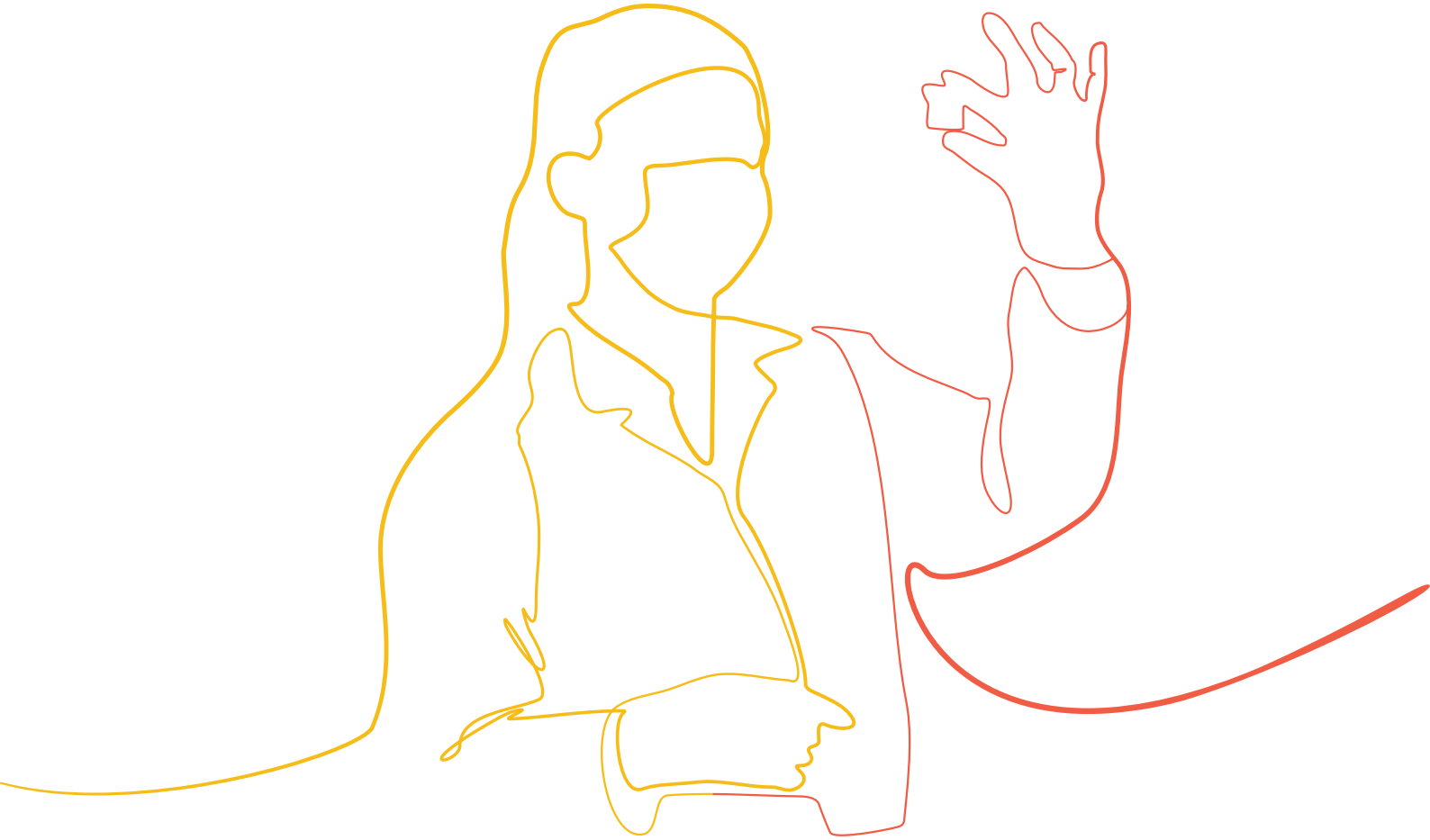
According to the National Health Accounts 2015, the public sector provides 30.26% of health funding, while the private sector provides 66.5% (Table 6). Included in the latter (66.5%), household out-of-pocket expenditure accounts for 32.7% of total health funding. Funding provided by donors represented 3.24% of the total in 2015, compared with 1.96% in 1998 *(27, 28)*.

Table 6. Sources of health funding (2015)[a]

Financing intermediaries	Funding sources					Expenditures
	Households		Employer	Treasury	Extra budgetary	
	Fees for Services (out of pocket)	Contributions/ Premiums	Contributions/ Premiums		Donations / Loans	
Ministry of Public Health				671 622 282		671 622 282
National Social Security Fund		173 369 763	606 794 171	260 054 645		1 040 218 580
Civil Servants Cooperative		31 729 960		173 641 952		205 371 912
Army				331 593 882		331 593 882
Internal Security Forces				140,814,982		140 814 982
State Security Forces				9 098 249		9 098 249
Customs				9 490 162		9 490 162
General Security Forces				31 692 400		31 692 400
Mutual funds, public		40 600 000		61 000 000		101 600 000
Mutual funds, private		178 088 855				178 088 855
Private insurances		476 495 623	379 740 897			856 236 520
International Organizations					180 900 000	180 900 000
Households	1 825 122 001					1 825 122 001
Total	1 825 122 001	900 284 202	986 535 068	1 689 008 554	180 900 000	5 581 849 825
Percentage of total health expenditure	32.70	16.13	17.67	30.26	3.24	100

GDP (2015, CAS)	75 336 000 000
Percentage of GDP 2015	7.41
Public	30.26
Private	66.50
Households (OOP and contributions)	48.83
OOP	32.70
Contributions	16.13
Employers (contributions)	17.67
Donors	3.24

[a] Amounts are given in Lebanese pounds (000s); US$ exchange rate = 1507.5.
Source: National Health Accounts 2015 *(27)*.



5 Access to health services

The commitment of the MoPH towards achieving the goal of "health for all" promoted the development of primary health care and the development of a referral system (through the use of a health card) between public and private health care institutions

Theoretically, all Lebanese citizens have access to health care services, either through private insurance schemes or through public schemes. Those who do not fall into these categories can still access health services through MoPH coverage. The commitment of the MoPH towards achieving the goal of "health for all" promoted the development of primary health care and the development of a referral system (through the use of a health card) between public and private health care institutions.

The services provided by public entities are mainly inpatient care (hospitalization), similar to private hospitals since both are subsidized by the MoPH *(29, 30).* Admission to both public and private hospitals is based on certain criteria. If applicable, the MoPH covers the estimated cost for patients in need. Under Decree No. 13, the MoPH approved an evidence-based guideline for acceptance criteria for hospitalized patients subsidized by the Ministry *(31).* Individual patient co-payments to the hospital constitute 5% (public hospital) or 15% (private hospital) of the hospitalization costs, with the MoPH directly reimbursing the hospital for the 85–95% difference. In specific cases, when a patient is unable to afford any financial co-payment, the MoPH will provide a ministerial waiver. Holders of the disability card delivered by the Ministry of Social Affairs and persons over 64 years of age benefit from full coverage.

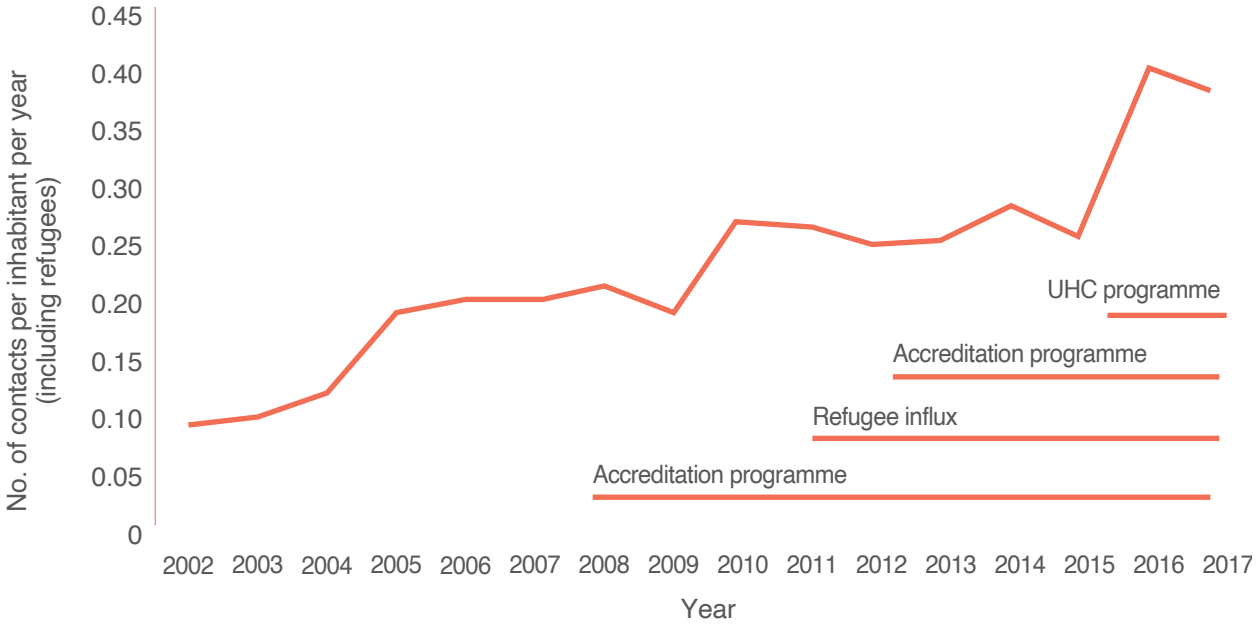
The not-for-profit organizations are mainly PHCCs. Having emerged in 1909, they were previously known as organizations for public benefit and primarily focused on orphans and older populations. However, with the civil war and the devastating economic, social and political challenges, nongovernmental organizations assumed the role of service providers and shifted their attention to social and political contributions, which primarily depended on funds and donors. These organizations provided a safety net for the MoPH during the war, especially in terms of care for vulnerable populations.

The total number of facilities in the mid-1990s was around 844, of which 110 were poor-quality public facilities; these facilities provided health care for 26% of the population *(28, 32).* It was not until 1996 that the MoPH recognized the efforts in service delivery and strong emergency response of the nongovernmental organizations. This led to the first established coalition between the MoPH and nongovernmental organizations, in the emergency response department, specifically focused on vulnerable populations. The collaboration, having proven successful, rapidly moved beyond emergency response to provide services to poorer groups.

By 2017, the primary health care network had expanded to include 920 public, municipal and nongovernmental organization facilities, all of which offered vaccinations. Of these 920 facilities, 435 were supplied with medicines for chronic diseases under a contract between the MoPH and a faith-based nongovernmental organization (the YMCA[2]). This contract provided 165 000 patients with medicines, covered by the MoPH (40%) and various donors (60%). The support provided by the MoPH improved the quality of care and access to care for the population in need (Fig. 6). The collaboration illustrates the social role of the MoPH to support the poorest groups of society. The national PHCCs were successful in covering low-income populations, including Syrian refugees, amid the crisis *(32).*

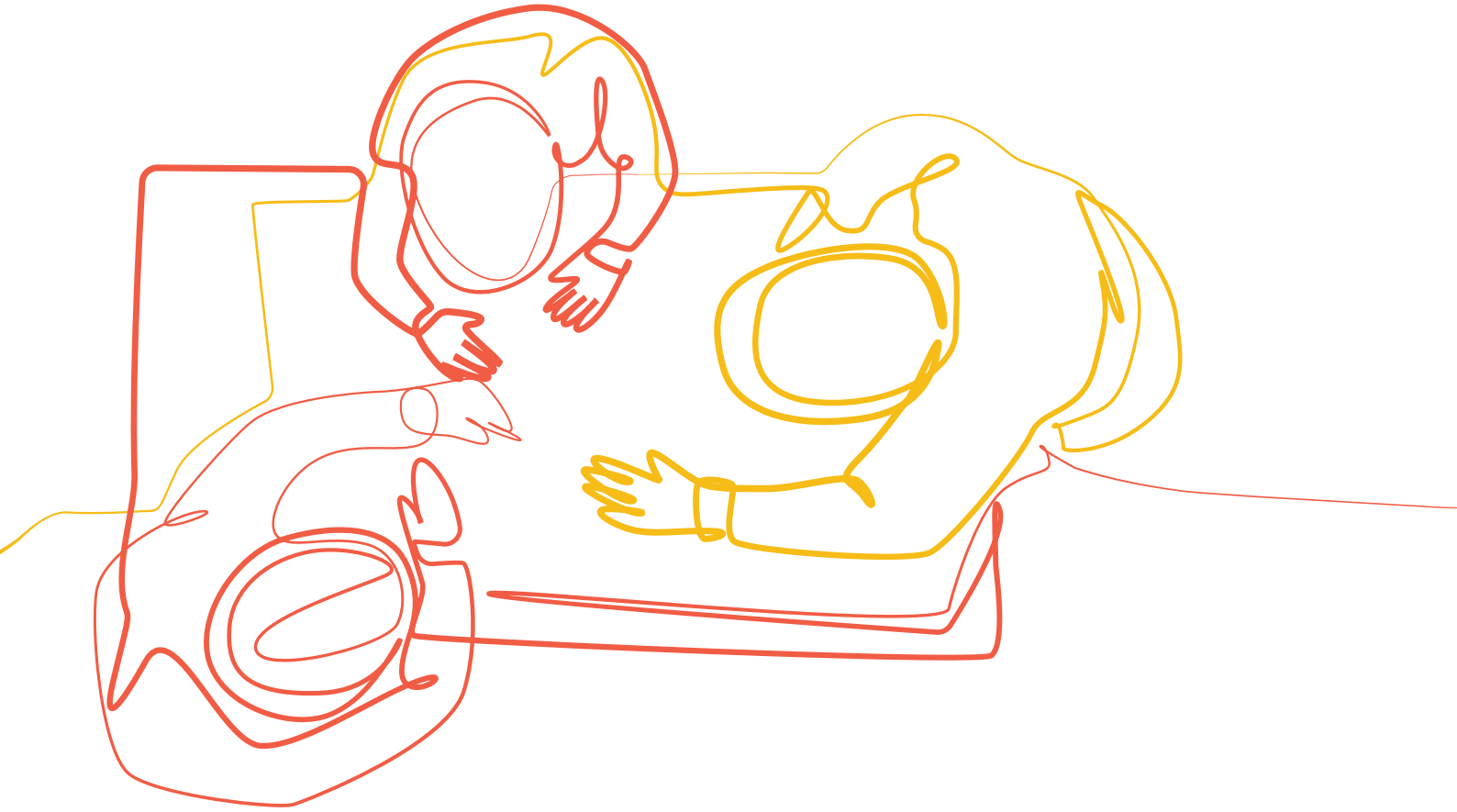
2 Young Men's Christian Association.

Fig. 6. Use of national primary health care network: contacts per inhabitant per year (including refugees)



Source: Van Lerberghe, Mechbal & Kronfol, 2018 *(32)*.

While the national primary health care network requires further improvement to unify the fragmented financial modalities and to shift from outpatient service provision to patient-centred primary care, it is clear that the collaboration of the MoPH with nongovernmental organizations continues to form the basis for future development towards improved quality of care and access to health coverage *(32)*. In fact, since 2016, the services available in PHCCs have been expanded to include screening for noncommunicable diseases, mainly cardiovascular disease, hypertension and diabetes *(33)*.



6

Private health sector analysis and stakeholder perspectives

6.1 Private sector growth and its determinants

The private health sector has been attracting investors since the post-war period when it became a hub for political and entrepreneurship investments. The increased capacity of private hospitals, physicians, pharmaceutical companies and technologies has helped to shape the sector *(32).* The private for-profit sector grew consistently in both number and capacity of facilities, providing 90% of hospital beds. The number of specialists also increased and 70% of physicians were working in private health facilities. Being a key player in the market, the private sector established a cooperative arrangement with the MoPH for service provision. This cooperation had critical consequences for national bodies' budgets, as the debt of the MoPH reached US$ 206 million from private hospitals alone, a bill that exceeded the entire MoPH budget *(32).* The country also witnessed a proliferation of private universities offering medical and health programmes.

The profit and expenditure of the private sector is mainly dependent on private–public interactions, as 64% of the private hospital budget comes from public financing and the MoPH provides 30% of the budget. In addition, the private (not-for-profit) sector, specifically PHCCs, delivers health care services under the direct supervision of the public sector *(28, 34).* As of 2019, there were 226 PHCCs within the national network: 66% were affiliated with nongovernmental organizations; 20% with municipalities; and 1% with academia; only 13% were public *(33).*

As the private sector remained stable, the number of hospitalizations in public hospitals increased. This shift in hospitalization to public hospitals, which accounted for 18% of reimbursements in 2006, reached 36% in 2016 *(32)*. Still, with the Ministry's 30% contribution to private sector admissions, along with those covered by the National Social Security Fund, the United Nations Relief and Work Agency for Palestine Refugees in the Near East, and donor contributions for Syrian refugees, the private sector remains dependent on pooled public funding mechanisms *(32)*.

6.2 Characteristics of t he private health sector

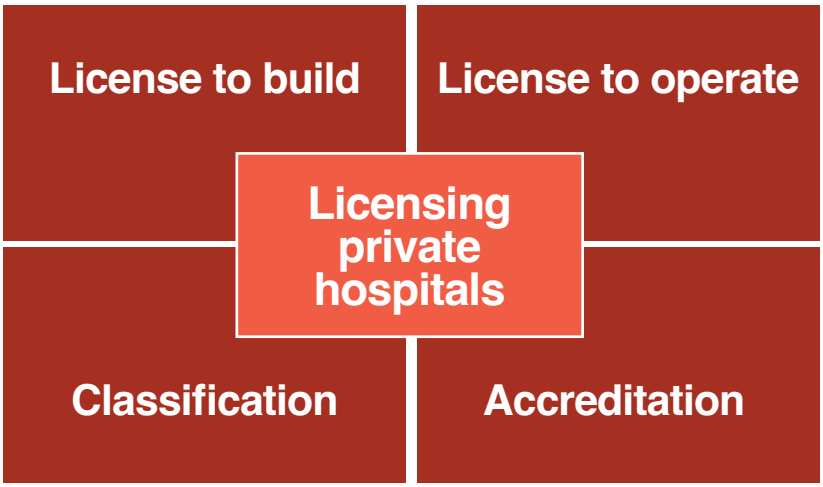
The MoPH is responsible for the overall governance and regulation of the health sector, including the purchasing and provision of some health services *(35)*. Professional orders and syndicates are the regulators of the private health sector. Lebanon has two Orders of Physicians as stipulated by Law 313 of 7 December 1946. The main role of these Orders is to "Unify the doctors' word, defend their rights, maintain their legitimate moral and material interests, raise the level of their profession, and ensure the ethics and dignity of the medical care" *(36).* Similarly, nurses, dentists and pharmacists have their own professional orders, which clearly define their missions and roles and regulate their professions. Private hospitals are regulated by the Syndicate of Private Hospitals, which was established on 15 November 1965 as the official representative of all private hospitals through Ministerial Decree 1/523. Its mission is to ensure high-quality services to all individuals and to promote Lebanon as a referral centre for tertiary health care in the Middle East. The Syndicate represents and serves private hospitals and works in partnership with stakeholders that are committed to improving and protecting health *(24).*

As the private sector greatly depends on the public sector, the MoPH has also sought to strengthen its leadership and governance functions through a national regulatory authority for health and biomedical technology, an accreditation system for all hospitals, and contracts with private hospitals for specific inpatient services at specified prices. The Ministry now has a database that it uses to monitor service provision in public and private health facilities. The aim of the database is to regulate several factors in both private and public service delivery, mainly cost containment, transparency, high reliance on hospitalization, and quality of care.

The first round of accreditation took place in 2001, with 47 of 148 hospitals being accredited as a result. Of the remaining hospitals that did not pass the accreditation process, the majority were small facilities with fewer than 100 beds. In the country's fourth round of accreditation in 2016, 89 out of 128 hospitals were fully accredited, while others were required to make improvements *(32).* This resulted in upgrades and improvements in the quality of service delivery, as the accreditation rate increased from 31.7% in 2006 to 69.5% by 2016 *(32).* The incentive-based regulation and quality assurance programmes set by the Ministry provided the market with a fair, competitive and transparent system to access public subsidies *(32).*

The visible involvement of the MoPH in private and public service delivery has proved to be an incentive for the continual improvement of both sectors. Thus, the private hospitals have become largely regulated (Fig. 7), mainly because of the introduction of performance-based contracting, third-party assessment of admission and the implementation of the current process of accreditation *(32, 34).*

Fig.7. Licensing private hospitals in Lebanon



Source: Romanos, 2012 *(34).*

It is agreed that the way forward is not through establishing greater control over private hospital care but through establishing a harmonized system to encourage cooperation among public, private and governmental service delivery centres, and for hospitals to establish a patient-centred approach, while providing ambulatory, inpatient and outpatient services. Mutual coordination between multiple stakeholders will be a key part of improving these services *(32).*

The MoPH is responsible for the licensing of all health care professionals seeking personal employment in Lebanon. Licensing is offered through a colloquium exam only. All private health professionals are required to pass the colloquium exam and register with their respective orders or syndicates to be authorized to practise in the country. However, the Ministry seeks no additional control over the quality of work and neither stipulates which qualifications medical professionals should hold, nor has preferences in terms of where they received their medical education or have previously practised *(23, 32).* Although the MoPH plays no role in the monitoring of human resources in private hospitals, the latter understand the importance of a comprehensive staff recruitment process, as the health workforce is the main driver behind improvements in service delivery. It is essential that private hospitals follow certain regulations to improve quality and engage in continual monitoring of health personnel. These measures should include ongoing education and training processes, orientation programmes for all new employees, appropriate and transparent accounting systems, and the collection and analysis of utilization statistics (accident rates, staff qualifications, education and in-service programmes, and staff appraisal).

6.3 Innovation in the private sector

Operating in a free market with unregulated development, most private hospitals in Lebanon have a considerable amount of high-tech equipment (Table 7), putting Lebanon – in terms of technology – at the same level as high-income countries. However, the main characteristic of the country's health landscape remains that of a chaotic sector with a surplus of beds, an overinvestment in equipment and an abundance of hospitals (almost 75%) with fewer than 100 beds. The main reason for this situation is essentially the absence of control from the MoPH , which has encouraged the opportunistic tendencies of consumers and suppliers.

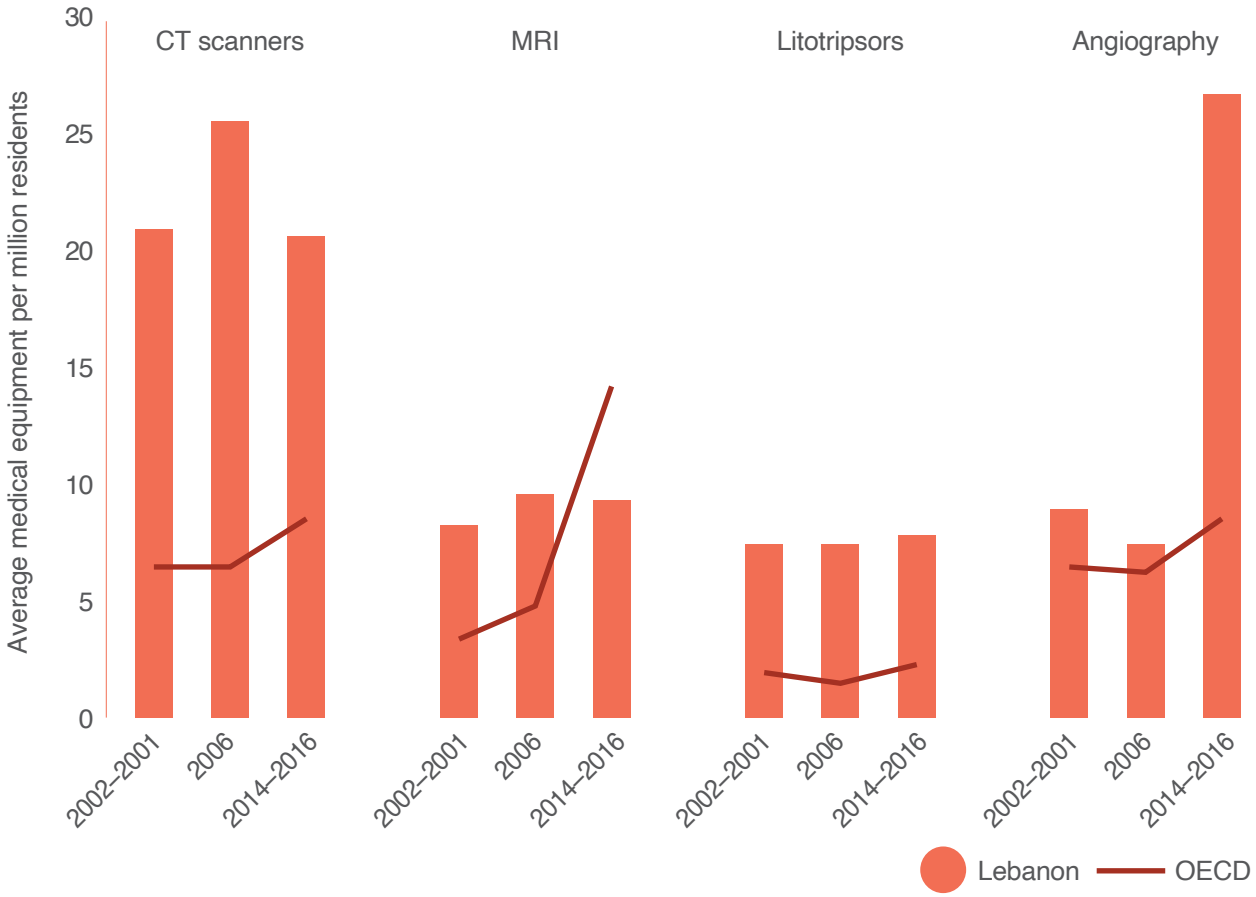
Table 7. Available technology in hospitals, 2014

	Private sector	Public sector	Total	Density per 1 000 000 population
Mammography[a]	112	19	19	370.23
Computerized tomography (CT) scanner	105	16	16	25.09
Positron emission tomography scanner	6	0	0	1.24
Nuclear medicine	n/a	1	1	0.21
Radiotherapy	7	2	2	1.87
Linear accelerator	4	2	2	1.24
Telecobalt unit (cobalt-60)	3	0	0	0.62
Magnetic resonance imaging (MRI)	39	1	1	8.29

[a] Density is per 1 000 000 females aged from 50 to 69 years old.
Source: WHO, 2017 *(37)*.

In 2009, the expansion of medical infrastructure in the private sector decelerated, as exemplified in Fig. 8, which illustrates the slowing use of the medical equipment in comparison to the growing population.

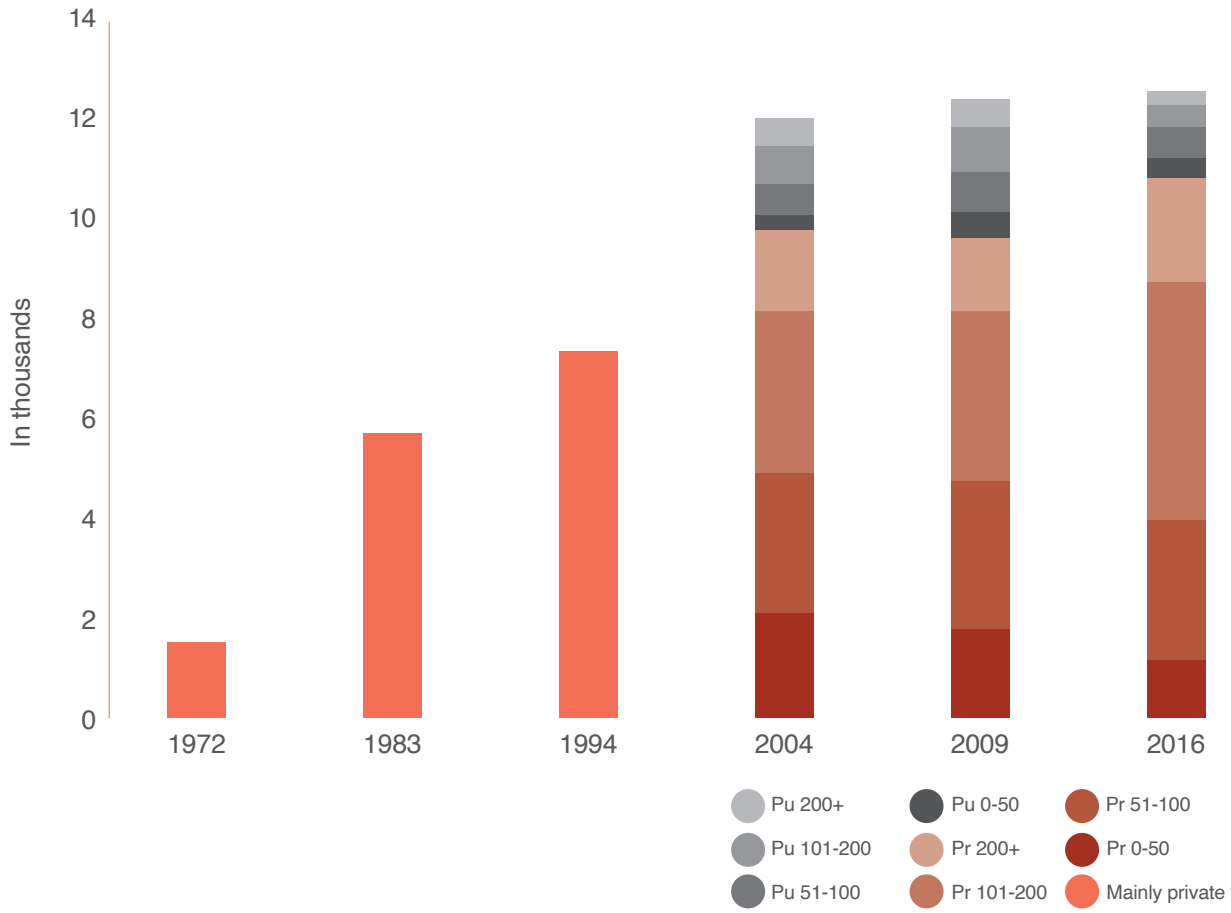
Fig. 8. Medical equipment per million residents: Lebanon compared to OECD countries[a]



OECD: Organisation for Economic Co-operation and Development.
Source: Van Lerberghe, Mechbal & Kronfol, 2018 *(32)*.

Similarly, hospital infrastructure – as measured by the number of hospitals and available beds – has decreased. Although the large private hospitals have continued to grow in size, most of the smaller ones have closed, as shown in Fig. 9.

Fig. 9. Expansion of hospital infrastructure per number of beds (public and private)



Source: Van Lerberghe, Mechbal & Kronfol, 2018 *(32)*.

In 2004, the ratio of hospital beds to inhabitants was 3.1 beds per 1000 inhabitants. Lebanon was at a similar level to other Organisation for Economic Co-operation and Development (OECD) countries; however, with the Syrian refugee crisis, the ratio decreased to 2.1%. The private sector continues to provide the largest proportion of beds and infrastructure in the country *(32)*.

6.4 Health workforce

The health workforce plays a significant role in overall population health outcomes. Defined as "all people engaged in actions whose primary intent is to enhance health" *(38)*, health care personnel are divided into three groups, all of equal importance in the harmonization of health care:

- **medical staff: physicians, nurses, pharmacists and dentists**
- **managerial and support staff: managers, ambulance drivers and accountants**
- **paramedic staff: physiologists, psychotherapists, speech therapists, etc.** *(23)*.

The MoPH is responsible for the health care workforce within and beyond its institutions (both public and private sectors). The health workforce is granted work permission through the MoPH and must register with professional orders or syndicates to obtain authorization to work in Lebanon. In general, physicians and dentists tend to have their own private clinics, while other medical staff seek employment *(23, 39).*

6.4.1 Physicians, nurses and dentists

In 2017, the number of physicians was 3.13 per 1000 population *(14).* This number had slightly increased from 2010, when the average rate was two physicians per 1000 inhabitants *(23).*

The number of nurses registered in the Order of Nurses in 2018 was 15 670 *(40).* Nearly 72.25% were active and working in Lebanon, with as few as 4.50% working abroad. Women comprised the highest percentage of the nursing workforce registered with the Order (79.64%). Approximately 50% of the workforce was within the age range of 31–40 years. The nursing workforce was, and continues to be, mainly concentrated in hospitals in Beirut and Mount Lebanon (62%) *(40).*

6.4.2 Dentists and physiotherapists

The number of dentists in Lebanon is 15.2 per 10 000 population, according to the latest MoPH statistics on the health workforce *(14).*

Practising physiotherapy requires a licence from the MoPH. There are 1523 physiotherapists in Lebanon, and six in 10 are female. All physiotherapists in the country (100%) are members of the Order of Physiotherapists in Lebanon *(41).*

6.4.3 Others

Lebanon trades three main types of pharmaceutical products: retail medication; vaccines and towxins; and gauzes and bandages *(8, 42).* There are more than 100 pharmaceutical importers in Lebanon. These importers, together with 11 manufacturing facilities and a selection of multinational companies present through local distributors, form the country's well-established pharmaceutical industry *(43).*

In terms of emergency medical services, the Lebanese Red Cross has seen a 54% rise in its missions over the last 10 years. The organization consists of 46 stations, 300 ambulances and 3200 emergency medical technicians, paramedics and ambulance technicians. Mount Lebanon has the highest concentration of Lebanese Red Cross stations, with 16 *(44).*

6.5 Financing and mode of access to services

The health care system in Lebanon is largely financed by the private sector, with a growing amount from the public sector. Recently, incentives from the banking sector have also been seen to encourage the development of the health sector, mainly in health tourism.

Across the Eastern Mediterranean Region, the purchasing of health services by the state from the private sector has increased. The

purchasing process aims to improve service access, quality and cost-efficiency. The recent shift in purchasing decisions made by the public sector involve primary health care services.

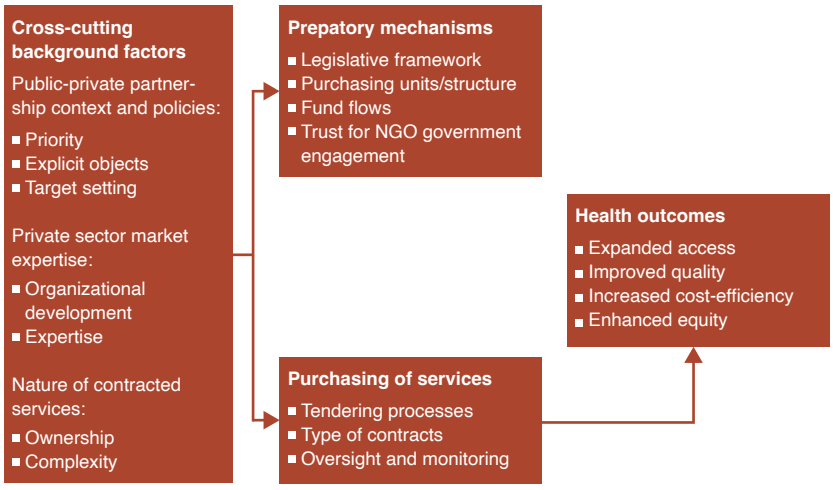
Engaging the private sector to work towards UHC has stimulated partnerships across both sectors to provide hospital services, diagnostic and clinical services, and primary health care. The capacity of the government to purchase high-quality and efficient services is important for cooperation between the public and private sectors, enabling a shift in the dynamics of the public sector, from a provider of health services to a purchaser and regulator of services delivered by the private sector *(17).*

The purchasing of health services requires well-developed contracts to achieve success, and is affected by certain factors, namely:

- **nature of the health services purchased**
- **market readiness**
- **policy positioning for public–private partnerships.**

Fig. 10 describes a framework for health service provision by the private sector. This framework considers interdependent aspects, from preparatory mechanisms and purchasing of services to influential cross-cutting background factors and health outcomes.

Fig. 10. Purchasing framework for the private health sector



Source: WHO, 2016 *(17).*

6.6 Legal, regulatory framework and governance of the private sector

Under Article 2 of Decree No. 8377 dated 30 December 1961, the Government of Lebanon states its mission to improve the health and well-being of all Lebanese citizens by ensuring availability of and access

to comprehensive health services across the country. In recognition of this and in the light of the MoPH's budget and the unregulated growth of the private sector, a new law on accreditation was introduced on the basis of 1962 legislation, amended in 1983, which set the legal framework for the MoPH to regulate Lebanese hospitals. Article 7 of the amendment specifically states, "the MOPH has the right to evaluate, classify and accredit hospitals according to their status, field of specialty and range of services provided" *(45).* The Ministry set up a Committee for the Evaluation, Classification and Accreditation of Hospitals. The Committee is chaired by the Director-General of Health and includes high-level representatives of the MoPH, the Syndicate of Private Hospitals, the Order of Physicians, the Army Medical Scheme, the National Social Security Fund and university medical centres *(45).*

The law states that the Ministry can seek assistance from external experts and consultants for the accreditation process, as long as the decision to approve a new contractual agreement was later tied to successful accreditation results. Although accreditation was not compulsory, it could be considered as a prerequisite for a hospital to be eligible for contracting with the MoPH and other public purchasers for service provision *(45).* While the amendment in 1983 was a step forward, it based its contracting criteria on the size of the hospital and the number and complexity of clinical services offered. This did not allow for direct control over the quality of services in private hospitals, and it certainly did not incentivize hospitals to improve in the event that they did not meet accreditation requirements.

In 1999, the MoPH decided to improve the existing accreditation system, which was allowed under the 1962/1983 legislation. The new accreditation system adhered to international standards and was developed to incentivize hospitals to continually improve the quality of its services *(45).* The accreditation process focused on patient safety, reporting of data, workload, infection control mechanisms and patient advocacy. The final evaluation would lead to the formulation of recommendations and quality action plans.

The Lebanese Code of Medical Ethics (Law No. 288 of 1994) mandates that physicians protect patient confidentiality and uphold professional ethics in their duties towards all patients. The law stipulates a patient's right to merciful, humane and just treatment, while receiving the attention and care they need. Other legislation has been passed that focuses on physicians and nurses include the Lebanese Medical Law, enacted in 1979, and the Lebanese Nursing Practice Law, enacted in 1979.

Laws should be drafted in full. Missing clauses usually relate to: (a) application; (b) regulation mechanisms; and (c) dissemination of information. The lack of such regulation has made it difficult to obtain the important information required for refining the framework and governance of the private sector.

The Annex to this report provides a list of laws and decrees related to the health care sector. Although not exhaustive, the list contains examples of many existing regulatory schemes.

6.7 Quality standards and public health responsiveness

The MoPH is responsible for accrediting most health sector institutions in Lebanon; this work is performed by three main bodies.

1. National Committee for Hospital Accreditation
2. Technical Committee for Hospital Accreditation
3. Bureau of Accreditation and Evaluation.

The Bureau for Accreditation and Evaluation is a newly established unit with the objective of following up on project implementation and revision.

The purpose of the accreditation system created by the MoPH is to ensure that hospitals follow certain guidelines to achieve optimal and measurable clinical outcomes for the patient, as depicted in Fig. 11 *(45).*

Fig. 11. The accreditation process led by the MoPH

Source: Adapted from MoPH, 2019 *(45).*

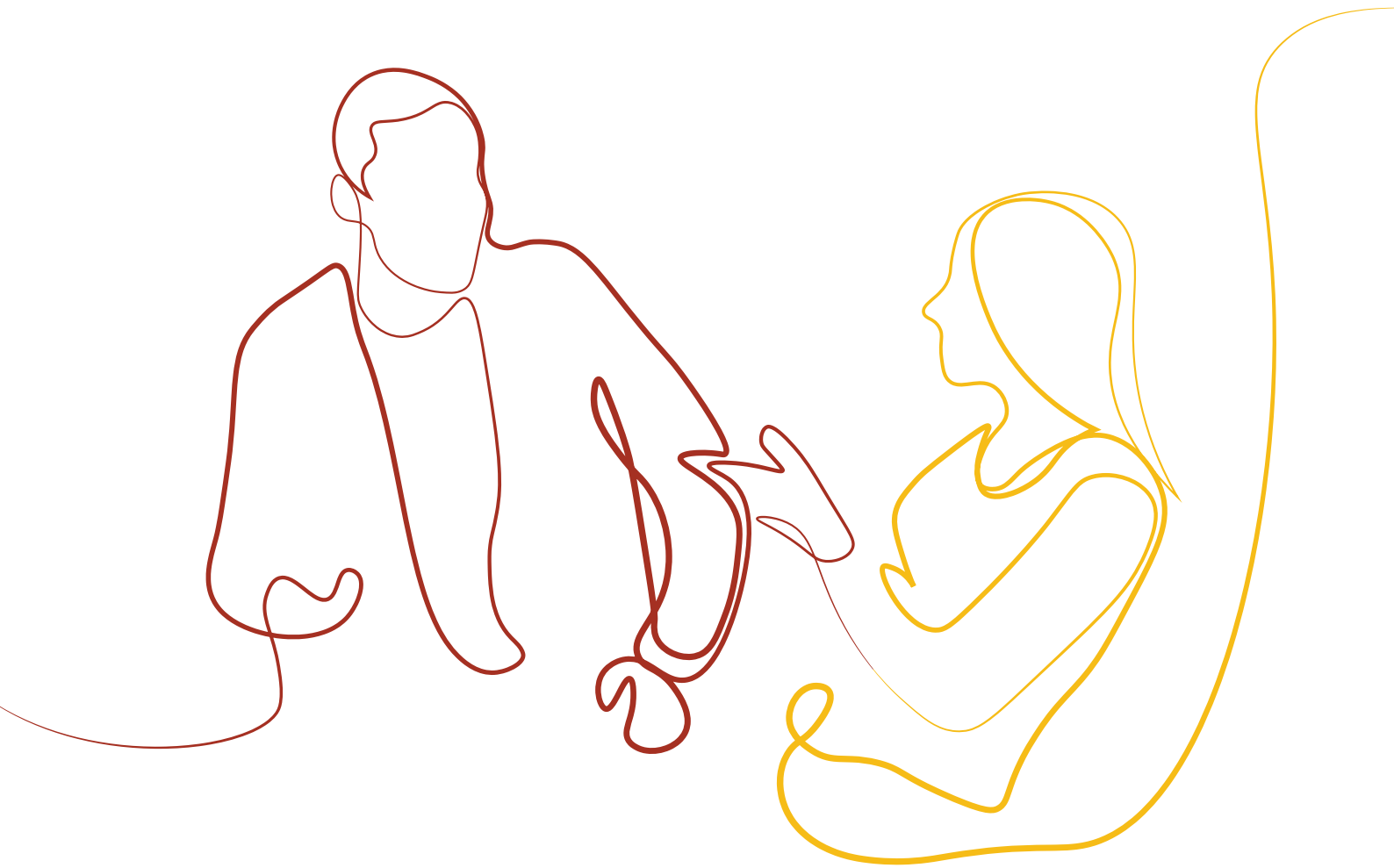
At the organizational level, quality usually falls within the remit of the hospitals' central management or department of quality, or within the remit of committees associated with different aspects of the accreditation process: goal setting; overall implementation; training; promotion of the accreditation process; composition of self-assessment teams; monitoring of the activities of the accreditation coordinator; and tracking of recommendations made following the accreditation visit. All Lebanese hospitals are subject to the national accreditation process. While some choose to submit to an additional international accreditation system, namely the International Joint Commission, others continue to align with ISO 9001, which was used before the national accreditation system was established.

The accreditation process for PHCCs was launched in 2009 by the MoPH in collaboration with Accreditation Canada. By 2016–2017, the Emergency Primary Healthcare Restoration Project with the World Bank, oriented towards UHC, had been initiated. Many reforms to improve quality and standards of PHCCs have been established, with 207 centres already part of the national network of PHCCs as of 2017 *(15).*

The MoPH has implemented accreditation and achieved a shift in the Lebanese health care paradigm from only focusing on the physical infrastructure and equipment aspects of a hospital to focusing on quality of care as an inclusive part of the overall quality. During the early stage of the accreditation process, the aim was to lay the foundations for an appropriate framework and to foster consistency as a vital part of quality practices. However, the introduction of "outcome indicators" is a direct reflection of the quality of hospital service delivery. The success and sustainability of the programme depends to a great extent on the efforts and ownership of the private institutions *(45).*

Improved quality of services in the public sector, at both the primary and tertiary levels, has resulted in increased utilization, particularly among low-income groups. As a more significant provider of services, the MoPH is now better able to negotiate rates for the services it purchases from private hospitals and can use its database to track the unit costs of various hospital services.

Overall, the accreditation process has had a positive impact on the quality of care in Lebanon. This has been demonstrated in several evaluation processes from different organizations in the Eastern Mediterranean Region. The Lebanese health care sector has ranked highly in various health indices in the years since the programme's inception.



7

Public–private partnership in health service delivery

In response to the fragmentation of the health system and lack of resources, the MoPH has developed a model of collaborative governance based on inclusive, participatory and negotiation-based leadership

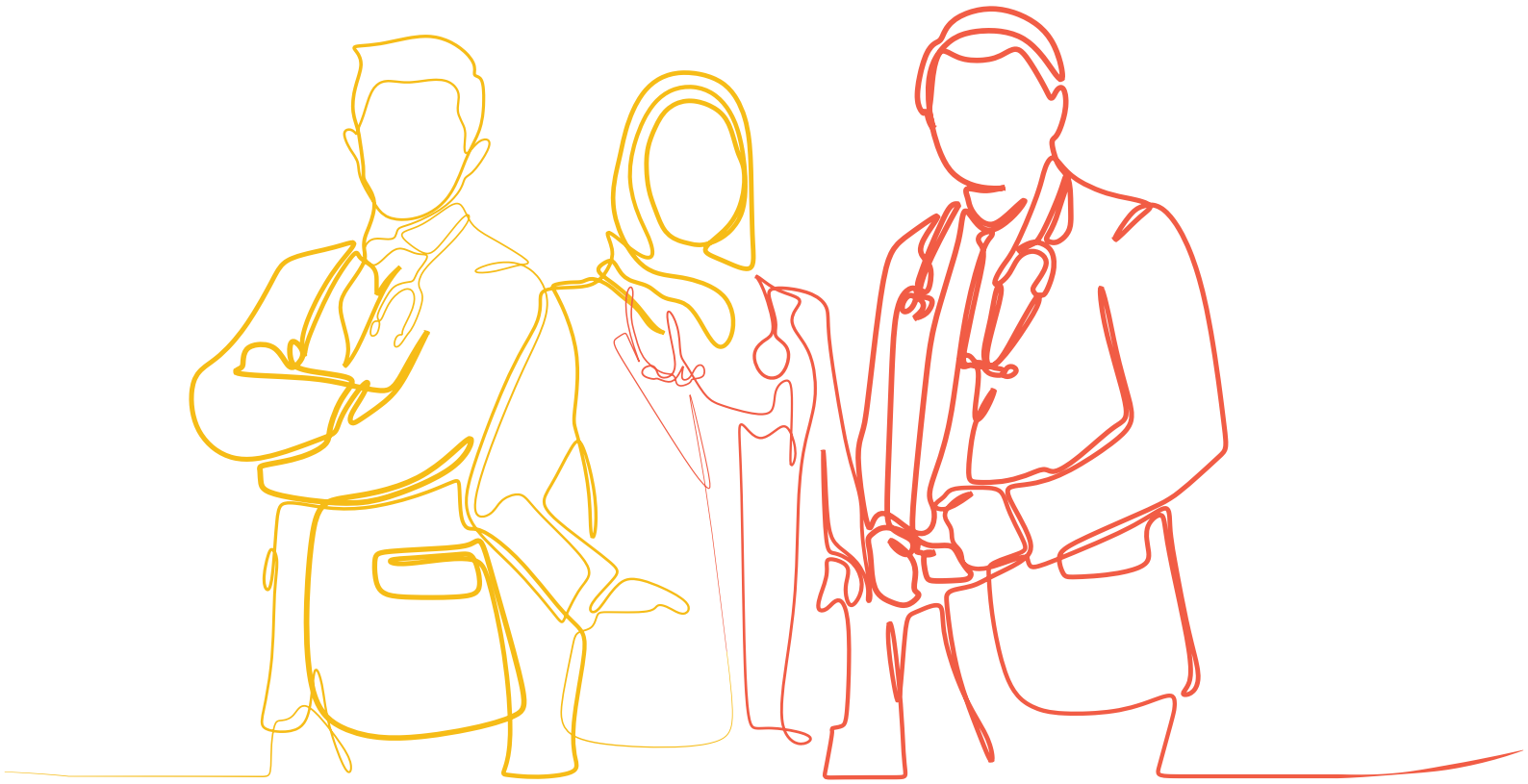
Over the last 20 years, despite the volatile political and economic context, large influxes of refugees and strong lobbying environment in which the MoPH evolved, the Ministry has emerged as a key authority within the health sector. In response to the fragmentation of the health system and lack of resources, the MoPH has developed a model of collaborative governance based on inclusive, participatory and negotiation-based leadership, bringing together public and private stakeholders in consensus-oriented networks. The emergence of collaborative governance networks is the result of long-term efforts by the MoPH in response to its recognition of the need to develop technical capacity and a strong health information system to use as the evidence-base for policy initiatives. This collaborative governance has been accompanied by a consensual leadership style and transparent communication between public and private stakeholders. The collaborative networks are wide-ranging and vary in terms of their complexity and level of formalization. Several key networks are built around sectoral priorities *(32)*.

Network-based collaborative governance has been a necessary and practical choice. As a result of the insufficient human resources allocated to the MPH, it has relied on expertise and collaborations to improve both its structure and capacity. Collaborations were diversified to cover all required areas of expertise and to allow positive steering of the entire health sector. These collaborations were developed with academic institutions, international organizations (such as WHO and the World Bank), national nongovernmental organizations and other stakeholders. The main objectives were to develop basic information datasets, exploit the operational system and provide scientific evidence that would allow a better understanding of the existing system, its resources and its requirements to move towards UHC. The MoPH intentionally established these networks with partners that had a track record of cooperation and shared a common public purpose with the MoPH. These alliances allowed the MoPH to succeed in the implementation of its reforms through exploring common interests around thematic priorities. This incremental strategy followed by the MoPH has resulted in mutually beneficial collaboration between stakeholders and ensured their early engagement in the development of the health sector. Moreover, it was built around total transparency to the public, achieved through several means (such as websites, mobile apps, hotlines and social media) to create openness and trust.

Collaborative governance has proven to be a success story for the MoPH and the entire health sector. To ensure the model's sustainability and enhance its performance, further consolidation and expansion are necessary, both technically (to institutionalize reliance on evidence, information and alliance-building) and politically (to build social consensus and support for collaborative efforts to rationalize the health sector).

The list below provides an overview of collaborative governance networks and public–private sector partnership. The list is non-exhaustive *(32).*

- The primary health care network.
- The Policy Support Observatory – a collaboration between the MoPH , WHO and the American University of Beirut aimed at providing analytical and informational support, introducing innovative approaches and tools, and anticipating future challenges and the next generation of health reforms.
- The hospital network (bringing together managers, academics and decision-makers in the hospital sector).
- Common interest sectors, such as accreditation or performance issues, both in informal and ad hoc collaborations and formal regulatory structures.
- The network of mental health stakeholders.
- Third-party payers' network.
- Collaboration with professional organizations on human resource for health regulations.
- The pharmaceutical policy network.
- The national cancer registry (cancer registry network), which emerged from collaborations on the provision of publicly subsidized cancer drugs.
- The epidemiological surveillance network (hospitals, health centres, sentinel private clinics and schools).
- The mother–child observatory vital statistics network.
- The emergence preparedness network, a collaboration between MoPH and nongovernmental organizations that emerged from the response to Israeli incursions in 1993 and 1996.



8

Stakeholder perspectives on private sector partnership and policy direction

8.1 General perceptions

In general, although national health experts consider the private sector (both for-profit and non-profit) relatively strong in its capacity to provide quality services, they expressed major concerns pertaining to its regulation. They felt that the quality of care and services provided by the private sector should be overseen by an authoritative body; in this case, the MoPH. This would allow greater control over the private sector's tendency towards increasing profits, which would in turn reduce household out-of-pocket expenditures on overpriced services.

> *"The general perception of the private sector in the country is relatively good, including perception of the nongovernmental organizations."* – National health expert

> *"The major concerns about the private sector are lack of regulation, the motive of profit overruling ethics, and out-of-pocket expenditures for health care services leading to catastrophic expenses."* – National health expert in the Lebanese health care system

This concern over lack of regulation was confirmed by the different public and private stakeholders, who added that, in order to work collaboratively towards UHC, the public sector needs to regulate the spectrum of services provided by the private sector.

8.2 Quality

Although the services provided by the private sector are comprehensive (primary, secondary and tertiary) and available in all regions of the country, they are not homogeneous in number or in quality. In Lebanon, 29.2% of patients seek diagnostic and surgical services in the private sector, which is considered to have high-quality secondary and tertiary services.

> "The private sector is well distributed across the region, and you can find any type of technology and health services available anywhere. The private sector is crucial for the overall needs of the population." – Private sector representative

> *"We cannot say there's a standard. Some provide extremely high-quality procedures, standards, creativity, and constantly look for new advancement, and some only have low or medium capacity so are unable to provide the best possible services."* – National health expert

> *"The private sector is heterogeneous. We cannot expect services to be consistent across different sizes and types of facility."* – National health expert

Patients cited various benefits that are often associated with private sector quality of care, such as: (a) the presence of an accountable body in case of medical errors; (b) innovation and technologies; and (c) trust in the private sector and its medical staff. Moreover, national health experts expressed the opinion that people seek health care in the

private sector due to social factors, including cultural similarities between the patient and the physician, in addition to the increasing needs of the overall population which cannot be met by the public sector alone.

Sixty-four per cent of patients in Lebanon seek private health care services. Their reasons for using private sector services (gleaned from exit interviews) include: geographic proximity (87%); quality of care (83%); effective treatment outcomes (82%); specialist consultation (75%); hospitable staff behaviour (62%); and shorter waiting times (61%). While patients have shown overall approval and good utilization of the private sector, the majority (69%) cited the high cost of care as a negative factor that prevents ease of access to quality health services.

8.3 Public–private partnership

The private sector has largely been in favour of the establishment of public–private partnerships, which are seen to provide fertile ground for growth across both sectors. Several stakeholders described their willingness to work in collaboration with the MoPH (under a public–private partnership) in different areas of public health, such as financial aspects, prevention and awareness campaigns, and delivery of specialized health services (providing secondary and tertiary services only).

> *"Maybe we could work on both screening tests and raising awareness so that we can reach a larger number of people."* – Professional pharmacist

> *"We would be willing to collaborate on all the laboratory services that we provide."* – Diagnostic centre representative

> *"We would specialize in providing health care services for people with disabilities and eventually become a PHCC for people with disabilities."* – Personnel from a nongovernmental organization

In addition, several stakeholders expressed that "governance" was a prerequisite for a successful partnership, as well as sharing expertise and knowledge to ensure the stability of the collaboration and allow sustainable growth.

> *"The most important thing is the governance of the project or programme, and for ownership not to eventually paralyse the system. You need proper governance."* – Private insurance expert

It was mentioned that a public–private partnership requires a framework with three main areas of focus.

1. **A clear policy agreement between the public and private sectors.**

> *"There should be a clear policy from the MoPH , stating the importance of engaging in a public–private collaboration. A clear strategy is important as well. If both are not established, you cannot begin a partnership."* – National health expert

2. **A clear vision and targets to harmonize the overall goal.**

> *"There are challenges, as most of the time their priorities are not the same as ours. Most of the time we need to create a win–win situation."* – Health professional

3. **Strong governance and political will.**

> *"We do not have good governance, in general, but in some places you'll find someone who is doing a good job. But besides this we cannot generalize; we have a lot of ideas but without the political will or the expertise we cannot do it; we are doing our best."* – Syndicate professional expert

The different stakeholders stated that a policy and framework for public–private partnership between the MoPH and the private sector had already been drafted but was not yet implemented. This prevents the partnership from taking shape and leads to fragmented collaboration across both sectors rather than an actual partnership. Considering that a partnership needs to be balanced, certain stakeholders stated that the current situation was skewed towards the private sector and could not be defined as an equal partnership.

> *"There is public–private partnership but I don't think we can call it an equal partnership. Today when you go into a public–private partnership you need to be equal, i.e. you cannot be stronger than me and you certainly cannot twist my arm. Now the public–private partnership I still feel is skewed towards the private sector, because there is no equal partnership. The private sector is the predominant one, the one with the resources; and the public sector is seen as the lesser partner."* – National health expert

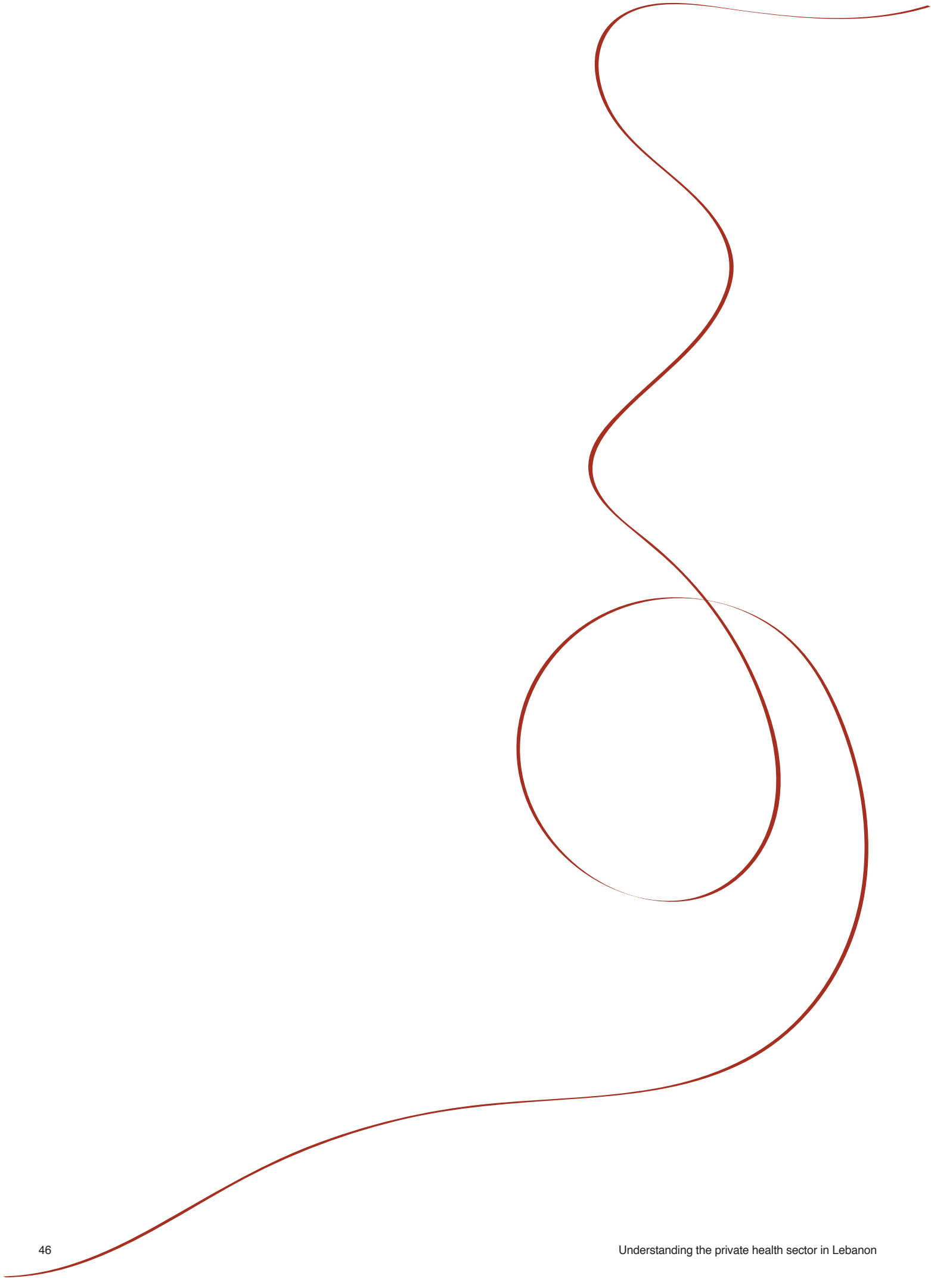
Stakeholders noted that a Policy Support Observatory has been created in Lebanon through a tripartite agreement between the American University of Beirut, the MoPH and WHO. The platform aims to gather all health-sector stakeholders to share expertise and knowledge to strengthen the role of the MoPH and support policy development.

The positive effects of private sector engagement include its promotion of technologies and innovation. The sector facilitates access to such technology, while providing flexibility, efficiency and less bureaucracy. The open market model characterizing the private sector allows its services to be readily available and tailored to patients. It also encourages competition in terms of quality of services. Some private hospitals provide fair tariffs for their services. The private sector is crucial to health service provision; thus, it complements the public health sector in Lebanon and is considered by many to be "the operational wing of the public sector".

> *"The private sector is the main service provider; the operational wing of the health sector. It has most of the hospital bed capacity, leads most of the innovation, and is much more flexible."* – Donor representative

"The other part is the free open market, and the absence of a health map, leading to the presence of many machines and resources, such as PET and MRI scanners, which are beneficial for the treatment of patients." – National health expert

"The major areas of possible negative consequences [of a market dominated by the private sector] in the country are cost, accessibility and affordability" – Donor representative



9

SWOT analysis of the Lebanese private health sector

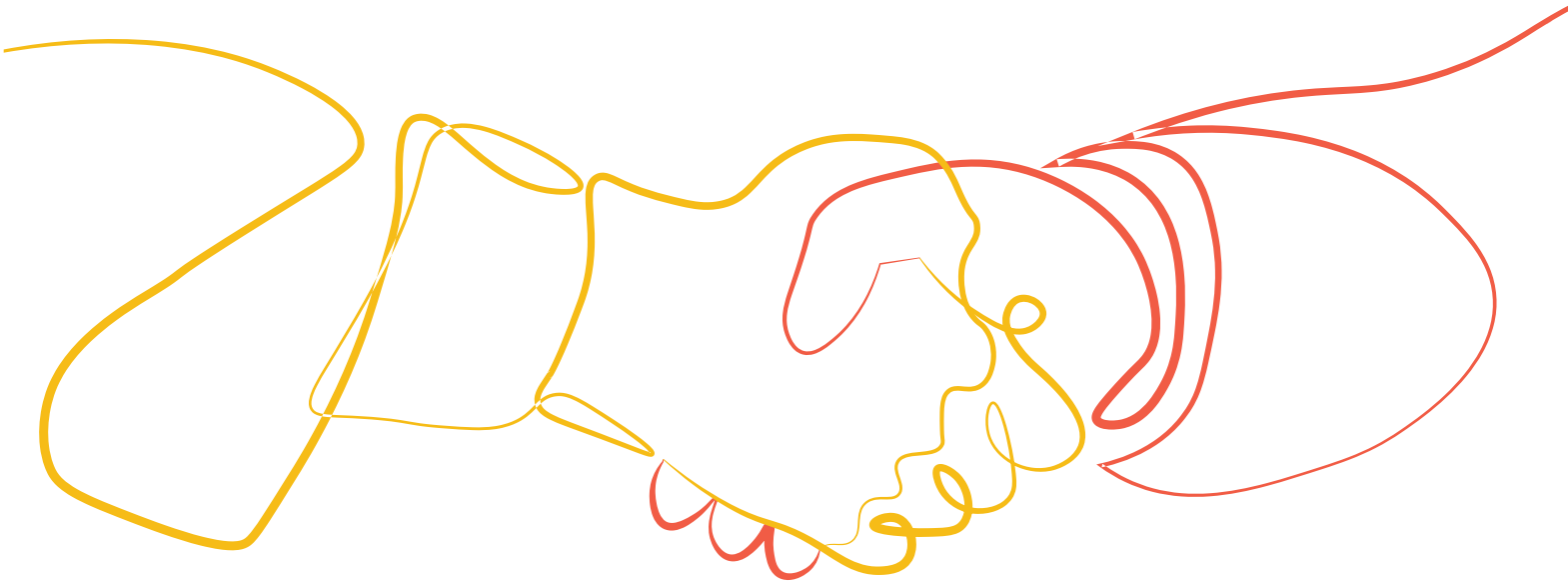
The findings discussed in this report are summarized in the strengths, weaknesses, opportunities and threats (SWOT) analysis shown in Fig. 12. This analysis highlights the strengths and weaknesses of the private health system in Lebanon as well as the opportunities that can be built on and the challenges that need to be addressed.

Fig. 12. SWOT analysis of the Lebanese private health sector

There are several opportunities for enhancing the engagement of the private health sector. The main opportunity lies in beneficiaries' trust in the services provided by the private sector. There is also consensus from various stakeholders on the private health sector being the "operational wing of the health sector". The MoPH has already demonstrated its strategic vision through strong political will and commitment, and the development of collaborative governance networks shows that private sector engagement to implement UHC

is already under way. These important achievements need to be sustained by strengthening the collaboration between both sectors and enhancing communication, transparency and capacity-building of human resources.

In parallel, several challenges external to the health system could jeopardize recent achievements. These include the volatile political situation and mounting security issues, the unstable economic context and financial constraints, and continuous brain drain and decrease in skilled human resources. The influence of religious factions and political parties on the composition of the Government and the frequent changes in governmental bodies also present considerable challenges to the continuity and efficiency of the private health system. In addition, such factors severely undermine the role of the MoPH as a regulator of the private sector, which – more often than not – has to compensate for any deficiencies in public management. This affects the planning of private service provision and equality of access, as providers tend to be concentrated in some areas and conspicuously absent in others. Any weakening of the MoPH's regulatory role would also have a significant impact on out-of-pocket expenditure, which would not be properly regulated. The political situation also has repercussions for the flow of financial resources and the motivation for investment in the country. The lack of financial back-up or incentives to invest reduces the potential for quality services due to lack of up-to-date infrastructure and equipment and an inadequate number of medical supplies. It could also place undue constraints on available services. Both the political and financial situations impact migration, as competent human resources leave the country to seek better compensation opportunities and more stable conditions elsewhere. This further weakens the health system, threatening its stability, sustainability and quality of service.



10
Recommendations

10.1 General

- **Strengthen the regulatory role of the MoPH to ensure that quality health care is provided equally and fairly to all.**
- **Ensure social equity and transparent communication, through a patient-centric approach.**
- **Apply and implement international standards of governance with appropriate supervision and oversight.**
- **Establish good governance from the MoPH.**
- **Create a clear vision and unified objectives for both the public and private sector, and ensure clear division of roles to reduce inefficiency.**
- **Strengthen the authoritative regulatory body to supervise efficient allocation of services.**
- **Establish clear regulations for the private sector.**
- **Strengthen the administrative capacity of the public sector.**
- **Expand the financial capacity of the public sector.**
- **Enforce budget ceilings to control excessive out-of-pocket expenditures.**
- **Improve financial procedures and capacities in relation to the private sector.**
- **Conduct further studies to ascertain the perceptions of all health-related stakeholders.**

10.2 Quality

- **Expand accreditation programmes to private clinics, laboratories, and medical and health facilities.**
- **Expand training on civic responsibility among medical and health professionals.**
- **Strengthen the PHCC network.**
- **Educate health professionals and patients to improve understanding of cultural, social and economic factors and to improve interactions between both entities.**
- **Focus on education regarding patient-centric approaches and patient satisfaction.**
- **Improve public hospitals by focusing on UHC parameters.**

10.3 Public–private partnerships

- **Use a bottom-up approach to draft a policy for public–private partnerships, based on dialogue and collaboration between both sectors and involving health professionals at all levels.**
- **Establish a Higher Council for public–private partnership.**
- **Build a financial model aiming to reduce out-of-pocket expenditure and benefiting both sectors equally.**
- **Provide the means for flexible collaboration to ensure a mutually beneficial partnership.**
- **Create a communication platform to share information and knowledge across both sectors and all departments involved in health care.**
- **Use expertise, knowledge and experience for mutual growth.**
- **Identify a MoPH budget to build a public–private partnership unit.**
- **Create a transparent list of priority areas to be covered by the MoPH and by the private sector.**
- **Update guidelines and engage in an efficient way.**
- **Ensure full transparency across public and private sectors.**
- **Improve the data-sharing system.**
- **Create a set of goals and objectives.**
- **Focus on a patient-centric approach and reciprocal acknowledgement.**

10.4 Overcoming barriers

- **Establish a platform for dialogue to promote synergy of major visions shared by the private and public sectors.**
- **Strengthen health system governance and leadership, including:**
  - strengthening the political will of the Government;
  - increasing the MoPH budget;
  - establishing an effective and reliable payment system;
  - Improving human resource capacity in the public sector and promote the sharing of knowledge and expertise between the public and private sectors;

- implementing strict regulatory reforms, to be developed by the MoPH;
- ensuring clarity and transparency within both sectors to encourage partnership;
- reducing and managing out-of-pocket expenditures;
- establishing a national health insurance scheme based on a patient-centric approach.

10.5 Policy directions

When formulating the proposed policy directions for public–private partnerships and further engagement, this report considers the stakeholder perceptions that emerged during the assessment. Stakeholders took a holistic approach to health and private-sector partnership, targeting the six building blocks of the health system: service delivery; financing; human resources; leadership and governance; medicines and technology; and information.

The policy directions proposed by the consultancy team involved in this report follow the structure of the health system building blocks towards UHC, as follows.

1. Promote health system strengthening to achieve UHC.
2. Ensure equity in financial coverage schemes.
3. Address equity and efficiency in service provision.
4. Improve human resource capacity in national institutions.
5. Strengthen national institutions and capacities for UHC.
6. Improve policy implementation.
7. Create a platform for dialogue between public and private institutions, supported by a system for follow-up, including a mechanism to generate evidence-based decision-making.

Although the sample of stakeholders interviewed for the study is not large enough to generalize, the study results provide valuable insights into the thriving partnership that has been established between the private and public sectors for working towards the achievement of UHC.

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Annex

Table A.1. Laws and decrees related to the health care sector in Lebanon

Purpose	Decree or law	Source, date	Sector
All pharmaceutical products (local or imported) are registered through the Drugs Technical Committee; any drug that is not approved by the Committee is considered illegal	Multiple	Ministry of Public Health (MoPH), 2014[1]	Pharmaceutical
Hospital accreditation system, with the objective of setting accreditation standards covering the structure, process and outcome of the system	Decree No. 139 passed on 16 September 1983, amended by Law No. 546 BU in 2003	MoPH, 2019[2]	Hospital
Primary health care centre (PHCC) accreditation system, with the objectives of improving the national primary health care network and setting an interactive regulatory framework for PHCCs	In 2010, a contractual agreement occurred between the MoPH and Accreditation Canada (the first pilot was in 2011)	MoPH, 2019[2]	PHCC
MoPH can assess, classify and accredit new private hospitals according to a set of criteria and conditions; after the building of a hospital, the MoPH does not exercise further control	Articles 3–6 of Law 9826 (22 June 1962), amended by Decree 139 (16 September 1983)	Romanos, 2012[3]	Hospital
Licensing physicians in Lebanon to practise medicine within the country	Under Law No. 1118 in 1978, Article No.11, the MoPH is the responsible body for the licensing of physicians	Lebanese Order of Physicians, 1979[4]	Medical (physicians)

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