hsr2020
SIXTH GLOBAL SYMPOSIUM ON HEALTH SYSTEMS RESEARCH
بحوث النظم الصحية
8 - 12 NOV 2020
DUBAI, UAE

The Political Economy of Non-Communicable Diseases in Fragile Lebanon: Identifying Challenges and Opportunities for Policy Change and Care Provision Reform

Presented at 6th Global Symposium on Health Systems Research, November 8-12, 2020

Dr Ibrahim R. Bou-Orm; Dr Karin Diaconu; Dr Pol deVos
Institute for Global Health and Development, Queen Margaret University – Edinburgh, UK

ibouorm@qmu.ac.uk **@ibouorm**

RUHF
RESEARCH UNIT ON HEALTH IN SITUATIONS OF FRAGILITY

@NIHR_RUHF

Introduction

- Lebanon is a middle-income country facing substantial fragility features.
- Non-Communicable Diseases (NCD) accounts for an estimate of 91% of all deaths in Lebanon with an increasing burden of NCD risk factors in urban settings.
- Adoption of evidence-based NCD policy and systemic reforms for targeting this burden is challenging in Lebanon
- Analysing the political economy of NCD is essential recently to identify gaps and opportunities for NCD policy change.

Methods

- The study research design is an embedded single-case based on a literature review using a problem-driven political economy analysis framework.

Results

Problem definition :
Worsening epidemiology of NCDs in Lebanon with high burden in terms of morbidity and mortality suggesting the inability of Lebanon to achieve several global targets related to NCD prevention and control

Structural factors
- Complex and dysfunctional routine in governance with frequent deadlocks within a political system based on confessional power-sharing;
- Failures in adopting economic reforms with striking poverty and unemployment levels and widened wealth inequities;
- Ageing population and unplanned urbanization along with the Syrian refugee crisis;
- Negative impact of globalization on local policy-making regarding determinants of health

Institutional factors (formal and informal)
- Limited capacity to adapt a health-in-All-Policies approach to NCD prevention
- Blockade of NCD prevention policies by opposed powerful stakeholders
- Limited economic growth and inadequate resource allocation implying weak financing and therefore compromised health coverage
- Highly privatized hospital-centred care model leading to healthcare commercialization and inequities in access to NCD care and NCD clinical outcomes
- Incremental reform towards strengthening a civil-society led primary care network but with limited institutional regulation of private outpatient services.

Stakeholder power and interests
- Opponents of policy change and system reform include the private health sector and industries with the highest power level as well as selected ministries and the parliament.
- Proponents include the MOPH and its partners (like international donors, civil society and academia) with various power levels
- Power imbalance towards policy / reform blockers is fostered by Lebanon structural factors and affects its institutional capacities

Political economy analysis identifying

Recommended solutions
- Policies limiting the availability and affordability of unhealthy products (eg WHO Best-buys)
- Comprehensive person-centred primary care model moving towards UHC

Public health implications:
- Need for sustained advocacy by civil society and academia who have acted as policy entrepreneurs for NCD prevention;
- Call for the establishment of a multisectoral mechanism for NCD prevention and control with sustainable human and financial resources as well as good governance practices;
- Need for innovative approaches to overcome the health system ‘stickiness’ towards major financing and service provision reforms.

Results

- Lebanon’s political instability and fragile governance negatively affect its capacity to adapt a Health-in-All-Policies approach to NCD prevention;
- Those factors also enable the blockade of NCD prevention policies by opposed stakeholders and their interests.
- Limited economic growth and reform failures imply weak financing, resulting in compromised health coverage (with high out-of-pocket expenditures as a major symptom) and health inequities.
- NCD care provision is twisted by the powerful private sector towards a hospital-centred care model, implying healthcare commercialization.
- Stakeholders like the MOPH, UN agencies, and NGOs have been pushing towards changing the existing care model towards a comprehensive person-centred primary care model and implementing policy change.

- An incremental reform has been adopted to strengthen a network of primary care centres, support them with health technologies and improve the quality of PHC services.
- Nevertheless, outpatient services that are covered by other public funds (serving almost half of the population) remained specialist-led without much institutional regulation.

Conclusion

- The political economy of NCD in Lebanon shows a gap in the prevention policy landscape due to an unbalanced power relationship between policy promoters and blockers.
- Despite initiatives to strength primary care in Lebanon, a collaborative mechanism among health funders is lacking and therefore impeding major care model reforms.

This research is funded by the National Institute for Health Research (NIHR) (16/136/100 NIHR Research Unit on Health in Situations of Fragility) using UK aid from the UK Government to support global health research.

FUNDED BY NIHR | National Institute for Health Research

UKaid from the British people