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SPECIAL REPORT

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MARKET SOLUTIONS FOR PUBLIC GOODS

BY THOMAS SCHELLEN

THERE IS A GROWING IMPORTANCE AND READINESS FOR REDRAWING PARTNERSHIP PARADIGMS FOR PUBLIC HEALTH ACCESS

The proverbial Lebanese entrepreneur is nothing if not agile and adaptive. She or he is a dealmaker par excellence and almost genetically primed to spot opportunities and seek to exploit them. Rules and processes are guidelines more than legal and cultural straitjackets that hold our archetypical entrepreneurs back from the pursuit of business and profit. Thus, whether you encounter them as a theoretical model of behavior or in real life, Lebanese entrepreneurs exemplify keen business senses similarly to any entrepreneur around the world, but just a little more so.

By contrast, the stereotypical setting of the public sector is institutional, inherently cautious and beholden to legal precedents, policy making entitlements and bureaucratic stipulations. When compared with the private sector's hunger for immediate gain, it moves at a snail pace. The Lebanese public sector, which in addition to the globally common public sector inertia, is infested from bottom to top with partisan identities and competing interests and has managed to make public administrations of other countries look like racehorses.

Despite their many divergent aspects, public and private are today understood to be indispensable partners in systemically important economic systems – including the management of public goods. But is the traditional Lebanese entrepreneurial mold conducive to the creation of good partnerships with a public sector that is still far from formulating a constructive national political will? The question is increasingly critical for a health system whose previous formulas of fragmentation, inefficiency, overlap, and competition by multiple self-interested stakeholders has proven invalid.

The question seems today increasingly relevant even in health concerns that are found on the periphery of a universal care model. Jad Rizk is a seasoned Lebanese entrepreneur who has spotted a problem in the wider health system that he sees as a profitable opportunity. "I am developing a high-end retirement home," he tells Executive.

Utilizing an existing $5 million hotel property, his plan is to invest $4 million into a refurbishment and expansion that will yield in the first phase 70 rooms for single or double residency of retirement-age Lebanese who will have access to nurses, medical care and a wide range of social amenities, all in-house. The project is planned in three phases, the first of which is the conversion of the existing hotel for opening around the first quarter of 2024 under the name 'SK Retirement Life-Style Suites'. In later phases, the facility will add 60 rooms and then

again 40 chalet-style apartments.

Partnership with a home care services company, the part-time contracting of doctors and other medical staff, and agreements with insurance companies, are either existing or being explored, Rizk says. Conversely, other than obtaining necessary state permits, the one thing that he would not do is venture into collaboration with the state for providing elderly care. "Anything that has to do with the government? Of course not," he exclaims, pointing to many bad experiences his business ventures have had in dealing with the public sector.

■ It can be argued that the increase in private sector offerings was a mixed blessing

With price tags of up to $1,800 per month for a couple's full-service residency, the addressable market for the project is both affluent and narrow. "What we are trying to do for expatriates is provide an alternative to 'warehousing' old people, or putting them in places to die there," Rizk says, arguing that this care offering for their senior family members would at the same time liberate the diaspora members of feelings of guilt, and give them an investment opportunity towards their own future care needs.

Having worked on the project since the second half of last year, Rizk goes on to say how he conducted market studies among his prime target group of Lebanese expatriates (in the Gulf region and elsewhere) and received 70 percent positive responses from diaspora Lebanese who are eager to find care facilities for elder family members, many of whom have been deprived by the Lebanese economic crisis of their social interactions and mobility. Undeniably, Rizk has an entrepreneurial market solution to a problem involving the public good of health.

A TOWERING NEED

From the perspectives of several social and economic business leaders to whom Executive mentioned the project, comments were that such a project may indeed be economically interesting. However, they also noted – some of them in addition to voicing fundamental concerns about retirement homes as often flawed businesses and imperfect societal alternatives to functioning family units – that a high-end retirement home project at this time does not meet a major societal need in Lebanon. Yet the fact that a niche market for luxury retirement homes is seen as interesting by 70 percent of expatriates polled for their responses to such a proposition, illustrates how market logic can work and mobilize investments for a private sector project. This is even at a time when the imperative of broader social safety is still languishing far below the threshold of an inclusive net with mandatory and inclusive coverage of health needs of residents of all ages.

However, this once again illuminates the social distortion factor of market logic that one can see as an historic impediment of the Lebanese health system. As private operators from the start of the post-conflict reconstruction time in the 1990s latched onto earnings opportunities in medical provision, it can be argued that the increase in private sector offerings was a mixed blessing. New medical offerings of private clinics and hospitals were accompanied by accommodation options of different room categories whereby non-medical services enabled private hospital administrations to level charges that only the affluent could pay. Specialized treatments or innovative procedures, machine-intensive diagnostics using the most sophisticated scanners, and branded drug recommendations with a bias toward expensive imported medications all contributed their share to the boosting of health expenses to developed-world levels approaching nearly 9 percent of GDP by the mid-2000s. This was even as the high out-of-pocket contributions and the

THE PHARMACISTS AND THE LYOPHILIZER

If there were nothing but data-driven truth to some of the quite widely promulgated assumptions about excessive male control and low participation of women in the Lebanese economy, a company such as Arwan Pharmaceuticals likely would only exist as a wishful fantasy. If a perfectly regulated setting of specialized industrial zoning and bureaucratic processes were to be found in Lebanon, investors might never have endeavored creating a company such as Arwan Pharmaceuticals.

As things are, however, the company paints its future in optimistic colors because of its qualified workforce, smart management, and regionally competitive value proposition, even against a backdrop of a slow development and a wishful corporate dream still brewing. It was founded as a joint shareholding company of some 25 investors led by seasoned Emirati businessman Abdul Razzaq Yousef and Lebanese pharmacist Ruwayda Dham 14 years ago. Three years after the founding, they began producing injectable drugs.

With a workforce of 150 and a capital of $30 million, Arwan Pharmaceuticals is among the largest and best-capitalized companies in the manufacturing industry niche of producers of pharmaceuticals in Lebanon. It is one of 12 companies that comprise the Syndicate of Pharmaceutical Manufacturers of Lebanon (SPIL) whose collective employee headcount is estimated at 1,500 by Dham, Arwan's managing director and a board member at SPIL.

Arwan also is the most recent pharmaceutical manufacturing company in the country which, according to Dham, was established in order to identify deficits in pharmaceuticals supply in the Arab World and produce in these niches to meet needs which are currently met by imports to the region. To achieve this, Arwan was set up in 2009 with a three-phase plan for, at first, the production of injectable drugs and then semi-solid and solid drugs used in tertiary care environments. Hospitals in Lebanon and across target markets in the Middle East, Africa, Eastern Europe and Asia comprise the clientele of Arwan Pharmaceuticals.

As Dham explains, the company invested in an advanced lyophilizer, a production unit that freeze-dries and stabilizes thermally sensitive liquid drugs, ranging form anesthetics and antibiotics to vaccines, so that these drugs have greater stability and an extended shelf life. According to her, this machine is the "backbone" of Arwan's production of vials and ampoules, or multi-use and single-dose containers for injectable drugs. It is the newest and most capacious of only three such lyophilizers in use by a drug manufacturing company in Middle Eastern markets. It has a capacity of producing 75,000 vials per shift, Dham tells Executive. "We were very ambitious when we started in 2009 and are now in phase one of the project. We have the infrastructure to implement Arwan 2 and 3 but unfortunately problems from Arab Spring unrest to economic crisis hindered our dream."

In addition to technical know-how and the state-of-the-art equipment, the company notes as a special feather in its cap that it received World Health Organization (WHO) prequalification of medical products and provides WHO-compliant quality control laboratory and testing capacities. "Whenever companies from around the region are looking for the closest approved or prequalified WHO laboratory in the Middle East, they come to us. This gives us important credibility with health authorities also outside of Lebanon," Dham says.

One factor that kept the company from realizing its high-flying ambitions and aggressive pursuit of export growth – something that was on its agenda from the start of production and is reflected in registrations of its products by health authorities in 17 markets – were the regional and local economic setbacks that began with the Arab Spring disruptions and peaked with the Lebanese economic crisis.

Yet on another level, the pharmaceutical manufacturing sector has not been receiving the fully committed state support that would have been needed for realizing the potential as a Lebanese pharmaceutical producer with a regional high profile. The importance of better manufacturing infrastructures, including specialized economic zones (SEZ), has been emphasized by United Nations Industrial Development Organization advisors since well before the time when Arwan Pharmaceuticals was established. Yet, loudmouthed Lebanese announcements of planning for specialized industrial zones have not been translated into SEZ infrastructures with such vital capacities as the collection and treatment of pharmaceutical manufacturing wastes.

The absence of incentives to create renewable energy solutions for industrial sourcing of electricity has been a problem for at least a decade. Even projects for the upgrading and maintenance of road infrastructure have been sitting in public planning drawers. While traversing the route to a company such as Arwan, one cannot avoid the impression of numerous structural deficiencies in the road infrastructure serving the industrial establishments in the area.

Adding to these disadvantages is the fact that other Arab countries have created rules in support of their strategic industries, or practice de-facto protections thereof, while Lebanese pharmaceutical manufacturers have been feeling left without effective government support in the face of market-access disadvantages and competitive barriers. Even today, as industries related to food and medication are more vital for basic economic sustenance than ever before, Dham does not experience pharmaceuticals being treated as a strategic industry.

"It is our position as local manufacturers that we don't want protection, because Lebanon is a free economy. But at least give us some privilege," Dham says, adding that it is extremely exhausting for a pharma manufacturer to operate in Lebanon. "Unless you have the will, determination, and the long vision to say 'I tolerate this' – but until when? We are suffocating as a pharmaceutical industry. We have very high costs and the government is absent. We just get to hear promises."

The deep absence of the state is a common lament of economic actors seeking to run viable businesses from Lebanon. It is just more painful to see it suffered by companies in sectors with strategic roles and moreover excellent regional growth potentials. In very simplified terms, one could argue that a company such as Arwan Pharmaceuticals exists despite rather than because of the "enabling economic environment" that a state might strive to provide to strategic industries, meaning those that play a strategic role for the wellbeing of many people.

The bittersweet pain of witnessing good economic activity which still could be performing much better, goes up another notch when one considers the social and economic contribution of science-heavy companies to equitable employment creation. In the case of Arwan, this is further exemplified through the evidence of women in management roles, which extends from the top of senior management into viable careers for capable pharmacists who entered the company a few years ago.

"The majority of staff and managers here are women," says Rasha Youni, the technical director. She describes the company's current research and development and shares how mundane problems such as importation of samples through customs adds to her daily workload. Although she had several opportunities to pursue a career outside of Lebanon, Youni chose to stay with the company where she had started her career as an industrial pharmacist fresh out of university and rose quickly through the ranks to become the plant's manager. The trust and support in her career development that she received has fueled her will to stay in Lebanon where she feels her work has a real impact and where she is confident that her experience will benefit others. "We deliver a high-quality product to the Lebanese. We are hiring new pharmacists and I feel that my [experience of trust and career development] here will help other people. They will learn from my growth and this will motivate them."

fragmentation of medical care packages in the first two decades of this century presumably dampened some moral-hazard factors seen in health systems with broad entitlements to care.

Today, as it is undeniable that trust in the Lebanese state's political readiness for delivering reforms and urgently needed services is exceedingly scarce and doubtful alongside the pernicious total vacuity of political promises during all stages of the economic crisis, several strong factors are pointing to the importance of redrawing partnership paradigms for public, private, and community collaborations. This is especially relevant regarding society's public goods, of which health is as weighty for the short-to-long term fate of Lebanese society as education is for the long-to-short term.

Global principles and local specificities both come into play as factors here. To summarize them in a short list, one global factor in support of an intensive discourse of public-private and public-private-community partnerships (PPP and PPCP) in the health sector, is the maturing of the principle of PPP from lessons learned worldwide. From failed and successful partnerships over the past few decades, a local collateral benefit of that factor is that PPP has wide support among local health system stakeholders and reform advocates.

Another weighty pro-partnership argument is that unstructured past coexistence of public and private health approaches – in many ways the opposite of an ordered, transparent, and contractual PPP approach – has cost Lebanese society, due to health system inefficiencies and public-private dichotomies in the provision of public goods over the past 30 years. A financial argument further along this line of reasoning is that investments with a PPP approach open new access to finance options, whereas financing of the National Health Strategy through anything but inclusive, innovative and transparent methods or unsustainable betting on concessionary loans and grant pledges by international development finance institutions and foreign governments, appear today as solid as betting a trillion lira on a roulette payout at the Casino du Liban.

Lastly, the perhaps most compelling practical argument from a macro-social policy perspective for the pursuit of public-private partnerships for Lebanon's public goods is that this country's private sector is forever racing ahead of the public sector in improving its productivity and performance, with the ongoing resurgence of health and pharmaceutical manufacture being a perfect example.

PRIVATE STORIES OF EXCELLENCE

The Lebanese pharma producers could meet a high portion of local drug needs during the crisis, ramping up their market shares. "Before the crisis, Lebanese pharma manufacturers used to cover only about 8 percent of the [domestic] market. Now we are around 40 percent of the entire market, but we

Arwan received WHO accreditiation and provides WHO-compliant facilities

■ This country's private sector is forever racing ahead of the public sector

do not produce everything. If you take the pie of what we are producing as Lebanese manufacturers, we are covering around 80 percent of the market demand for the products that we produce," says Ruwayda Dham, Ph.D., vice-president and managing director of pharmaceutical manufacturer Arwan Pharmaceutical Industries and board member of the Syndicate of Pharmaceutical Industries in Lebanon (SPIL). According to her, the coverage ratio of local pharmaceutical needs with local production more than doubled from 34 percent in the years before the economic crisis.

Dham emphasizes that meeting the needs of the local market is something that all member companies in the pharma manufacturers' syndicate are committed to do. While profitability concerns and frustration with delayed or broken state promises are motivating them to look at export markets, manufacturers have a moral stake in their home market and also have invested too much into building their positions in Lebanon for them to cede their hard-won market shares to manufacturers of generics from lower-cost production countries. "We will not leave what we have established here up for others to grab. We never export at the expense of the needs in the local market. All of the SPIL companies have committed to the priority of satisfying the local market," Dham tells Executive.

The numbers she provides on the increasing role of domestic pharma manufacturers are the same as the ones cited in the National Health Strategy: Vision 2030 document. On the distribution side of the pharmaceuticals supply chain, they are also corroborated by non-profit partners in the health system. Lina Traboulsi and Guita Abou Haidar, the quality assurance pharmacist and chief pharmacist supervising the central drug warehouse of the Order of Malta's (OML) primary healthcare (PHC) network, confirm that most drugs in the warehouse – which do not include injectable drugs nor oncological and psychotropic ones – are sourced from local manufacturers. "Of the drugs that we procure from the local market, 80 percent are produced by local manufacturers. But we have products that we receive as donations from abroad, which used to constitute a good portion of our stock," Traboulsi says.

Their commitment to satisfy the Lebanese pharmaceutical needs as much as possible does not mean, however, that a pharmaceutical manufacturer such as Arwan is resting on their laurels of their recently improved domestic market share and exports-shy orientation of the past few years, which actually meant that some products incurred losses because of cash flow issues and price divergences rooted in the huge volatility of the Lebanese pound.

For the current year, the company's expectation is to operate without losses and aggressively pursue export earnings. "Our plan for 2023 is to sell 55 percent of our products in Lebanon and 45 in exports," Dham says, emphasizing that in addition to the growing interest in Arwan's product range of injectable drugs by hospital clients in the Arab region as well as African and Eastern European markets, investors have shown interest in the company.

> "We will not leave what we have established here up for others to grab."

While the market positions and production capacities of pharmaceutical manufacturers are improving gradually, there is, however, also no doubt that the pharmaceutical needs of Lebanese patients remain under-served and require more local supply. According to Abou Haidar and Traboulsi, the drug warehouse they are managing serves the needs of OML's national network of PHC centers. OML primary care distributed 1.7 million units of medication in 2022 and the need is still growing, while the supply is not always keeping pace. "With the increasing number of beneficiaries and the increasing demand, the rotation of our stock is very fast," the pharmacists say, adding that the OML network's projected need for medical drugs this year is much higher when compared last year.

They also say that the predominance of locally manufactured drugs in their stock is a reversal of a previous pattern under which until mid-2022 in-kind pharmaceutical donations coming from abroad accounted for up to 70 percent of the stock at the warehouse. The shift to locally produced drugs correlates positively with both the improved value chain position of local pharma companies and with an attitude change among Lebanese patients who now welcome any medication. However, it also reflects the shifting priorities of European donors in the face of other crises, such as the Ukraine-Russia war, and budget restraints on the side of international NGOs. The drug supply for primary healthcare beneficiaries around Lebanon is further complicated by temporary disruptions in the provision of some essential medications by the Ministry of Public Health (MoPH).

OUT OF THE FUNDING ABYSS

To progress on the financial management side from today's health system which is in every respect – from the supply of drugs to the securing of funds for generators at primary and tertiary healthcare providers – dependent on international donors' good will and hard cash will require integrated solutions for to

According to Nasnas, coverage of health insurance needs is part of an economic and social revival plan

Nabil Khairallah, a dentist at Order of Malta's Primary Healthcare Center

cover costs through a new public-private insurance partnership, explains Elie Nasnas, a long-standing leader in the private insurance sector of Lebanon.

According to Nasnas, coverage of health insurance needs is part of an economic and social revival plan for the Lebanese economy that is being prepared by the economic associations of Lebanon. "We need to regulate all the existing schemes of healthcare provision, such as charities and primary healthcare centers by long-standing NGOs and make this into a scheme that will align for all the citizens," he tells Executive.

He concedes that universal health coverage containing an element of basic, ideally mandatory, health insurance is an ambitious vision under the circumstances. It would have to be achieved in a stepwise approach, which he suggests can commence by addressing gaps between the medical coverage provided by the National Social Security Fund (NSSF) to enrolled Lebanese employees and the actual payments required by hospitals. "Today the offerings of social security are very low compared to what hospitals are asking. Our view is that the private sector needs to fill the gap in order to ensure the access to healthcare for the maximum number of Lebanese citizens," he says, adding that increasing numbers of employers – driven by concerns over employee productivity and retention – are keen on securing such insurance covers for their employees.

Under the initial concept of such an insurance that would augment the NSSF scheme, all employers should have been obligated to acquire for their employee's health insurance covers with dynamic tariffs and benefits that are determined by what the NSSF provides. However, Nasnas admits that discussions have already shown that institution of a mandatory cover under a new law would be very difficult and likely not be approved by lawmakers.

Noting that concerns over an extension of any mandatory scheme to public sector employees have been presented as a barrier but opining that the rule could be limited to private sector employees, he reasons that costs per insured employee would be lowered significantly under a mandatory cover of basic health insurance for a large swathe of the population. "We have to keep in mind the situation today where employees are forced to tell their employers that they cannot pay a hospital bill of a few thousand dollars. However, if the costs are mutualized for all employees, the cost per policy will be much lower. And once the scheme is compulsory, there will be no anti-selection. This is the principle of it," Nasnas says.

After filling the gap to NSSF coverage with an insurance solution that works with a correct price and very narrow margin, and demonstrating the scheme's success, insurers and public health authorities could proceed to tackle the challenge of universal health coverage equitably with a basic insurance component, Nasnas advises. "Lebanon is receiving aid from donors for the health sector. Our view here is that the government should not be a risk taker. It has to offer access to healthcare to all citizens but with a cap in financing, so as to run no future budget deficits."

In his view, it would be possible to achieve this risk mitigation by dedicating aid funds into giving people access to private health insurance at very low rates in form of a low-cost basic product with add-on options for more extensive needs that the insured could buy as top-up covers. "The public-private partnership would be in regulating all this under a regulatory authority that includes numerous stakeholders, NSSF, hospitals, the MoPH, insurance companies, and also representatives of the stakeholders, the insured," Nasnas enthuses.

This endeavor, according to Nasnas, is on the agenda of public and private sector stakeholders today and would involve the entire qualified insurance sector as a private stakeholder, but under a tight regime of accountability and transparency with participation of stakeholders from the international com-

munity who might be willing to help the Lebanese government in financing health coverage: "If we are very transparent and if the donors have a seat on the board of the regulatory and supervisory institutions, proving that there is no abuse or whatever."

As the entire project in his estimation would hinge on international funding and require convincing donors, he cannot predict if international funding and donor support would suffice to move Lebanon into socially equitable universal health care but acknowledges that the prerequisite will be a public-private partnership of trust and transparency. "The solution is definitely a public private partnership," he says, concluding that "the crux of the matter is a change of mindset. The main change of mindset will be to have transparency. If we can succeed in this, it would be a first experience to be duplicated in other areas of PPP."

THE WIDER PROBLEM OF HEALTH

The idea of building sustainable partnerships in health is daunting in the global context. The sheer multiplicity of stakeholders in health will make it more complicated to reach any standard partnership platform anywhere. The prospect of reaching the respective United Nations sustainable development goal, SDG3, "To ensure healthy lives and promote well-being for all at all ages" - is today tainted by detriments such as health cost inflation, losses of social cohesion, global increases in income and wealth inequality, and ever-sharper divergence in political convictions and approaches to defining what constitutes a natural, dignified, good and healthy life.

On the front of medical innovations, unsolved ethical challenges, and divergent quality of life experiences within societies and between countries, humanity in 2023 continues to face risks of exponentially increased, different health speeds between tech dreams of eternal life harbored by some superwealthy and the fates of an estimated 8 billion humans. Most humans are immersed on one hand in the reality of recurrent infectious disease risks for the highly populated countries with specters of epidemics and pandemics, and on the other hand in the hardly less worrying presence of non-communicable lifestyle diseases and chronic illnesses that accompany the progressively higher age profiles and sedentary urban modes of post-industrial denizens in more and more countries.

In the bottom line of health system developments of the past 38 months since the alarm signals of the Covid-19 pandemic shook up everyday life of the Lebanese people, it is to be expected that distortions and dichotomies in the health system will not diminish in the near term. The MoPH-owned strategy for the national health system contains important insights into the system's past and present successes and weaknesses, but it has in itself a fundamental deficiency when measured against two essential components of any viable strategy: a clearly sourced budget and an executable timeline.

Arwan's local production more than doubled from 34 percent in the years before the economic crisis

From the organizational challenges to a rebuilding of basic and advanced insurance for the resident population at large, to operational pressures experienced by private hospitals (see comment page 42) to the reduction in the number of pharmacies – reported in the National Health Strategy as over 15 percent at some point before 2023; Executive's attempt in vain to conduct an interview with the Order of Pharmacists in Lebanon for a current assessment of this segment in the health system – the challenges on private sector stakeholders in the health system must be expected to linger, especially if political barriers to systemic health solutions fail to be removed.

■ The MoPH-owned strategy for the national health system contains important insights

Wins of new and well-structured partnerships in health cannot be sustainable without sound contractual, governance, and finance underpinnings that bind together the multiplicity of stakeholders in health. This is despite the current hopeful signs in provision of mental health services (see 'Last Word'), and of astonishing progress by health system stakeholders as diverse as the pharmaceutical manufacturers and non-profit organizations that operate PHC networks. Some of the latter have evolved into meeting needs for non-PHC supplied medical solutions such as dental prostheses, with the daring (and to some almost cheesy) promise to give the Lebanese people, and at least their beneficiaries, back their smiles.

LEBANON'S FIGHT AGAINST INFECTIOUS DISEASES

BY ROUBA BOU KHZAM

INVESTMENT IN RESEARCH AND EDUCATION CAN IMPROVE PUBLIC HEALTH AND THE RESPONSE AGAINST DISEASES

Lebanon has been historically renowned for its healthcare system; Lebanese physicians have staffed hospitals in the Middle East and North Africa (MENA) region, while travelers have flocked to Beirut for medical tourism. For years, high class facilities and training among the country's university medical centers enabled international standards to prevail and created a trusting and respected environment. This applied to both Lebanon's public and private hospitals and was also demonstrable through their performance during various infectious disease challenges.

Lebanon has experienced several infectious diseases including influenza, tuberculosis, hepatitis A, typhoid fever. The most recent global health pandemic, Covid-19, saw Rafic Hariri University Hospital (RHUH) at the forefront of the country's fight against the infectious disease. With the public healthcare system overseen by the Ministry of Public Health (MoPH), the country's coronavirus response initially centered on state healthcare. RHUH is the largest mental health facility, and has not been without its problems: material and logistical issues, poor maintenance, and unsatisfied staff. Yet despite these setbacks, during the pandemic it transformed into the leading public hospital in the fight against the disease. Though, it should be noted that Lebanon's healthcare system is dominated by the private sector: the country has 157 private hospitals and only 29 public hospitals, according to the MoPH. The public healthcare system is funded by the government and provides

free or low-cost healthcare services, while private healthcare is often expensive, making it inaccessible to many people, particularly those who are uninsured or have low incomes.

Lebanon's fight against Covid-19 began with the MoPH's operational plan which was implemented in March 2020, a few weeks after the first recording of a positive test detected in a woman who had travelled from Iran, where an outbreak was flourishing. As the government sought to contain just a handful of positive cases, restrictive measures were rapidly introduced. Universities, schools, nightclubs, bars, restaurants were ordered shut, and then in a dramatic move, the country's land, sea, and air borders were closed and there was an implementation of a state of emergency. Citizens who had corona-like symptoms; headaches, sore throats, or fevers, were told to stay at home and avoid mingling with others. Severe cases were to be treated in hospitals. During that period, the government's quick reflex in implementing containment measures was widely lauded.

GOVERNMENT RESPONSIBILITY

Led by now caretaker Health Minister Firass Abiad, RHUH played a vital role in caring for coronavirus patients and leading the crisis response. As a 430-bed public hospital, RHUH needed to step up to the challenge and ensure its services could meet those most in need. A collaboration with the World Health Organization (WHO) boosted its services, thanks to the provision of technical support and training to staff, as well as through medical supplies, including personal protective equipment, and creating public awareness campaigns. Despite this external support, the hospital, alongside other public hospitals, was suffering from the country's dollar shortage - a ramification of the economic crisis - which was hindering the ability to import medical supplies.

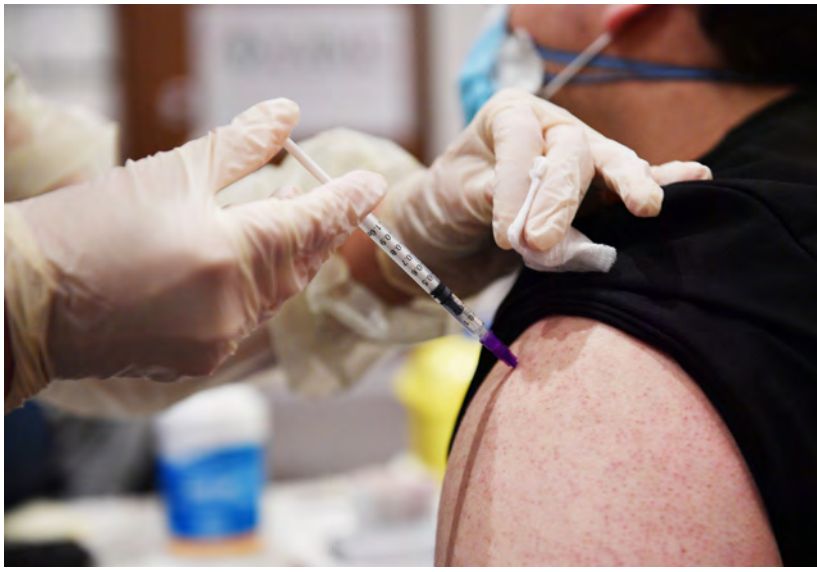
Human Rights Watch (HRW) reported in March 2020 that the government had only paid 40 percent of the dues owed to RHUH from the previous year and was yet to make any payments for 2020. Public hospitals in the north of Lebanon also said they had not received all their reimbursements from the government. Private hospitals, though not at the full mercy of the state, were not exempt from dealing with it. The government owed private hospitals an estimated $1.3 billion worth of unpaid bills since 2011, HRW noted in the same report. The financial imbalance meant the hospitals were struggling to maintain quality services just as the pandemic took hold.

In fact, this precarity was just the start of a long decline in the quality of the health sector. One of the major impacts of the economic crisis has been the dearth of drugs. Despite the government's subsidy policy, basic painkiller tablets to cancer medication have been at times impossible to source. There have been widespread reports of patients and their families scrambling to find alternative sources for drugs; reaching out over social media, scouring the black market, or asking friends and relatives abroad. These stories epitomized the broken state of the health sector: a population left with no alternative but to resort to private initiatives to meet needs.

With this in mind, Lebanon's ability to address infectious diseases like Covid-19, as well as cholera, tuberculosis, typhoid or hepatitis A, is dependent on state finances or the involvement of external aid. This was tested last October, when cholera, an acute diarrheal bacterial illness, was detected in Lebanon for the first time since 1993. It was considered a major regression in public health and was believed to have crossed the border from Syria, where an outbreak was underway. Cases were quickly identified in Akkar, the Bekaa valley and the Baalbek-Hermel regions, mainly in Syrian refugee camps, where living conditions are squalid and access to clean water is not guaranteed for the many thousands of families living there.

Like the coronavirus, the cholera outbreak was another instance of the country's reliance on

The government's quick reflex in implementing containment measures was widely lauded



external organizations, such as the WHO. Due to the WHO's involvement, the cholera outbreak was able to be monitored and controlled, and vaccines were brought in by the WHO and distributed among refugee communities. But such measures have been simply band-aid responses, and health experts have warned that without a thorough reform of Lebanon's water system and improved sanitary measures, there remains a risk of future disease outbreaks. The crisis also highlighted that without this external support, the government alone would struggle to contain the disease.

Dr Aline Mouchaham, a specialist in regenerative medicine, says disease outbreaks could become more common: "The lack of adequate funding and resources has resulted in a shortage of medical supplies, equipment and testing kits," she tells Executive. Mouchaham also says that disease outbreaks are likely to occur in areas where there is conflict, inadequate waste-water management, contaminated water, and accumulations of garbage. These conditions are often prevalent among Lebanon's poorer communities, who live in overcrowded and unsanitary conditions, which can increase the chance of infections spreading rapidly, she says. The situation is worsened by the lack of access to health services for these communities. "It is not surprising that Lebanon experienced a cholera outbreak when large numbers of displaced individuals lack access to clean water, proper hygiene, and healthcare," Mouchaham says.

■ Without this external support, the government alone would struggle to contain the disease

THE BLIND SPOT: THE LACK OF SCIENTIFIC RESEARCH

"It is disheartening and astonishing to witness individuals prioritizing their personal beliefs over scientific evidence and expertise, especially in times of crisis," Dr Tamara El Zein, the secretary general of the National Council for Scientific Research, tells Executive. El Zein points out that the lack of awareness and access to reliable information about diseases can have significant implications for public health. In the context of infectious diseases, this can lead to delays in diagnosis and treatment, and ultimately contribute to the spread of disease.

"For example, during the Covid-19 pandemic, there were concerns about the accuracy of information being disseminated on TV and social media, which may have contributed to confusion and mistrust among the population," El Zein says. The debate in Lebanon about the Covid-19 vaccine, which was warped by fake news and disinformation campaigns, highlighted a broader issue in public health about the importance of access to safe and reliable information. "Some people believe that vaccines can cause harm or are part of a larger conspiracy to control the population," El Zein says, before adding: "However, these beliefs are not supported by scientific evidence, and it is important to look at the history of infectious diseases in Lebanon and the lessons learned from past experiences." El Zein touches upon a concern for the MOPH to tackle public misinformation and the need to place greater resources on awareness and information campaigns.

Past disease outbreaks in Lebanon have surfaced from a variety of factors, including poor vaccination coverage, inadequate health infrastructure, and a lack of importance placed on vaccination and disease prevention. "Without a connection between scientific research and society, individuals are limited in their ability to educate themselves about the advancements in science, particularly with regards to vaccines and their benefits," El Zein says.

Prioritizing scientific research that matches the

challenges is essential, according to El Zein. More targeted and impactful research can lead to the development of expertise and knowledge in specific areas. "For example, Lebanon now is facing a high incidence of cancer cases; it would be more beneficial to invest in research that focuses on cancer treatment rather than research on artificial intelligence," El Zein says, noting how research can have a direct benefit to the population's wellbeing.

Strengthening the scientific culture in Lebanon can have a positive impact on the status of the public health system. For example, through the promotion of science education and "encouraging scientific inquiry and supporting research institutions." This can be achieved through partnerships between academia, industry, and government, as well as promoting interdisciplinary collaboration, El Zein says. In addition, supporting development of research infrastructure and increasing funding for research can enable the scientific community to address the challenges posed by infectious diseases. "By prioritizing scientific research and promoting a culture of evidence-based decision-making, Lebanon can better protect its citizens from infectious diseases and build resilience against health threats," El Zein says.

COMMUNITY EFFORTS

The Covid-19 pandemic brought to light the importance of community awareness, engagement and response in public health campaigns in responding to infectious diseases. Taking recent infections as examples, one of the main drivers of cholera and coronavirus' rapid spread was the lack of communication and awareness among the population. "This is a reminder that we need to be ready to respond to outbreaks at all times, and that means investing in things like clean water and adequate healthcare facilities," Mouchaham says.

Regarding community engagement, Mouchaham notes: "It involves educating the public, clarifying any doubts or misunderstandings, and engaging community leaders and organizations in response." Individuals must also do their part by practicing good hygiene, wearing masks, and social distancing. Infectious diseases can be spread easily and quickly, and each person has a role to play in preventing their spread. If individuals take responsibility for their own health and wellbeing, it can ultimately help to reduce the burden on the healthcare system. "Outbreaks can be stressful and challenging but is important to remain focused on the goal of protecting public health and working together to overcome the challenges," Mouchaham says.

> "We need to be ready to respond to outbreaks"

A GLIMPSE INTO THE FUTURE OF PUBLIC HEALTH?

BY THOMAS SCHELLEN

A Q&A WITH LEBANON'S MINISTER OF HEALTH

At the nexus of the Lebanese health system with its numerous components and competing private stakeholders, and as a historic refuge of last resort for those in desperate need of medical services, the Ministry of Public Health (MoPH) represents both all that is excellent and all that has been deplored in the narrative of the people's experience with medical treatment, care, and prevention. At the conceptual core of the ministry's – and the entire health system's – future today towers the National Health Strategy: Vision 2030. To fathom its promise, Executive sat down for an in-depth interview with Dr. Firass Abiad, the caretaker Minister of Public Health.

E The National Health Strategy Vision 2030, along with many goals, makes a strong case in presenting past achievements of the Lebanese healthcare system, demonstrated in improved health indicators in the years up until 2020, but also reveals numbers related to shocks suffered by the system in recent years. For example, the Vision 2030 document states that "excess mortality rates of 15.4 percent in 2020 and 34.4 percent in 2021 were recorded mostly due to non-Covid 19 related illnesses." Did this excess mortality rate already reflect the economic crisis in its asperity?

Probably. It is very clear that starting with the financial crisis in 2019, patients faced many limitations to access [of health services]. We had already seen this at Rafic Hariri [governmental hospital] where we were noticing more late presentations among patients that were coming to the emergency room. The second thing we noticed was [an increase in] the average size of the tumors we were operating on. The reason for that also was probably that people were going to the emergency room later in their disease. Especially early in the crisis, patients had almost no access to their money and access to care became a problem. This is reflected in many of the numbers that we have seen.

E Do you assess this high excess mortality as a problem for years to come or do you expect it to recede again?

There is no doubt that our health system is more fragile than it was. But we are seeing that the health system is still coping in different respects. With all this crisis, it is amazing that the health system is still standing on its feet. But we are witnessing that people have less and less financial protection of health and have to pay more and more out of pocket for their healthcare.

That means that especially the most vulnerable will have limitations in access to care; and this is worrying because it might be reflected in excess mortality.

E Universal health coverage is a declared target of Vision 2030. But was it not so that a form of universal health coverage was present before the crisis?

The health packages available [back then] were such that the Lebanese had a lot of access to advanced care, whether at the hospital level or at the level of innovative medication. What was unfortunate was that there were areas where people were covered less, especially when it comes to secondary care and also to primary care. The vast majority of the Lebanese were not enrolled in primary health-

care centers or had a primary healthcare physician. If they got sick, they would directly go to a specialist. We know that this is much more expensive than [care is] in a system that has set up a primary healthcare (PHC) network. This is why one of the major points in the national strategy is that we need to shift more to a PHC-based health system, and we are talking about preventive care and primary care more than about innovative medicines and hospitalization.

How many primary healthcare centers are currently under the supervision of the MOPH?

It has gone up to just above 270.

I was told at one PHC that the number of annual visits has increased to over 200,000 from about 49,000 a few years ago. Is this a typical rate of increase for the PHC system as a whole?

Yes, it has tripled or almost quadrupled in most of the entire system.

Are there plans to further expand the PHC network?

What we are working on is sustainable financing for the PHC. We are very weary of expanding the network without proper financing that will allow us to have sustainability.

A central financial insufficiency of the healthcare system in general seems to be that funding is today largely dependent on the international community and donors.

That is correct, and especially so in PHC. The primary healthcare program is heavily supported by the international donors. This is welcome but it is unsustainable. Therefore, we have been working on a transition where Lebanon is able to put more support within the PHC system.

Is there a figure on how much annual financial support has reached the PHC system from all the diverse international donors and funders?

We believe that it is anywhere between $70 to $100 million annually. [Taking into account the global situation], it is clear that there are other crises, donor fatigue, and other priorities that prohibit expecting this to continue in the long term. That is why as the Lebanese government, we want to move more and more into supporting [our PHC system].

The Vision 2030 document speaks of integrating "WHO building blocks", "essential public health functions" and frameworks of six or seven health system components, or perhaps what one could call distinct systemic pillars that compose a well-functioning health system. Would you please explain what the frameworks refer to and how they rank in priority?

I like to put them as five areas as I like to combine the financing and governance. Thus to me, the five pillars are financing and governance as one pillar; then the second pillar of the health services delivery, which moves more towards having the primary healthcare program as the cornerstone; the third is the health security, which is reflected more in the public health functions at the ministry, such as emergency preparedness, the central public health laboratory, and quality control. The fourth pillar is the healthcare workforce, which we believe is going to be the biggest challenge in moving forward, and the fifth one is the digital transformation.

Is this characterization of a health system coming from the World Health Organization (WHO) and could it therefore be interpreted as mental framework that was superimposed as an international theoretical model on the Lebanese National Health Strategy?

The WHO was part of the process. This [National Heath Strategy] was a document that we wrote together between us and the WHO, and our vision on the future of health in the country is very much aligned. But it is not just a WHO document. It is important that this is a document that is fully endorsed by the ministry and fully owned by the ministry. The ministry had several active participants in the process of coming up with this document.

> "There is no doubt that the health system is more fragile than it was"

You noted that the component with the greatest challenge going forward is likely to be the human capital pillar. Which pillar would you say will be least problematic?

I think all of them are challenging, simply because we are working in a resource-poor environment. One of the things about systems in health is the word "interdependence." Each one of these pillars depends on the other and has an impact on the other. For me, it is not anyone of these pillars that is easier than the others, but I think that the human capital is always going to be a big challenge, simply because it is a universal challenge and not just a Lebanese challenge. We are unfortunately seeing an attrition of the human capital in health [everywhere] and this makes it even harder for Lebanon to address. Especially within the current circumstances, we are seeing a lot of people who want to move out [of Lebanon].

If one looks at some incongruences in the health system that are not directly covered in the five structural components of Vision 2030, one of the issues flagged in the document were supply-side driven, exaggerated ex-

pectations by patients. Are you still facing strong patient demands for branded import medicines that carry higher costs than the equivalent generic medications?

This is the issue of supply-induced demand, which is one of the areas which we are addressing in our drug policy. We have moved forward quite well in that direction of better managing our drug bill. If you look at our bill for [medical] drugs, Lebanon used to spend almost $370 per capita before the crisis. That is almost as high, if not higher than the average in OECD countries. Denmark, for example, spends $380 [annually per capita] in average on medications. This [sending pattern] is obviously something that could not be continued after the financial crisis. However, despite the fact that we could bring our drug bill down, when considering that Lebanon is now a low-middle income country, it is still higher than what is expected. The way we have worked around our drug bill was first concerning generics. We brought a lot of generics into the country, and we have been advocating for the use of generics. I think also that people have become very price sensitive and [shifting to generics] is something that resonated well with the people. The second was that we introduced protocols and guidelines for the use of innovative medications. This has also helped us control how much we pay for those medications. Finally, we have been working very hard on supporting our local pharmaceutical industry. We have seen their market share – in the products that they produce – move from almost 20 percent to 75 percent.

> "We brought a lot of generics into the country, and we have been advocating for the use of generics"

On the flipside of the equation, are the domestically produced generics getting enough acceptance and respect in the population?

Gradually, they are; the proof is that their market share has increased. Clearly, people are buying those medications. Knowing that the other [imported brand medications] are available, I think that [generics] are being well received as people are trying these medications. These are some of the opportunities that are lying in the crisis.

Is there a number on the current per-capita spend on medications?

Our estimate is that it is almost $170 per capita per year now, and our importation bill is down by 50 percent.

Does that mean that our lower importation bill of medication is not an indicator that the availability of medication is lower by the same degree?

Especially when it comes to most of our chronic diseases, patients are able to find their medications. I [note that] shortages of medication are now being seen all over the world because of problems of interruption of logistics and other reasons. In Lebanon, we have been able to address many of the shortages that we have had previously, and from where I can see it, the situation is better.

The Vision 2030 document mentions several committees and funds to be established, such as a health financing and coordination committee, a health insurance authority, a Health Crisis Response and Recovery Fund and a Health Crisis and Recovery Council. What is that Health Crisis and Recovery Council about?

This is part of the first pillar, which is governance and finance. All of this stems from the fact that if you look at the way in which we governed health expenditure in the past there was a lot of fragmentation. What we wanted to achieve in this difficult time was create a more participatory decision making to allow everyone to have ownership and understand what we are doing. That was why there is a lot of talk about the Council and about bringing people together.

From the perspective of universal health coverage versus the idea of universal health insurance, how much would it cost annually to have universal health coverage in something like two years from now?

Let us compare this with [the situation in] some countries around us. In Turkey, the expenditure per capita was around $370 and they were providing universal health coverage. At the same time, Lebanon was spending around $680 per capita, and we were not providing universal health coverage. This attests to a lot of inefficiencies in the expenditure. The crisis that we are passing through is an opportunity for us to address those inefficiencies. The challenge is how we can work around those inefficiencies without limiting access, especially to the vulnerable for whom access to care is becoming much more difficult.

Leaders in the private insurance industry told me of plans for gradually filling the gaps in affordable access, beginning from filling the gap between health costs and the offerings of the NSSF. How do you view such concepts?

We have been working with the private insurance [industry] on several different schemes, some of them relating to private healthcare and some to insurance, whether a complementary insurance or introduction of micro-insurance schemes that we are seeing in other countries that are in the same position as Lebanon. It would be interesting to see if we could agree on some of those.

Do you have any models in mind that are successful in other countries that you think Lebanon could emulate?

There are several models, but the issue is that there is no universal model that everyone is following. Each country is creating a model that is customized to its needs and to its resources. The problem with Lebanon is that we are a country that is in rapid transition, which we have not finished. This makes it more difficult to create stable programs, because of the day-to-day changes in the situation.

Among the many levels of transition, how could the human capital at the MoPH transition into a situation with enough supply of qualified employees and civil servants?

We have been working on this with some of our international partners, but it requires a lot of development funding. Unfortunately, in the current situation, not much funding is allocated to development. Most of the allocations that are made are going to humanitarian support. This has affected our ability to build capacity or do task shifting and other things that we wanted to do. We hope that now, with the introduction of our strategy that makes visible to everyone what we want to do, international partners can come and help us with these things.

By how much has the staff at the MoPH decreased if one were to compare the levels at the end of March 2023 with those at the end of March 2018?

It is very difficult to say. If you are talking about the MoPH itself, I would say around 20 percent. But if you look at the government hospitals, the number might be even higher than that.

Does a 20 percent contraction in public health staffing at MoPH or government hospitals signify a severe attrition of human resources?

Twenty percent might not sound like a lot, but if you look at many of those who left, they tend to be the people with the higher skills. Thus I think that the impact of those who have left is much larger than what the number would suggest.

One of the intrinsic problems in the Lebanese political governance system, which also appears to affect the MoPH, is that ministerial chairs have been more of hot seats than places where you can develop a strategy over the long term. Is this a problematic factor for the new National Health Strategy?

[In most countries] ministers come with their mandates, but a lot of the longer-term work is done by the [senior ministry officials] and civil servants. Lebanon has been an exception, especially post-Taif, where a lot of the problem was with the ministers who not always were people coming with the right background to take a certain sector forward. Irrespective [of that], about your point regarding the hot seat, I think that with the crisis, that seat is extremely hot at the moment. I would also say that within the crisis lies an opportunity for change and that is why [we have] the National Health Strategy.

> "We have been working with private insurance on schemes"

You have been described to me by industry leaders, and have even been portrayed by some media colleagues, as very clean, performance oriented, and competent. Did you have to take a crash course in politics in order to be the minister?

In politics? I took a crash course in public management when I managed Rafic Hariri Hospital for six years. Managing within the public sector has its own challenges, which is something you do not see in private sector management. I think that the time I spent managing Rafic Hariri University Hospital, which is the largest public hospital in Lebanon, during different crises, including the Covid crisis, were good preparations for the job I am doing now.

You wrote in your introduction to Vision 2030 that a "high-level political will" will be needed for passing this strategy into legislation. Is there enough political will on the horizon?

At the end of the day, it is in their interest even for politicians for the population to receive health services. From that aspect, I don't think that there is political will not to provide services. The question is if there is a political will to make the required sacrifices. For example, when we talk about unification of public guarantors, each public guarantor is obviously a fiefdom and when you talk about unification of this, there are many political interests that have to be sacrificed. Also, when we talk about efficiencies, that will affect employment, performance, and a lot of the contracts that are in place. All of this will require some kind of political support. But what is important is that without those reforms, the system will stay broke. The clear message of the health strategy is that it is not an optional strategy. It is a mandatory way forward, especially within the context of low resources.

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PRIVATE HEALTH CARE AT RISK: CHALLENGES AND SOLUTIONS

BY ROULA GHARIOS ZAHAR

THE ONCE FLAGSHIP SECTOR NEEDS URGENT RESCUE

According to several international studies published by the World Health Organization and Bloomberg, Lebanon's healthcare was ranked in the top tier class among healthcare systems in the world in both 2015 and 2017. To illustrate this point, the Lebanese living abroad prefer to be treated in Lebanese private hospitals as the quality of care is comparable to high international standards and waiting times to perform procedures are close to zero (it is even several months in some developed countries such as France, Canada and the UK).

Thanks to its high ratio of qualified physicians, private investment, hence the availability of the latest treatments and medical equipment, Lebanon was able to score extremely well in all major international health indicators such as life expectancy, maternal and infant mortality, and disease control. This situation was key in addressing the Covid-19 pandemic which was relatively well managed in Lebanon. For these reasons, the consequences of the economic crisis took longer to impact the healthcare system.

The 2020/21 subsidization policy of the Central Bank provided short-lived relief, though it was an expensive policy for the government and caused shortages, imbalances, and the hoarding and smuggling of medication. Today, the Lebanese health sector remains among the top performers in the country in terms of quality medical care and the availability of services, although it is facing serious threats.

HOSPITALS, PATIENTS OUT-OF-POCKET

In Lebanon, a large portion of the population historically has been covered by employers of the private sector, while the other portion is covered by the government and individuals. As all public services (including the National Social Security Fund) have not adequately adjusted their payments since the Lebanese pound's decline, most Lebanese are left with practically no medical coverage. The absence of the NSSF and governmental co-payment coverage, along with the soaring costs of hospitalization, is resulting in substantial out-of-pocket payments for hospital services, exams, and medication, jeopardizing the access to care for the poor, the very ill, and uninsured population. Along with this financial coverage issue, the sector witnessed

shortages in medication due to the unintended consequences of the subsidization policy of the central bank. The high cost of oncology drugs and the partial lifting of subsidies in 2021 has left countless cancer patients without treatment and dialysis patients with the terrible prospect of having no access to care.

Along with financing problems and medication shortages, another serious threat to the healthcare system is the brain drain, as physicians and nurses are departing "en masse" towards better-paid jobs and better living and working conditions abroad.

Private-sector healthcare providers nevertheless have been innovative in circumventing the consequences of the crisis. Better salaries and job flexibility – such as the ability to partially work abroad - have been offered to healthcare workers. Prices have been revised to adapt to the high costs. Solar panels have been installed to reduce energy costs. Mergers and acquisitions have also been trending in the sector. Cash flow has improved by the de facto reduction in payment delays resulting from cash transactions. By the end of 2021, the private insurance companies converted their prices into US dollars and had obtained substantial discounts from hospitals, allowing them to gain important market share and provide coverage to middle- and upper-class populations.

At Mount Lebanon Hospital University Medical Center, there has been a massive brain drain. Since 2019, 120 physicians and about 150 nurses have left. The hospital has been fighting to avoid shortages in life saving medication, which it did at a high cost (by direct imports and high inventory which ultimately resulted in expired products being discarded). For the past two years, chemotherapy drugs have been unavailable for numerous patients and remain so today.

In order to retain our existing staff, salaries have been offered in US dollars, alongside medical insurance and schedule flexibility. The hospital has also had to reduce the number of beds by 20 percent, down from 250. Another catastrophic issue that we are facing is the unaffordable costs of dialysis sessions, which cost hospitals $60 per session and are currently reimbursed at 2.5 million Lebanese pounds (equivalent to $25 per session). Several attempts have been made to increase the prices and index them to the dollar and improve the payment delays to prevent further losses, but negotiations are stalling and payments are pending since the beginning of 2023. The official reason is that the NSSF board is not meeting to renew the budget. Dialysis patients are extremely vulnerable and cannot skip any of their sessions and are in an absolutely devastating situation.

The hospital is looking for an alternative financing scheme through private insurances, international franchising projects and diversification into paramedical activity lines, in a hope to overcome these challenges.

ALTERNATIVE INSURANCE SCHEMES

Several initiatives are being studied by an expert group at RDCL - the Lebanese Business Leaders Association - health GPA committee, whereby the private sector is proposing a project that conceives complementary, employer-sponsored, mandatory private insurance for the employees of the private sector with proper governance.

Despite these efforts, the challenges resulting from the Lebanese pound devaluation and the slow pace of change in prices of healthcare services is putting pressure on hospital costs. The increasing cost of fuel, supplies, maintenance, and salaries, along with shortages in medication, and shortages in qualified healthcare workers are creating worrisome challenges. In such precarious conditions, hospitals will no longer retain competent healthcare professionals, be able to pay maintenance fees, or update their equipment.

To retain our existing staff, salaries have been offered in US dollars

This will cause a contraction in the sector, leading hospitals to reduce the number of beds or even to close while avoiding any additional investment in equipment. The aggregate offer for healthcare services will decline, driving costs higher and reducing quality. We will end up with the waiting queues that the Canadian, British or French experience. This is a serious threat to the population and will foremost affect vulnerable groups, but also citizens' ability to work, produce and grow. It may well induce social unrest.

Several objectives should therefore be envisaged for the long-term sustainability of the system:

1- Guaranteeing access to basic healthcare for most of the Lebanese population - in an optimized and equitable manner - without having them endure financial hardship;

2- Ensuring medication availability and access throughout the country;

3- Providing a healthcare workforce retention strategy to prevent further losses of human resources;

4- Supporting and upgrading the healthcare system's infrastructure to ensure continuous quality care.

The Lebanese health sector deservedly has been described as a flagship in the region. Before it is too late, this vital sector should be rescued from the claws of the financial and economic crisis.

Roula Gharios Zahar is co-founder and deputy general director of Mount Lebanon Hospital

A CHECKUP ON THE BEATING HEART OF HEALTHCARE

BY THOMAS SCHELLEN

PRIMARY HEALTHCARE CENTERS HAVE BEEN PLAYING A GREATER ROLE IN SOCIETY

THE GROWING IMPOVERISHMENT AMONG THE POPULATION MEANS THE AVAILABILITY OF AFFORDABLE HEALTHCARE HAS BECOME AN ESSENTIAL ASPECT OF MEETING BASIC NEEDS TODAY. PRIMARY HEALTHCARE CENTERS HAVE EMERGED AS AN OPTION FOR LEBANESE STRUGGLING TO ACCESS NOW UNAFFORDABLE PUBLIC OR PRIVATE HOSPITAL CARE. EXECUTIVE VISITED TWO MAJOR CENTERS, THE KARAGHEUSIAN PRIMARY HEALTHCARE CENTER AND THE ST. JOHN THE BAPTIST COMMUNITY HEALTH CENTER, TO HEAR ABOUT THEIR OPERATIONS.

It is a crisp spring morning. Life is awakening on the streets of Bourj Hammoud. The sun strafes the rooftops of the countless low-rise apartment buildings that huddle cheek to jowl along alleys in the densely populated town, which is an integral part of the Beirut conurbation. While shops start opening along streets that are often barely wide enough for a small truck, life is already bustling at the Karagheusian Primary Healthcare Center (PHC), an unassuming complex of four buildings tucked away in a side street near the Beirut river.

The odd journalist and even a visiting delegation from an international funder organization coming here this morning (independently from each other) are immersed in a steady stream of visitors to the Karagheusian PHC. They are locals and resident refugees seeking relief from toothaches and eye problems, mothers looking to have their children vaccinated, persons in need of medications for their chronic ailments; they are the sick, weary and the suffering of many backgrounds and communities who have made Bourj Hammoud their home and live mostly in walking distance.

"We have a multi-disciplinary team of healthcare workers, both full-time staff and physicians who work with us half-time or part-time in such a way that 30 clinics in our 500 square-meter compound are ready to receive patients throughout the day, so that our center is able to welcome 700 pa-

■ The flows of the ailing never cease in Lebanon and elsewhere, but Lebanese residents' needs for affordable healthcare have quadrupled

tients per day. This is our philosophy: we are here to provide healthcare services for all. We believe that primary healthcare should be attainable, accessible, affordable, sustainable, and continuous for all, without discrimination," says Serop Ohanian, the center's director.

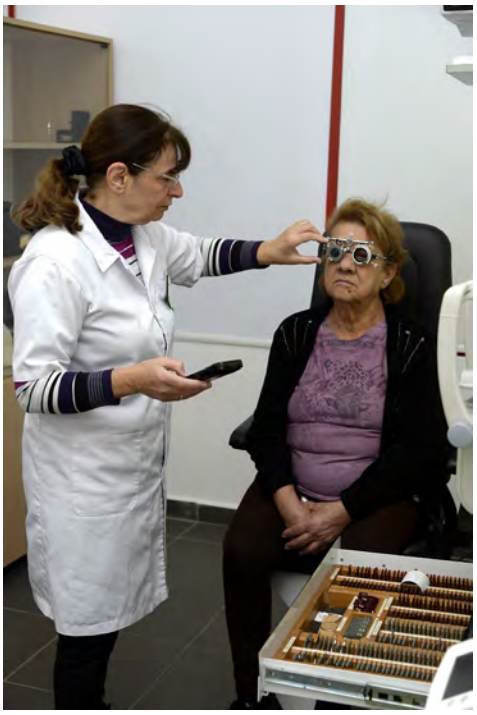
While I have splurged 200,000 Lebanese pounds or the equivalent of about $2, on a ten-minute taxi ride coming here this morning, and whereas nearby shops – advertising apparel such as $4 skirts, $5 belts, and $6 tops – visibly seek to cater to consumers with very modest purses, those with even tighter purse strings are served at the Karagheusian for a consultation fee ranging from an amount as symbolic as 30,000 Lebanese pounds to at most 200,000 Lebanese pounds for some advanced services. The fees for the standard PHC offerings represent a meaningful sacrifice to patients here and according to Ohanian are still a barrier to too many, even as in spring of 2023, 30,000 Lebanese pounds is just a few dimes for people who have access to livable amounts of veritable cash.

That the poor and needy are present in all types of societies is a historic truism. The flows of the ailing never cease in Lebanon and elsewhere, but the Lebanese residents' needs for affordable healthcare have quadrupled when comparing present beneficiary numbers to those of 2019. More than reflecting the Covid-19 pandemic and the economic

■ The number of beneficiaries at this PHC has exploded tenfold in the space of a decade

crisis, however, the rapid growth in needs commenced with the arrival of refugees from Syria around 2012. The number of beneficiaries at this PHC has exploded tenfold in the space of a decade, increasing from around 20,000 in 2013 to some 200,000 visits in 2022.

It is not in the least coincidental that the affordable provision of services at a long-standing charitable organization in Bourj Hamoud is done under a partnership of stakeholders, which includes the Ministry of Public Health, foreign donors and international NGOs, as well



"After 100 years, history is repeating itself. We are still seeing refugee crises and pandemics"

as the Karagheusian organization in its position as a local NGO.

According to Ohanian, the government's growing enthusiasm for primary healthcare objectives such as disease prevention and health promotion in recent years has led to more and more synergies and partnerships between the public sector and local NGOs which have been delivering charitable works in Lebanon since the 1960s and 70s. "There is a commitment by the government to create synergies and there is a commitment from iNGOs to keep primary healthcare functioning as the best way possible," he says.

Encased in this narrative of new synergies of social and charitable stakeholders, there is, however, a connotation of the persistent human inability to address predictable human needs without first having had to witness the impact of reiterated human decision errors. Explaining that the roots of the Karagheusian organization, which operates PHCs in Lebanon and Armenia, link back to both the early 20th century refugee experience of the Armenian people and to one Armenian family's tragedy of losing a teenage son in the 'Spanish flu' pandemic, Ohanian says that "as an organization we have tasted the meaning of pandemic, and the meaning of refugees, and today, after 100 years, the history is unfortunately repeating itself. We are still seeing refugee crises and still seeing pandemics."

"I am on a mission". The center's oldest and longest serving volunteer, Victoire Douaihy Massoud.

THE PHC AS PARADIGM

Notwithstanding the massive likelihood that humanity's baseline problems in assuring dignity and healthy living environments for all planetarians will not be solved in any digitally empowered future, the importance of Lebanon's shift to a health system engineered from a cornerstone of primary healthcare centers is a positive momentum in the midst of the ongoing socioeconomic troubles. Simply said, PHCs appear more and more as the beating heart of not just the health system but also of social hope, community and solidarity.

Both a witness to and a monument to this recent and still unfolding shift in the Lebanese health system is the St. John the Baptist Community Health Center in Chiyah. Operated by the Order of Malta in Lebanon (OML) as a flagship facility in a network of OML's eleven primary healthcare centers and additional mobile clinics around the

The facility was the first in Lebanon to receive a license as a PHC in the late 1990s

Majdaline discovered the center one year ago and has been coming ever since

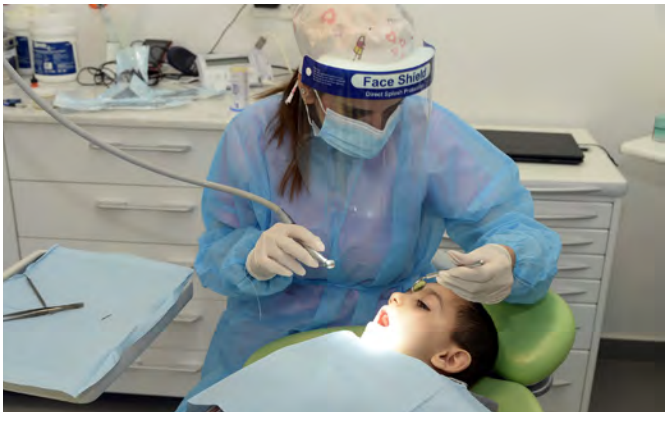
Elie, a long-standing beneficiary who says the center is like family

country, the current four-story building in Chiyah comprises 14 consultation rooms, a pharmaceutical dispensary, two laboratories, general admission and administrative areas, and a training center, plus an underground warehouse for medical drugs. The PHC serves 450 to 500 patients per day and has 35,000 families, comprising close to 180,000 persons, registered in its database, says Laurette Matar, the director of the center.

Located southwest from Bourj Hammoud in the Beirut conurbation, the facility abuts what during the civil war was a demarcation line between territories controlled by different parties to the Lebanese conflict. Today a peaceful footpath with – rare for Beirut – urban greenery runs behind the center that is situated beside a church and sports courts amidst spread-out apartment buildings. In general, the quarter where the St. John the Baptist Community Center is located looks like a quiet neighborhood and disturbingly normal street in the context of Greater Beirut, meaning a street where undeveloped plots would benefit from tender care and one where motorists are habitually oblivious to traffic rules.

Still, in terms of the Lebanese PHC story, this is something of historic ground. In service as a community center since 1989, the facility, according to Matar and OML spokesperson Oumayma Farah, was the first in Lebanon to receive a license as a PHC when the government started acknowledging the validity of the national health system's PHC building block in the late 1990s. Initially a structure of consisting of one and a half floors, an expansion project was initiated in 2017 but delayed until con-

■ The facility conveys a strong sense of identification with the PHC's mission of serving all who suffer without distinction



struction and refurbishment was accomplished during an 18-month period up to early last year, while the center kept operating in the basement of the adjacent church under pandemic and economic restraints.

The center's oldest and longest-serving volunteer, Victoire Douaihy Massoud, remembers how in the center's early years of operations the bombings and shelling of the civil war years constituted the main fears of visitors. To her recollection, those fears of violence were not as encompassing and damaging to people's quality of life as the multi-faceted worries of the ongoing economic disaster. At the start of the 1990s, when the St. John Community Center was first operating from a converted military outpost, "people's fears were triggered by bombings, but nowadays their fear is the fear of not being able to take care of their basic needs, of finding medication. Even with the bombings of the civil war, people were able to secure their daily needs, but the fear is bigger now. The situation is perceived as full of danger by the Lebanese today," Massoud tells Executive.

According to OML officials, this observation is further supported by the fact that OML was compelled to add special training programs for its PHC staff to mentally equip them for dealing with frustrations and anger, especially at the beginning of the crisis when people felt that they had no other choice left.

As a strong sense of identification with the PHC's mission of serving all who suffer without distinction is conveyed by long-serving volunteer Victoire, and it deserves stating that the same community spirit permeates the work of young and older staff members and professionals at the PHC. Administrators, warehouse employees, social workers, dental technicians, pharmacists and a specialist doctor in gynecology and obstetrics at the center, all describe or silently emanate a sense of belonging to a place with a mission that flies in the face of defeatist sentiments that one encounters in abundance in less purpose-oriented social and economic environments. "We [medical professionals] have the choice of working in other countries, or in my case going back to Paris. But every time, we chose Lebanon, because the lifestyle is good, the family is here, and we have a moral obligation to stay," says obstetrician Dr. Julien Lahoud, on the side of conducting an ultrasound examination.

Several patients who are relying on the St. John Community Center as long-standing or recent beneficiaries are also not at all reticent to share with Executive what PHC access means to them in practical terms and in terms of emotional stability and communal belonging. Beneficiary Majdaline readily explains that she discovered the PHC one year ago as a home care team came to provide her mother-in-law with medication and checkups. She has been coming to the center ever since and because she is widowed and a caregiver for her mother-in-law, the PHC is now a central part of her social and mental safety. "Were something to happen to the center, of course, I would be very much affected. If the center closes, I would no longer be able to get the medicine that my mother-in-law needs. I rely on this center, next to the fact that I trust and rely on my God," she says.

For Elie, a long-standing beneficiary, the center appears to fulfill the function of his extended family. "I have been coming to this center for 20 years and more. The beautiful thing about it is the welcoming [attitude]. There is discipline, it is clean, they welcome you, and they take special care about the elderly. I come here every day to do my exercise walks," he tells Executive, further emphasizing how he sees the staff members arrive every morning well in advance of the center officially opening its doors to the public at 8am. As he has been relying on the center to help his cancer-afflicted wife, he cannot see himself living without being part of the center's spiritual family. "I have personal relationships with the people of the center, and if they were to close for any reason, it would be like losing my lifetime friends. I would be affected in my mental health and in my financials."

■ PHCs appear more and more as the beating heart of not just the health system but also of social hope

Fees for consultations and services – which are

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increasingly extending beyond the range of primary healthcare also at this center – are assessed on basis of social need and in accordance with rules set by the MoPH. "A new patient will meet our social worker. She will conduct a social vulnerability assessment so [the patient] can pay a participation that preserves her dignity," the center's director Matar explains. She elaborates that the standard fee at a first consultation is currently 18,000 LBP per patient as per MoPH stipulation (which she expects to shortly be adjusted again) and disbursement of medications for patients with chronic diseases is 12,000 LBP per month.

Very important beyond the equation of international subsidies and affordable access to health in the short-term, in the views of Matar and Farah, is to note how a facility such as the St. John Community Center has contributed to dissolving social taboos against receiving aid and how the PHC system has become accepted and embraced by the people they serve. "The people who were most affected by the crisis and who lost all their savings, were the middle class who had worked hard all their lives," Farah emphasizes.

For many clients, asking for help in such a place as a PHC was a huge taboo, she adds: "They faced the dilemma of either not being able to take their medications which they could not afford to pay for in the market or to come to a PHC. And this is why it is so important for a center such as this one to provide a quality that is even better than what is found in some privately run clinics. The dignity of the people who come here is of greatest importance to us, especially since we know that those who cross the threshold of our doors, have already seen their dignity shattered."