

Health Strategic Plan

Strategic Plan for the medium term (2016 to 2020)

Ministry of Public Health, Lebanon

Beirut, December 2016

FINAL DRAFT



REPUBLIC OF LEBANON
MINISTRY OF PUBLIC HEALTH

Preface

In end of 2014 the MOPH embarked in a large exercise of developing a 2015-2020 strategic plan for the health sector. All MOPH departments, main stakeholders, the academia and renowned experts were involved in this exercise. In mid 2015 OMSAR, in the framework of an EU financed project, recruited consultants to assist 4 ministries, including the MOPH, to develop a strategic plan according to a nationally standardized model.

Based on the many documents produced by the MOPH drafting team and following thorough consultations with the MOPH departments and national experts, the consultant produced a draft strategic plan 2016-2020.

Given that this document was inspired, to a large extent, from the discussions with the MOPH drafting team, and in order to be consistent with other ministries' plan, the MOPH decided to adopt the general structure and content of the document produced by the consultant. The current final document is based on a pre-final draft produced by the consultant, that was fine tuned and revised by the drafting team at the MOPH, to highlight important facts or analysis, that were indispensable for contextual understanding.

We deplore however the lack of analysis of the socio-political context and of the historical development of the Lebanese public administration, considering their important implications on the health system and on the feasibility of certain reforms proposed by the consultant.

Therefore, thematic and programmatic operational plans developed by the MOPH drafting team would be considered as an integral part of the overall strategic plan for the health sector.

Finally, we would like to highlight the following:

- This is a Budget neutral plan.*
- Each program has its own pace and independent dynamic for assessment and planning.*
- This strategy is meant to be a living document that would evolve in parallel to the progress at each front.*

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Director General of Health

Acknowledgment

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1. General background and Introduction

The background documents for this report including draft strategic plans have been prepared by the Ministry of Public Health (MOPH) of Lebanon in cooperation with OMSAR (The Office of the Minister for Public Administrative Reform). The Ministry of Public Health of Lebanon had an on-going process of consultation and strategic planning for the Health Sector. OMSAR, through an EU supported project, has been piloting an approach to supporting strategic planning in 4 Ministries in Lebanon. The goal of the pilots is to establish mechanisms for long-term improvements in the quality and consistency of strategic planning and plans across the public administration.

The current strategic plan is therefore a fusion of these two processes. An attempt has been made to combine the considerable background work and thorough consultation process of the MOPH Strategic Planning Working Group (SPWG) with the methods and frameworks proposed by OMSAR. There is general consistency across the two input processes but clearly also areas of difference. Where further progress is needed in harmonizing the processes, this is footnoted. These footnotes are then hopefully an input for both: the MOPH, as it moves to final internal strategic plans and document, and; OMSAR when it comes to evaluating and consolidating lessons learned across the pilots.

Introduction

In the complex, constantly and rapidly changing environment of the Lebanon, any Ministry proposing a strategic plan for its activities should certainly do so with the necessary modesty or risk being over-taken by events. With these precautions in mind, this document is one of two the Ministry of Public Health produces to support the planning, implementation and later monitoring of its activities¹:

- **The Strategic Plan:** Provides a concise and clear overview of the context in which the MOPH operates, the challenges it faces, its long-term *Strategic Goals*, and the broad approach chosen to reach these goals. As such, the document is intended to represent a relatively stable point of reference both for its own staff and the many partners that support the MOPH in striving to achieve its permanent mission: improving the health and well-being of the people of Lebanon. The time frame for this Strategic Plan is 5 years.
- **The Operational Plan:** Provides a far more detailed specification of specific *Courses of Action* and *Activities* on an annual basis. It is therefore also a document that must be updated regularly or on a 'rolling' basis to remain relevant. The Operational Plan is intended to provide a specific point of reference to: specific actors assigned, or partnering with the MOPH; for the achievement of specific and logically sequenced tasks; over specific timescales; with specific resources, and; towards concrete and clearly measurable outputs.

¹It is noted that increasing numbers of public administrations, irrespective of development status, also budget and plan in medium-term frameworks with rolling forward estimates of 3 (to 5) years. The fact that no annual state budget has passed into law in Lebanon since 2005 limits possible analysis.

The MOPH is also grateful to OMSAR for providing support on earlier drafts of this document and on the basis of whose guidelines this simple but useful distinction has been made (OMSAR 2014). The clear link between the Strategic Plan and Operational Plan is also explained in the final chapter of this document.

The Plan is structured using the broadly standard format for this type of report. After a general background and introduction in Chapter 1, Chapter 2 provides a descriptive overview of the organization of the MOPH including public administration and public finance (state budget) considerations in its operation. Chapter 3 describes the (external) context of the MOPH and within the sector the sector and sub-sectors of the economy it is primarily responsible for regulating. Chapter 3 is split into three sections: the first covers the public health and epidemiological situation in the country; the second covers the medical, public health and related professional markets and services – or ‘health system’ – situation; the third covers the context beyond the sector and factors within the country that may (also) affect it. Each of these first three sections concludes with a summary of Key Strategic Issues (i.e. summary of Strengths Weaknesses Opportunities and Threats) identified during analysis and consultation regarding contextual factors behind the plan.

The second half of the Strategic Plan moves from diagnostics to planned interventions. Chapter 4 therefore starts by first laying out the Vision, Mission and Values of the MOPH. On the basis of the analysis of the context and clear statements of the intent of the MOPH, Chapter 5 sets out the contours of the Strategic Plan itself and is structured in terms of the main *Strategic Goals* of the MOPH and its *Specific Objectives* in aiming to achieve each of those goals. These *Specific Objectives*, while they have a clear output and results focus, are also formulated on the basis of expected divisions of labor within the MOPH and hence link clearly to, and introduce the *Courses of Action* that are then described in full detail in the Operational Plan to accompany this document.

Finally, Chapter 6 specifies the frameworks for on-going monitoring and mid- and end-of-period evaluation of the Strategic Plan for purposes of performance measurement and reporting. These frameworks also form the basis of the more detailed activity specifications of the subsequent Operational Plan.²

²*Italics* indicate the use of terms which are specifically defined for the purpose of this report, or translated, and terms used consistently throughout.

2. The Actor: The Ministry of Public Health

In this Chapter, the organization of the MOPH and its affiliated organizations is briefly described and challenges and opportunities discussed. The Chapter ends with the key strategic issues identified for purposes of strategic planning over the next 5 years. More detailed descriptions of the MOPH are available through a number of formal legislative and descriptive sources (Ammar 2009).

Description of the MOPH

The current organization of the Ministry of Public Health (MOPH) was set out in law in 1961. There have been numerous attempts to update the organizational structure of the Ministry but these have been severely hindered by the political log-jam that has affected all branches of the public administration over the last decade (Ramanos, 2010) (Chapter 3). Employing highly qualified individuals, of which there is no shortage in Lebanon, has proven difficult for the MOPH with the exception of temporary contracts typically linked to externally financed (special purpose) projects. Contract workers continue to make up an important part of the total human resource capacity of the MOPH but this trend has also seen a steady decline in capacity through both internal Government of Lebanon (GOL) and external sources (Figure 1).

The decline in the number of staff represents a serious threat to the sustainability of MOPH performance and reflects clearly the lack of political commitment to strengthen the public administration. This applies to all the consecutive governments for the past 2 decades. The current number of the MOPH staff barely exceeds one thousand employees. For comparison, the number of staff in one university hospitals AUBMC is around 2700.

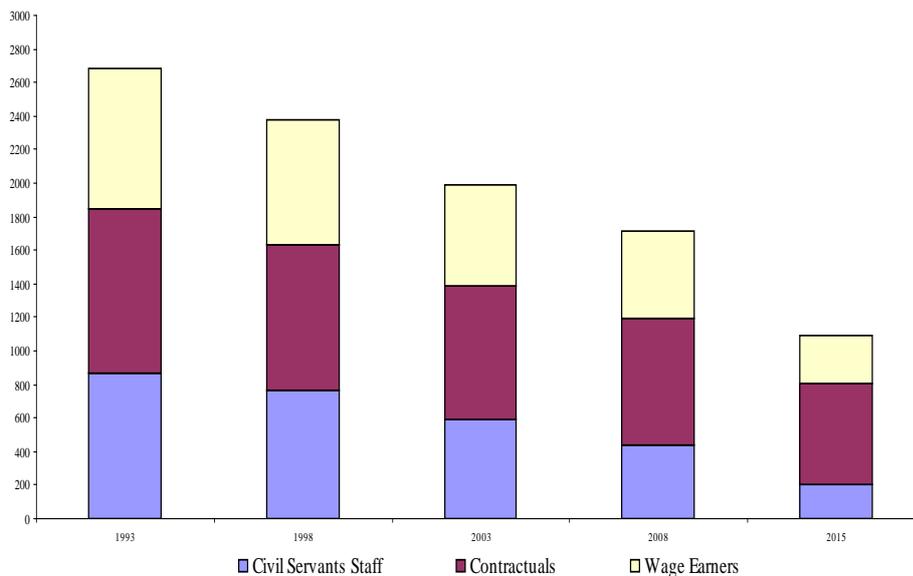


Figure 1: MOPH Employment by Category 1998-2015

Until the beginning of 2016 the physical working conditions of the main building of the MOPH left much for improvement. However, in January 2016 a planned move to a new building has been achieved and the working environment of MOPH staff has improved as a result. It is an important start and symbolic step in long-term efforts to operations of the MOPH (See Chapter 5). Employment conditions in MOPH, even taking into account civil service job security, and particularly for the high skilled for example: medical, ITC, registered accountants, economists, epidemiologist and other post-graduate technical staff, etc., are all modest compared to those in the (robust) private sector in the country. This creates considerable challenges in terms of hiring and retaining particularly skilled staff (Textbox).

“If I think about how much I earn per month I would stop working; if you believe in what you are doing, you do not ask. (But)... We do not recruit through the Ministry; we look for projects.”

Senior manager in response to consultation interview questions on public administration terms and conditions

Despite all these limitations in terms of both strength and depth of capacity, the (much dated official) organizational structure and organigram of the MOPH is quite extensive and has two main features (Figure 2). The first feature is that, in the governance structure, no distinction is made between the MOPH as a regulatory and legislation (policy formation)“executive”, and what are typically referred to as “agencies” or other bodies and departments that implement regulations or various services. That is, while the precise nomenclature can vary between jurisdictions, there is no clear distinction therefore between the (policy/oversight) executive and implementation bodies.

The MOPH has always been aware of the importance of the financier-provider split to enhance efficiency and accountability. This was behind the issuing of the law on public hospitals autonomy with independent corporate governance and budgeting. Regulation became the main role of the MOPH. Whereas the financing function is used as a powerful leverage for regulation and introducing change.

Such separation is typically aimed at increasing transparency and providing clear divisions of authority. In practice, the separation between the executive and policy implementation bodies has evolved and the MOPH continues to try to formalize these evolutions while modifying the relevant legal bases. The legislation covering state employees is: extensive, complex, long-standing, and limits both administrative innovations and modern Human Resource management and development (See below).

The second feature of the organizational structure and arrangements is that the MOPH maintains close working relationship with a number of International Organizations and (large non-profit) Enterprises, and most notably the World Health Organization (WHO).

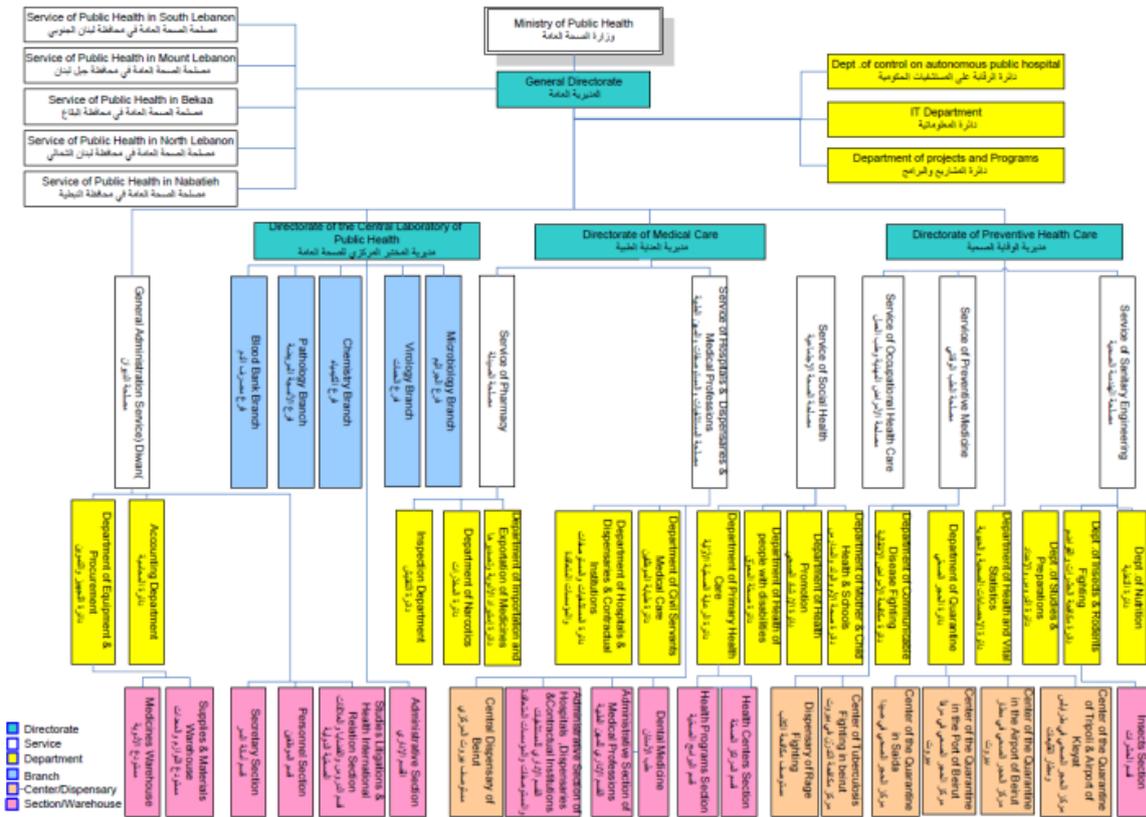


Figure 2: Organization of the Executive branch

The primary fields of implementation activities are difficult to characterize as they have few international comparisons, particularly with respect to interventions in medical markets. With respect to the hospital services the MOPH describes itself as the ‘insurer of the last resort’. The MOPH is therefore a medical insurer/purchaser (“(third-party) financing agency” in National Health Accounting terms), contracting private and autonomous public hospitals for services. Through this function the MOPH has not only a regulatory, but also a significant operational and implementation role in the sector, with ‘market making’ influence on particularly (service definitions and) prices and tariffs in hospital services (secondary and tertiary care) (See Chapter 3).

With respect to primary services, again, providers are largely private (non-profit) entities, but in this case the MOPH does not ‘contract’ as a conventional ‘Insurer/Purchaser’, but provides in-kind supplies to a nationwide network of “affiliated” primary care (medical and public health services) providers. The MOPH is therefore acting as what might be described as a ‘network facilitator’, *obviously the MOPH was not playing a mere facilitating role. The well recognized achievements of the MOPH would not have been possible without a vision and an effective stewardship role to steer the system towards reaching goals agreed upon with major stakeholders.*

And it provides a very practical case study of a 'distributed' (plural and collaborative) rather than 'integrated' (centralized and hierarchical) primary health care network (Rhodes M. G., 2013).

In 2016, and with funds from the WB, the MOPH initiated a pilot phase for implementing a performance based contracting with NGOs operating PHC centers, whereby a set of services is delivered to the most vulnerable Lebanese population (based on the national poverty targeting project).

The accreditation program started by acute hospitals in year 2000 that has evolved in terms of governance and standards which is currently at the fourth version.

Accreditation of Hospitals: A merit system serving efficiency, not only quality

Since May 2000, the quality of hospital care in Lebanon has been witnessing a paradigm shift, from a traditional emphasis on physical structure and equipment, to a broader multidimensional approach that stresses the importance of managerial processes, and clinical outcomes.

The impetus for change came from the MOPH that has developed an external evaluation system for hospitals with the declared aim of promoting continuous quality improvement. This was possible through a new shade of interpretation of an existing law, without the need for a new legislation.

The MOPH sought international expertise to overcome allegations of partiality, and the accreditation was intentionally presented as an activity independent of the Government and other stakeholders to foster elements of probity and transparency.

Accreditation standards were developed following a consensus building process and issued by decrees. Hospitals were audited against these standards in a professional, educative, non-threatening manner, respecting confidentiality, not without initial resistance from hospitals. For, results of the first auditing survey revealed a shocking failure by majority of hospitals in complying to basic standards, only to recover through a high success rate in the follow-up re-audit, showing a better use of resources and a higher degree of commitment to the programme. This allowed for standards upgrading and another round of auditing. The step-wise approach adopted by the Ministry ensured a smooth and gradual hospitals involvement, and led to the creation of cultural shift towards quality practices, although contracting with MOPH was an important incentive for compliance. The MOPH's undeclared aim was in fact to strengthen its regulation capabilities and to attain better value for money in terms of hospital care financing. As the selection of hospitals to be contracted could then be made on objective quality criteria, freeing the system from any kind of favoritism or discrimination, especially confessional and political ones.

The vital importance of transparency and data reliability for such potentially sensitive areas are good examples of functions that are therefore typically publically or self- financed, but are managed by autonomous bodies (therefore independent), therefore at some distance from direct control by an Executive – hence fall under the category of agencies and quasi-governmental (non-executive) bodies.³

It is worth mentioning though that Lebanon's overall experience in autonomous public bodies is not really encouraging to be generalized, and the concept of having an Agency to oversee a Ministry is hardly compatible with the administrative and legal environment and would certainly be rejected politically.

³Both the SARS (2008) and Ebola (2014) outbreaks provide critical examples of the vital (life-saving) importance of being able to transparently produce credible, authoritative and robust data on 'bad news' in some areas of public health regulatory operations.

Yet, while there are no ‘agencies’ or ‘non-executive’ bodies, even in areas where operational independence is potentially mission critical, there are a number of ‘programs’ that do operate at some arms-length from the MOPH. This relates particularly, to a number of disease and/or demographic group focused programs in collaboration with the World Health Organization (WHO) and Young Men’s Christian Association (YMCA), including:

- National HIV/Aids Program
- Chronic medications program operated by YMCA
- Epidemiological Surveillance & Response Program
- Mental health program
- Performance contracting program

The strong role of external parties in the development, financing and execution of these programs does not confer formal non-executive body status but mean some degree of *de facto* operational independence is possible. Most importantly, it enables the MOPH some degree of freedom beyond the constraints of recruitment (particularly for high skill positions) though the formal civil service; formal positions and conditions.⁴ Particularly for the analytical and policy development tasks of the MOPH, considerable use is made of standing and *ad hoc* committees and Working Groups. The Strategic Planning Working Group that prepared this report is itself a good example. Persons in such committees and Working Groups often take part on a *pro bono* basis. The use of such groups also means a number of sub-sector (strategic) plan and policy documents are also produced regularly and allow the Ministry to increase participation in their formulation. While clearly creating the potential for conflicts of interest, where a specific policy might be formulated by a party responsible for or connected to implementation, this risk is taken as mitigated by strong peer cross-reference in the sector.

MOPH took several initiatives to steer clear of conflict of interest. The Good Governance for Medicine (GGM) program; is only an example. The conflict of interest declaration form is currently a common practice in all concerned departments of the MOPH.

Many of these documents also inform this plan.

The MOPH also maintains some sub-national structures and administers (collective) public health and programs through 6 Mohafazat and 25 districts health offices.

Despite the institutional weakness of the MOPH devolved administrative units, which also reflects the political overlooking, the MOPH was able to make breakthroughs in several domains such as epidemiological surveillance and response, immunization, and food safety.

These are typically headed by a (public health) physician (*Chef Medicine*) with few if any support staff. This institutional arrangement dates to, and reflects a previous integrated model of particularly primary care – or the called Alma Ata model (Ammar, 2009). However, it is clear that since the civil war, all hospital capacity and almost all primary care capacity is operated by private, non-governmental, or public autonomous company actors (See below). A number of factors have therefore lead to these offices having considerably reduced direct influence over providers. At the same time, they are also not deeply involved in the emerging ‘purchasing’ function within the MOPH. Nor is it clear, as a 2015 garbage crisis illustrated, that these relatively decentralized authorities are necessarily equipped to make timely and

⁴ A large primary care focus pilot project (i.e. “horizontal” operation platform that can substitute for “vertical” programs approaches (i.e. disease or demographic)) was agreed with the World Bank on July, 2015 for 3 years.

critical interventions that may support mass public health (prevent risk factors) in what is an increasingly densely populated and urbanized population. The department for mass public health campaigning and information in the MOPH is also small and enjoys zero budget.

The situation of the Mohafazat (Area/Regional) and Qada (District) public health administration is compounded by strong developments in Information Technology, particularly since the foundations of the existing administration were laid. Developments in Information Technology and Communication (ITC) over the last twenty years mean that the MOPH can communicate and transfer large volumes of data directly from providers to central servers (Harb & Abou Mrad, 2009). The volume and quality of (health and other) information available from providers with which the MOPH maintains direct or 'affiliate' (contractual) relations is now considerable. On the other hand, it is clear the information on and from the private medical sector is limited. The annual statistical bulletin, for example, largely reports vital health (epidemiological) information from public and affiliated provider sources. This also points to gaps in the comprehensiveness, timeliness and quality of data for purposes of public health security (i.e. surveillance activities); a weakness that maybe particularly exposed as a result of the on-going, and indeed poorly understood but clearly huge, refugee crisis in the country. Regular National Health Accounts (NHA) provide some 'market' or 'sector' (delivery and finance systems) information; but are limitations in the availability of primary data. Given the capacity for the production of such basic sector intelligence is quite limited this itself is a remarkable achievement but one that will require continuous effort to sustain, and increased effort to improve.

Finally, while not part of the MOPH or non-executive bodies, it is important to note that self-regulation and professional networks play an important role in sector regulation in the health (care) sector in Lebanon as elsewhere; particularly through, for example: professional bodies, associations, syndicates, etc. Through licensing (and indirectly quality accreditation) the MOPH does have some role in these bodies. It is not uncommon, however, particularly as a mechanism to facilitate relationships, that various (and often self-financing) non-executive bodies fill the space between formal and self-regulation in the sector. (Medical) Quality Assurance and Medical/Health Technology Assessment agency or body would be good examples (See below).

Key Strategic Issues

The basic organization of the MOPH pre-dates the civil war (1975-90). Since that time, also as a result of the war, it is clear that factors both in- and out-side the sector have changed radically and permanently. These are discussed in more detail in the following section. There have been attempts to update the organization but did not materialize to date due to political issues.

Despite the enormous internal and external challenges facing Lebanon, and the small and dwindling human and (real) financial resources available to the MOPH, health outcomes in the Country have remained strong and the health care sector has proven remarkably resilient in providing good access to essential services (See below). These are considerable achievements. At the same time they are no reason for complacency given the circumstances of the country; but nor do they suggest any radical change in strategy. Indeed, perhaps because of rather than despite these challenges, the MOPH can be seen as a pioneer in an alternative, what might be called, **Open Network Model** for sector governance. This model continues to evolve in response to practical limits to health system integration in a highly plural society and fractious political-economy. However, it means that the MOPH can combine highly ambitious goals for the sector, with a pragmatic and practical approach to reaching those goals.

In the long-term, it may therefore be necessary for the MOPH, together with its international partners, to more formally re-consider its approach to and narratives of governance and leadership in the sector. To some extent, and with some external support, this has already started.

The external support has been quantitatively minimal (less than 1% of the MOPH budget), but was instrumental to improve MOPH work. The effectiveness of the external financing is attributed on one hand to bypassing bureaucracy channels and on the other hand to restricting discretionary spending that is commonly practiced by the ministers in using public money.

But the urgency of maintaining some basic coverage of essential services has meant the main focus to date, and for the immediate future has been to maintain basic functionality and narratives; despite a decade of almost continuous erosion of personnel and capacity, and clearly a vastly changed (and still changing) context to that pre-civil war. The relative stability of the situation within the MOPH should also be supported in the short to medium term by a large (15 Million \$) World Bank 3 year project agreed in July 2015(World Bank, 2015). At the same time, current stability rests on a narrow base of fragile foundations. Finding and pursuing more systemic, country-based (endogenous) systems must remain the long-term objective but will require lifting constraints affecting the whole of government

The key strategic issues for the MOPH as an organization are therefore: how to strengthen its capacity to promote sector governance, leadership and accountability on one hand, and; how to maintain and improve population health status and health security on the other hand; particularly in an environment of considerable risk and uncertainty.

Specific Objectives will be:

- How to modernize and strengthen the executive (and non-executive) branches of the MOPH administration?;
- How to strengthen information and statistical systems to provide accurate and timely sector-level data and intelligence? (as a basis for;)
- How to strengthen the analytical, evidence, and consensus forming capacity of the MOPH to allow it to continue to build on its achievements as a 'network facilitator' creating numerous and successful partnerships across a wide full range of actors and activities; and continuing to produce high positive impact for health in Lebanon?

3. The Operating Environment

The Ministry of Public Health, as any public body, is as much a function as master of its environment. In this section, the external context of the MOPH is described both in terms of the sector in which it operates and the wider society and economy of which it is a part - therefore to which it contributes in terms of a healthy population, but also help to define it and the constraints within which ambitions must be realized.

Within the health sector

The health sector context in any country is typically divided into two parts for analysis: The health and epidemiological context, i.e. the fundamental (biological and medical) purpose and challenge addressed by the sector, and; the health care delivery and finance context, i.e. the use and sources of means to address those challenges. Two vital sources of reference for sector level information are provided by the MOPH: an annual statistical bulletin (covering mostly epidemiological information), and National Health Accounts (covering mostly 'market' or 'system' information)(MOPH, 2013). Both comply broadly to accepted international standards for the production of such statistics while capacity constraints clearly affect the: timeliness, depth and detail (particularly quality and detail of primary data), and due diligence, with which sector level statistical data can be reproduced (WHO, 2007)(OECD, 2014)(Chapter 2).

The Demographic and Epidemiological Context

The population of Lebanon (citizens) has been relatively stable over the last decade although recent trends suggest a modest fall in the rate of growth below replacement rate, and an aging population (Figure 3). Life expectancy is high for both males and females (m/f: 80.27/82.11 years). However, Lebanon hosts the largest number of refugees per capita in the world, whereby its total population size increased by 40 % in less than 5 years (since the start of the Syrian crisis).UNHCR planning figures indicate that between January and December 2016 the refugee population in Lebanon was expected to increase from approximately 1.4 to 1.8 million persons (UNHCR, 2015).⁵The epidemiological and health services impacts of human flows of such (absolute and relative) magnitude are effectively impossible to estimate. What is almost certain is that these impacts are likely to be significant, and continue into the long-term. Increased infectious disease risks are a particular concern.

	2011	2012	2013	2014	2015
Population Estimate ('000)	4,036	4,104	4,168	4,231	4,292
Number of Registered Births	97,887	90,167	86,950	88,704	85,453
Number of Registered Deaths	23,257	22,792	23,414	25,117	25,275
Pop Growth Rate (%)	1.8	1.7	1.5	1.5	1.4

Figure 3: Basic demographic indicators indigenous population (Source: MOPH)

⁵In May 2015 UNHCR was asked by the Government to stop registering refugees

With respect to the mortality and morbidity statistics there are number of limitations, particularly for example: default biases in death certificates (towards unspecified cardiovascular conditions) and limitations in information on the private sector and refugees populations. However, information from public (subsidized) health services would indicate that, in common with higher income populations, non-communicable diseases account for the major burden of disease with: diseases of the circulatory system, neoplasms (cancer) and disease of the respiratory system the primary causes of (public subsidized) hospital admission (Figure 4). Despite a relatively high population density (and high and increasing urbanization) and the relatively small geographical area of the country there is some variation between Mohafazat (regions) across the country.

In terms of key public health (and vertical program) indicators, Lebanon achieved the MDG goals related to maternal and child health. Rates of immunization are reported as high. Immunization rates have also increased between 2009 and 2015 in three key areas: polio (93 – 99.85%), measles (93 – 99%) and pentavalent vaccines (93 – 98%). There was a significant outbreak of measles in 2013. Recorded maternal and child health indicators are also strong: the infant mortality rate is estimated at 9/1000 live births (2009)); the <5 mortality rate at 9/1000 live births (2009), and; the maternal mortality rate (/100,000 live births) reduced from 25 to 18 between 2011 and 2013. Finally, access to safe drinking water was estimated at 100% but the last available data date from 2004. These indicators are all consistent with the levels and achievements of the bulk of high(est)-middle income countries, and are also strong in regional comparison (Middle-east and North Africa (MENA)) (IHME, World Bank, 2013).

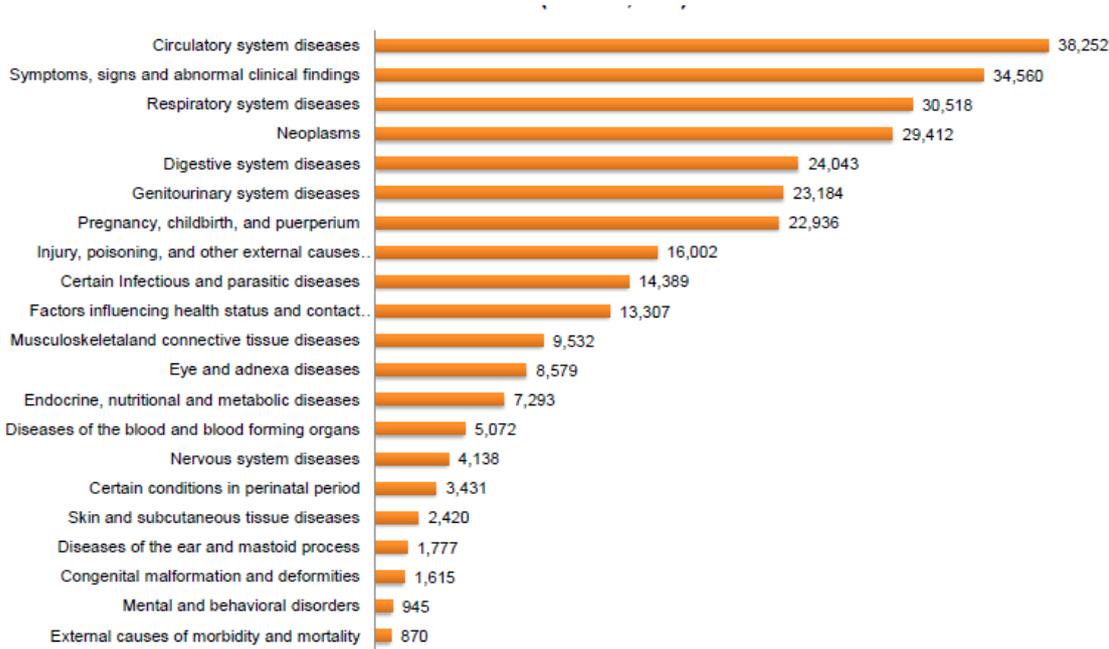


Figure 4: MOPH subsidized hospital admissions by ICD10 code 2014 (n=292,275)

In summary, health indicators have remained good despite the many challenges facing the country. Given additional risks and challenges facing the country even maintaining these is likely to require extra effort. The ability of the MOPH to forge partnerships and the evolving sector governance model and focus on building networks to ensure essential services coverage, is almost certainly an important ingredient and strong explanatory factor in the resilience of the health care system in the country (Ammar, 2016).

The Health (Care) System Context

By the end of the civil war in 1990, only one third of the country's 24 public hospitals, were operational. They had an average of only 20 beds and very low occupancy rates. Since that time, not only has there been considerable investment in public hospitals (28 hospital with 2550 beds, 2016), are also autonomous enterprises under a 1996 law, there has also been a rapid and large scale investment in private hospitals. There are now 150 hospitals and (specialist) clinics in the country in total. Since May 2000, all hospitals are subject to common external (quality) accreditation (contracted-out by MOPH). While there is some variation, public and private hospital services in the country now count amongst the highest quality and most technologically advanced in the Middle-East and attract clients from throughout the region. The precise size of the export market (i.e. inward patient flows) value is unknown but may be significant for particularly (high profile) hospitals in the Beirut area. It should also be noted that travel restrictions from some Gulf countries may also have affected these flows.

This brief history provides a microcosm of the current context and challenges of the health care system in Lebanon. While there is a strong commitment to a (public) integrated system, and the MOPH has recently committed to the WHO's Universal Health Coverage agenda, there is clearly also a large and vibrant private (profit and non-profit) health care sector and significant and highly organized private practice. Therefore in practice the MOPH regulates a highly plural system. It has also proven difficult to control those entering medical education (*numerus clauses*), as

Human resources training and selection criteria for higher education such as, numerus clausus, fall under the responsibility of the Ministry of Higher learning.

Medical professional licensing does, however, fall under the MOPH.⁶

While there is a large pool of qualified Medical Doctors there are significant shortages in trained and licensed nurses. Improving public medical services may therefore remain an important tactical focus but, increasingly, finding approaches to harmonize effort between the public and private sectors is likely to become the primary long-term strategic challenge. This strategic challenge, and indeed innovative responses to it, is also evident in the primary health care sector.

⁶Relating also to a relative imbalance between physicians and nursing capacity.

Amounts in 000 LL

FINANCING INTERMEDIARIES	FUNDING SOURCES				EXPENDITURES
	Households: Fees for Services: (out of pocket)	Households: Contributions/ Premiums	Employer Contributions/ Premiums	Treasury	
Ministry of Public Health				647,220,844	647,220,844
National Social Security Fund		120,608,667	422,130,333	145,005,250	687,744,250
Civil Servants Cooperative		33,110,290		250,000,000	283,110,290
Army				240,985,225	240,985,225
Internal Security Forces				97,870,001	97,870,001
State Security Forces				9,494,444	9,494,444
Customs				7,346,716	7,346,716
General Security Forces				18,445,265	18,445,265
Private Insurance		446,992,958	292,391,892		739,384,850
Mutual Funds		128,011,108		31,000,000	159,011,108
International Organizations					21,793,445
Households	1,735,230,986				1,735,230,986
TOTAL	1,735,230,986	728,723,023	714,522,225	1,447,367,745	4,647,637,424
%Total Health Expenditure	37.34	15.68	15.37	31.14	100
GDP (2012 preliminary figures, MCF)	64,800,000,000				
THE % GDP 2012	7.17				
Public (%)	31.14				
Private (%)	68.39				

Figure 5: Sources of funds (NHA 2013)

The primary health care sector has experienced a similar evolution to that of the hospital sector in the post-civil war period, but the emerging solution to harmonizing public and private effort is innovative and potentially unique to Lebanon. In 1991, the MOPH and relevant stakeholders developed a National Strategy for Primary Health Care. This initiative choose 29 among 800 facilities to form the nucleus of a “*National Network*”(of “affiliated”) primary care centers that has grown to include currently about 214centers (out of approximately 1080 in total) with most belonging to NGOs (i.e. private non-profit enterprises). Each health center has a defined catchment area- population with on average an estimated 17,500 inhabitants; with only few exceptions. This implies close to national coverage of essential (primary) services. Hence while private (non-profit or ‘social’) enterprises make up the ‘nodes of the network’; the MOPH can be described as a ‘network facilitator’ (Rhodes G. , 2012) whereby

- the MOPH supports this network of centers through: the provision of essential drugs, vaccines and some (medical consumable) materials, some incentives, some equipment, and; the development of guidelines, health education materials, training activities, etc.⁷
- In exchange: The centers commit to provide a comprehensive package of services including: immunization, essential drugs, cardiology, pediatrics, reproductive health and oral health, and to play an important role in school health, health education, nutrition, environmental health and water control. Affiliated centers also do not differentiate between insured and uninsured patients regarding nominal fees.

Through this public-private or “blended” organizational management and financing approach, the MOPH is able to ensure a (primary medical) safety net, also providing an alternative to secondary care to the uninsured to have access to affordable essential services. This network also provides (health and some operational data) through direct on-line reporting to

⁷ In turn, important material resources distributed by the MOPH also come through private (charitable) organization (See above), as well as international donors.

the MOPH for subsequent analysis, evaluation and reporting. This forms the backbone of the public health information (IT) and management systems of the MOPH. Finally, this horizontal approach to primary health care can therefore also complement the vertical (collective public health) programs (See above).

The complex mix in the supply/provision of public health and medical services is also reflected in health care financing and insurance (demand side) arrangements (Figure 5). National Health Accounts indicate that private out-of-pocket expenditure remains the major source of financing in the sector and of funding to providers.

It is worth mentioning that the MOPH has developed a tool to select providers based on performance indicators such as case-mix in the framework of performance contracting.

There are a number of public sector financing/purchasing agents of which MOPH is the largest. MOPH contracts services for registered ('visa' holding) clients in its role as 'insurer-of-the-last-resort'. In 2003, a unified Beneficiaries Database (of 'visa' holders) was created, including beneficiaries of: MOPH, National Social Security Fund (NSSF), Civil Servants Cooperative (CSC), Army, Internal Security Forces (ISF), General Security Forces (GSF) and State Security Forces (SSF). The unification of beneficiary information reduced double-coverage or double-billing from more than one (public) fund. It also aimed at simplifying administrative procedures and reducing waiting time for getting the prior authorization of the MOPH for hospital admissions. In its role as 'insurer-of-the-last-resort' as well as regulator the MOPH is also able to enforce contracting and reimbursement arrangement and tariff structures. Co-payments are also lower (5%) in public hospitals when compared to private hospitals (15%).⁸

The key strategic issues are:

- introducing and enforcing supply side controls (and potentially interventions) to maintain quality and safety across all types of providers and professionals – and contain (price and volumes inflation) pressures driving up both public and private expenditure and hence reducing affordability;
- Exploring additional insurance and pre-payment mechanisms to provide increased, and ultimately universal, financial protection.
- The expansion of financial protection across the population depends of course also on many factors outside the health sector.

Country context beyond the health sector

This section draws on earlier PESTLE (Political, Economic, Social-Cultural, Legal and Environmental) analysis and consultation of the wider context of factors that affect, and indeed are affected by, human health and the health sector in Lebanon. Analysis also drew on technical literature, case studies and specialist inputs in each of the specific areas of analysis, and wider stakeholder consultation, in the preparation of the plan. For purposes of presentation, the areas of the PESTLE analysis are grouped under three headings: political and legal; economic and socio-cultural, and; technological and environmental.

⁸Emergency services are currently run largely by NGOs and particularly the Red Cross. A full consideration of these services is noted but not discussed in detail in this Plan.

Political and legal context

The current political situation in Lebanon is clearly complex and fragile (Salamey, 2014). For the past 12 years, all ministries operate on provisional budgets based on the 2005 budget. Constraints exacerbated as the classification used in the state budget is long outdated and no longer reflects organization or operational realities in the MOPH or sector. This long-term log-jam in domestic public decision-making clearly affects all aspects of the public administration and subsequently the performance of public services. More recent and considerable regional risk and uncertainty may further affect the delicate balance in the country; particularly as a result of mass refugee flows (Economist, Nov 13th). Measures that require large scale or ambitious (top-down) political support (or public financial (re-)allocations) must be considered improbable for the foreseeable future.

With respect to the health sector specifically, as 'service of general interest' the sector is characterized by complex stakeholder networks and interactions and numerous and strong self-regulatory (particularly professional) bodies.⁹ There is clear legal obligation to health or health care under the constitution; however enforcement of these obligations remains weak and infrequent.

Key and specific strategic issues:

- The MOPH has managed to facilitate public-private (profit and non-profit/charitable) stakeholder collaboration at the (sub-)sector governance level; particularly, for example, in the (national) primary care 'affiliate' network, and the hospital sectors;
- Further developing sustainable (bottom-up) collaborative networks and partnerships also requires additional 'governance' focused efforts such as evidence to also support 'convergences of ideas' amongst potential partners.

Economic and Social-cultural context

Lebanon is a high middle income country with moderate growth and a (relatively) stable credit rating; subject to political risks (IMF, 2015). Following a sharp drop in 2011, growth has crawled upward to about 2–3% but remains well short of potential. Recovery before 2019 is not expected. The Syrian refugee crisis is straining local communities, adding to poverty and unemployment, and placing further pressure on the economy's already-weak public finances and infrastructure (World Bank, 2013)(IMF, 2015). Public finances remain under pressure and debt stock is expected to continue to rise from relatively high levels (public debt remains at 132 percent of GDP, despite one-off fall in 2014 and is very high by international standards) braking fiscal initiatives.

Despite the unprecedented humanitarian and economic spillovers from the conflict in Syria, Lebanon has broadly managed to preserve macroeconomic stability and market confidence. Nevertheless, and against this background, there are calls on the international community to provide greater humanitarian and development assistance to Lebanon. Such flows are, however, difficult to predict and are both volatile and subject to additional (external) decision-making. The MOPH is gradually becoming more familiar with all key modalities external

⁹A choice is made for the term (EU legal) term 'services of general interest' rather than public services as the latter does not reflect operational realities in Lebanon and is subject to possible framing biases.

support might take, particularly at the sector and strategic level, and across the full spectrum of potential sources.

As discussed in the previous section, the health economy specifically, is subject to: some weaknesses in expenditure controls on the supply side, and; greatly reduced but still considerable out of pocket payment (it dropped from 60% to 38% of total expenditure; this is a success story) as a significant source of finance (demand side factors). This can constrain universal and equal access to available services.

The World Health Report 2010 documented the case of Lebanon as a success story on how to decrease total health spending in terms of % of GDP by lowering mainly out of pocket while at the same time improving health indicators. This supports the sound health policy of strengthening PHC and rationalizing the cost of hospital services while promoting the MOPH regulatory capacity.

Health Reform in Lebanon: A success story in the "WHO Report 2010 on Health Care Financing"

Date: 11/26/2010 | Author: WHO | Source: WHO

This special box on Lebanon has been copied verbatim from "World Health report 2010 on Health Care Financing"

Box 4.2. Lebanon's reforms: improving health system efficiency, increasing coverage and lowering out-of-pocket spending

In 1998 Lebanon spent 12.4% of its GDP on health, more than any other country in the Eastern Mediterranean Region. Out-of-pocket payments, at 60% of total health spending, were also among the highest in the region, constituting a significant obstacle to low-income people. Since then, a series of reforms has been implemented by the Ministry of Health to improve equity and efficiency.

The key components of this reform have been: a revamping of the public-sector primary-care network; improving quality in public hospitals; and improving the rational use of medical technologies and medicines. The latter has included increasing the use of quality-assured generic medicines. The Ministry of Health 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 contracting with private hospitals for specific inpatient services at specified prices. It now has a database that it uses to monitor service provision in public and private health facilities.

Improved quality of services in the public sector, at both the primary and tertiary levels, has resulted in increased utilization, particularly among the poor. Being a more significant provider of services, the Ministry of Health is now better able to negotiate rates for the services it buys from private hospitals and can use the database to track the unit costs of various hospital services.

Utilization of preventive, promotive and curative services, particularly among the poor, has improved since 1998, as have health outcomes. Reduced spending on medicines, combined with other efficiency gains, means that health spending as a share of GDP has fallen from 12.4% to 8.4%. Out-of-pocket spending as a share of total health spending fell from 60% to 44%, increasing the levels of financial risk protection.

Key and specific strategic issues:

- While there may be strong internal (and indeed external) support for centralized (i.e. “(public) integrated”) solutions requiring substantive public /compulsory finance to address challenges in the health sector these, will likely face significant implementation constraints and challenges;
- Improving pre-payment and risk sharing arrangements is likely to be a necessary, but not sufficient, condition to promoting (universal) access, and strengthening (health related) social safety nets. An open and broad-ranging review of financing options is therefore planned.

Technological and Environmental context

Health and medical services have been, and continue to change rapidly as a result of technological changes (including pharmaceutical technologies). The sector has gradually evolved from one characterized by largely services (labour intensity) to one of increasingly technology (and capital) intensity. From the disastrous situation at the end of the civil war, to one where it was estimated in 1998 that Lebanon spent 12.4% of its GDP on health (care), more than any other country in the Eastern Mediterranean Region, it is clear that country has invested heavily in medical technology and services over the last 20 years. More recently this figure has moderated.

Despite the investment in high technology, Lebanon is well rated in terms of cost-effectiveness. According to the article published in the Economist Intelligence Unit Healthcare " Health outcomes and cost: a 166-country comparison" Lebanon is ranked 32 just after Denmark and ahead of the USA in terms of outcome with remarkably low cost per outcome point¹⁰.

Rapid and extensive technological diffusion illustrates that the primary strategic challenge facing the country with respect to medical technology is; moderating that technology diffusion to the most effective and efficient technologies. In a situation of high levels of non-institutional provider funding and contracting (i.e. high out-of-pocket direct to consumer services) this is likely to remain a formidable challenge (See above).

The 12.4% of GDP spent on health in Lebanon was decreased to 7.4% as a result of targeted strategies and not a coincidence resulting from variations in investing in expensive technology that kept growing ever since.

Finally, environmental concerns in the sector relate mainly to the safe waste management. However, health care waste management is another area where the MOPH has been successful in facilitating networking; in this case approximately 70 hospitals(around 50% of all hospitals) to collectively contract the collection and disposal of hazardous medical waste with a specialized NGO (Arcnciel).

Key and specific strategic issues with respect to the technology context are:

¹⁰ Health outcomes and cost. A 166-country comparison. A white paper from The Economist Intelligence Unit Healthcare. www.eiu.com/healthcare

- Establishing the effectiveness of, and mechanisms for prioritizing, technologies for affordability and plausible public/collective responsibility (typically referred to as Medical/Health Technology Assessment (HTA) systems and procedures)¹¹, and;
- Gaining an increased understanding of the general economic potential of (high-tech) 'export' and employment markets in health care for Lebanon and encourage the use of generic drugs as reducing drug prices further is not possible.¹²

Strategies that proved to be effective in improving health while decreasing out of pocket include:

- *Strengthening primary healthcare and promoting essential drugs.*
- *Scaling up Epidemiological Surveillance and Response.*
- *Autonomy of public hospitals.*
- *Human resources: Strategy focusing on enhancing nursing graduation and improving their working conditions. And post-graduate training of medical inspectors, controllers and other physicians.*
- *Upgrading the registration process of pharmaceutical drugs and revisiting the pricing structure.*
- *Implementation of the WHO Good Governance for Medicines Programme (GGM)*
- *Accreditation of hospitals and PHC centers.*
- *Performance contracting with hospitals and containing cost of hospitalcare, including:*

The creation of a Unified Beneficiaries Database, its maintenance & updating

Development of the visa system, its decentralization and linkage to database.

Setting of a financial ceiling in every contract between hospitals and the MOPH.

Utilization review and introducing incentives through new payment mechanisms.

<http://www.moph.gov.lb/en/Pages/17/1275/health-reform-in-lebanon>

¹¹Ministerial decree 455/1 (April 2013) sets out current regulations regarding the importation and use of medical devices to Lebanon.

¹²As much of 80% of pharmaceuticals are imported

Summary of Key Strategic Issues

The epidemiological challenges facing Lebanon have clearly been complicated by instability in the region. Future developments are extremely difficult if not impossible to forecast. A relatively prosperous country, with generally good health indicators, now finds itself confronted not only with the demographic pressures of high numbers of refugees but also the increased epidemiological risks such dramatic flows of human beings in such desperate circumstances bring. Clearly, these same factors are also affecting and affected by social and political-economic uncertainty in the country and region, further compounding the challenges. In a densely urbanized society, there can be few more obvious and pungent indicators of the public health risks and uncertainties facing the country and those living on its territories, than the garbage crisis from the summer of 2015. The country therefore faces a dual burden of responding to a long-term non-communicable disease burden, while increasing vigilance to public health risks and potentially emergencies.

Since the civil war, social, economic, technological and political factors have all combined to produce a radical transformation in medical and health care services and delivery. The overwhelming majority of health care services and delivery units (medical and social-medical facilities) are now privately operated and owned. Lebanon, and particularly Beirut, now enjoys some of the most advanced medical facilities and services in the region. Medicine is therefore also a sector of increasing, but currently difficult to quantify, economic and trade importance. The bulk of private providers also operate as non-profit legal entities. In the primary health sector the outcome of the recent World Bank funded 'Towards UHC- Emergency Restoration Project' will need to be closely monitored.

At the same time, innovations in medical delivery systems and markets have not been matched by innovations in financial protection, saving and/or insurance and mutual markets. Out-of-pockets payments remain one of the main sources of finance to the sector.

While there is considerable support within the sector to re-establish the more integrated (public) health system of the pre-civil war years, the political and fiscal (public finance) situation of the country give few reasons to believe that this might be achieved over any foreseeable time horizon. On the other hand the MOPH has been a rare international example of efforts to find "open networking" solutions where integration is not possible in an otherwise highly pluralized health care sector.

The MOPH has also been shifting the focus of its own operations in the sector. In the hospital sector it is not a direct major supplier of services but an 'insurer-of-the-last-resort' (services contractor), and; within the primary and extra-mural out-patient care sector it is a 'broker' or 'facilitator' in a more open *national network* that brings together subtle webs of public and private activities and interests. There is therefore also a mismatch between the prevailing governance structures and narratives, and the *de facto* situation in the sector (See Chapter 2).

Over all internal and external factors, key strategic issues can be brought together under four Strategic intervention areas for the MOPH for medium term:

- How to respond to public health, prevention and promotion challenges for an increasingly: urbanized, educated and mobile population with a pre-dominantly non-communicable disease burden? (Particularly in light of reducing direct control over);

- How to ensure universal access to, and the affordability of: high quality, safe and responsive medical services?
- How to remain informed and vigilant against: communicable disease, vector, social determinant and other risks factors for ill-health; and particularly in the light of an on-going and extremely large scale refugee crisis that will bring more public health security risks for many years to come?
- How to consolidate the still evolving but to date successful and innovative open network governance model that has made it possible for the MOPH, with very limited organizational resources, to support the many and plural actors in the sector in also strive towards some important collective and general public health goals?

4. Vision, Mission & Values

In the previous sections, a brief overview has been provided of the challenges facing the MOPH both internally and externally.

The close association on the sector to medicine and public health particularly, means that values and the mission are central to what the MOPH does and what drives the organization and its people. This section sets out that vision and mission, and the values of the organization and its people.

Vision

The vision of the Ministry of Public Health of Lebanon is:

An equitable health system that identifies and addresses the key determinants of health and promotes, develops and sustains the highest attainable health status of all Lebanese.

Mission & Values

The mission of the Ministry of Public Health of Lebanon is:

To build and sustain an effective, high impact organization that can develop partnerships across the various stakeholders and the Lebanese society to achieve the vision of promoting health and improving the quality of life of even the poorest and most vulnerable of Lebanese society thereby contributing to the sustainable social and economic development of the country.

The Ministry of Public Health is civil service organization that shares the values of the Government and civil service of Lebanon and abides by the laws of Lebanon. As the supreme regulatory authority in matters of public health, the organization also attempts to not only meet but lead in terms of sharing values essential to a vision of Global Health:

- The right of all to a healthy life
- A duty to promote health through the life cycle of every individual
- The universal coverage of essential high quality, evidence based, medical care services
- Client friendly, safe, health (care, prevention and promotion) services, medical technologies and pharmaceuticals
- A health system that is inclusive and cares for especially vulnerable groups
- A health system that is affordable, and provides solidarity, equity and financial protection
- Shared responsibility for collaborative partnerships in promoting health and access to services
- Transparency, accountability and integrity

Moving from strategic issues to strategic solutions

In the second half of this document the plan moves from diagnostic analyses of the challenges and opportunities facing the MOPH, to proposals for interventions as to how to meet these challenges. Clearly, any plan for the future faces uncertainties. In Lebanon currently, and for the immediate future, these uncertainties are also clearly quite considerable. The final section therefore also provides some details of contingencies made during planning with the aim of preparing to deal with or at least attempt to mitigate these risks and uncertainties.

In compliance with broadly accepted protocols for this kind of document and public sector administration and planning frameworks (and later potentially also budgeting and accountability), the Strategic Plan: starts with large scale, long-term *Strategic Goals*; moves through ('zooms in' on) *Specific Objectives* under each of these goals, and; moves towards *Courses of Action*, and *Activities* (and sub-activities) to be implemented and later monitored. This approach also has advantages in terms of monitoring, and ultimately evaluating (sub-) plan performance. Identified measures also 'cascade' in clear hierarchies and timelines. In this way, it is also possible to identify critical paths and 'chains' of (expected) causes and effects.

In terms of presentation, the approach here, and that recommended by OMSAR, is to clearly separate the Strategic Plan (this document) from an Operational Plan. The two are however clearly linked in the attached spreadsheet. *Course of Action* in the Operational Plan are also stated under each *Specific Objective* in the next Chapter.

Finally, in public budgeting terms, this approach can also be compared to (and even form the basis for) moving from an input orientated (typically 'administrative classification' based) state budget and organizational management; to a so-called functional and outcome orientated or so-called 'performance budgeting' approach. While the public budgeting (and planning) process in Lebanon has clearly faced severe challenges since 2005, an advantage therefore of this approach is that it potentially paves the way for any future attempts to link strategic planning to modernizing Public Finance Management (PFM) and public administration arrangements in the future. The MOPH is therefore prepared to some extent for any such initiatives.

The itemized budget structure, vindicated by the Ministry of Finance, remains a major obstacle for health programs planning and evaluation. The MOPH succeeded in introducing program budgeting by allocating a total budget per program in few items within its budget. This had a positive but limited effect.

5. The Strategic Plan and *Specific Objectives*

Despite the enormous internal and external challenges facing Lebanon, and the small and dwindling human and (real) financial resources available to the MOPH, health outcomes in the Country have remained strong and the health care sector has proven remarkably resilient providing good access to essential services. These achievements are no reason for complacency given the circumstances of the country; but nor do they suggest any radical change in strategy. Indeed, the MOPH can be seen as a pioneer in an alternative, what might be called, *Open Network* model for sector governance. This model continues to evolve in response to practical limits to health system integration in a highly plural society and fractious political-economy. However, it means that the MOPH can combine highly ambitious goals for the sector, with a pragmatic and practical approach to reaching those goals.

To continue to allow this *Open Network* model to evolve, and to continue to build on its achievements, the Strategic Plan for MOPH for the coming years is built on four fundamental pillars. These pillars are the *Strategic Goals* of this Strategic Plan. These *Strategic Goals* also relate to four key areas of strategic operations of the MOPH, and indeed four broad management and organizational 'skill-clusters' with the MOPH. Each of these Goals is then divided into *Specific Objectives*. The achievement of these *Specific Objectives* may not always rest purely on factors and/or activities that are under the direct control of the MOPH. This plan therefore also lays out where, due to: technical, financial or other factors the MOPH pursues partnerships and cooperation agreement – i.e. facilitates networking - to help the organization achieve its fundamental *Strategic Goals* for the sector. The full specification of the *Courses of Action* and the (very large number of) activities to achieve these *Specific Objectives* are then laid out in the Operational Plan and framework that supports this document.

The precise timescale and monitoring/indicator arrangements for performance assessment against these goals and objectives are within the operational plan-spreadsheet (annexed). It should be clear that at the level of the entire sector, and in the long-term, Strategic Goals may change in tone but to some extent are continuous. The fundamental areas of strategic operations in any health sector evolve only very slowly. It is in the area of *Specific Objectives*, and subsequent *Courses of Action and activities*, that context *Specific Objectives* and interventions become clearest (Chapter 6).

The Strategic Goals

The *Strategic Goals* for the MOPH (2016-2020) have been identified as follows:¹³

- 1. Modernize and strengthen Sector Governance:**
To modernize and strengthen the executive (and non-executive) branches of the MOPH related administrations to improve sector: governance, leadership and accountability;
- 2. Improve collective Public Health and Promotion:**
To improve collective public health, prevention and promotion services to mass promote health through the live cycle of each individual, and in all stages/phases of life;
- 3. Continue progress towards Universal health(care) Coverage:**
To make concrete steps towards universal coverage of: high quality, safe, affordable, (personal) medical service to the people of Lebanon, prioritizing the poor and vulnerable;
- 4. Develop and maintain emergency preparedness and health security:**
To strengthen capacity and systems for: timely, accurate and reliable epidemiological surveillance intelligence for public health security and emergency preparedness and response

Specific Objectives to Achieve the Strategic Goals

To achieve each Strategic Goal a number of *Specific Objectives* are identified and form the basis of moving: from medium-, long-term and more abstract goals; towards practical day-to-day operations and activities both of the MOPH, partners, and wider stakeholders in the sector and beyond. Each *Specific Objective* therefore concludes by listing the 'Courses of Actions' for its achievement. These *Courses of Action*, and subsequent projects and activities are then set out in detail with timetables and resource frameworks in the Operation Plan to accompany this document. Key indicators to clearly measure performance against each *Specific Objective* and plan are presented in annexed spreadsheet.

Strategic Goal 1: Modernize and strengthen Sector Governance:

The MOPH is mandated by law to be responsible for public health and safety. The present structure of the MOPH dates back to 1961 and has not kept up with changes in the country or indeed general developments in Public Administration, Public Finance Management (PFM) and so-called 'governance' practices. The Ministry, as others, is also affected by general constraints affecting the government and public administration over many years and leading to very limited number of personnel and capacity.

The MOPH has been able in several circumstances to bypass legislative bottlenecks by creating new programs such as the Epidemiological Surveillance and Response Program and sustain its activities without amending the MOPH organizational structure. On the other hand external financing, such as World Bank grants and loans, was instrumental in introducing change not for involving important amounts of money but rather because it offered an alternative disbursement channel to the public administration. A striking example

¹³Strategic Goals are given summary headings for purposes of brevity. This is to make documentation easier as the Strategic Plan moves towards the Operational Plan and more detailed, and more quantitative and tabular, formulation and reporting (Chapter 6 and annexed spreadsheet).

for this alternative mechanism is the Trust Fund financed by the MOPH and managed through WHO for the implementation of the International Health Regulations, HIV program and NCD program.

There are on-going attempts to modernize both the internal organization of the MOPH and wider sector governance arrangements. The wider sector governance arrangements are complicated as: not only because (human) health is affected by many factors and not just medical services; but also because the sector involves large numbers of self-regulatory bodies such as professional societies and orders. The first *Specific Objective* is therefore to strengthen and continuously improve both the internal ('executive') and external ('non-executive') regulatory bodies and agencies (*Specific Objective 1.1.*). Improving the internal organization of the MOPH also affects its sub-national administrative branches (*Specific Objective 1.2.*).

Finally, challenges also exist as the MOPH also currently mixes regulatory ('steering') with a number of operational ('rowing') functions and (sub-) organizations. This strategy includes a number of steps to more clearly distinguish these functions, and particularly that of the 'insurer-of-the-last-resort' (See 3.3). Focusing more on its regulatory and so-called *Stewardship* functions, and its emerging *Network(ing) Facilitator* role, the fundamental challenges are: improving the quantity and quality of underlying data and sector intelligence as a basis for engaging and mobilizing both key stakeholders and the wider community towards the Ministry's fundamental mission: better health for all Lebanese (*Specific Objectives 1.3., 1.4.*).

1.1. *Strengthen executive and (quasi- and self-)regulatory bodies*

The executive branch (i.e. MOPH) has to rely on a number of (sub-) contracts and collaboration with self-regulatory bodies to ensure its fundamental regulatory functions are pursued.

Efforts will be made during the coming planning period to further strengthen formalize coordination between non-executive and self-regulatory bodies such as MMUs and national support committees (e.g. Infectious diseases, HIV technical committee, etc.) Areas and agencies/bodies of focus will be: Quality Assurance; Hospital services pricing and contracting; Accreditation and Licensing; Health Technology Assessment (HTA), Consumer protection, medicines and medical technologies; Medical Research; Medical standards. The Good Storage Distribution and Packaging and Good Laboratory Practices commissions are good examples where it has been possible to develop and implement strategies for agencies/bodies for (self-) regulation in specific policy and technical areas. In both case the strategy has been to create self-financing bodies.

The executive branch and Ministry of Health itself still requires (external) support to fulfil even basic functions and positions and it is likely that this will continue into the medium-term. Some immediate support is available through an on-going World Bank project but systematic approach will need to be found to supporting the re-organization of the MOPH and a critical mass of essential staff (See *above*). To also simplifying procedures for citizens a 'one-stop-shop' concept has also been developed and will be implemented.

1.2. Strengthen sub-national public health administrations

Health Area ('province') and Qada ('district') health administrations have existed in Lebanon since before the civil war. Traditionally these supported the MOPH in the management of a public integrated health system in each Qada. As other areas of the public administration, with their capacity reduced, radical changes in the health system over the last two decades, and, important developments in the use of information technology by the MOPH, the role and function of sub-national administrations has become less clear and could be reappraised and potentially re-formulated while accepting current roles are set under law with the constraints implies for change to any part of the public administration.

The primary option has been to re-build this administration levels in line with their traditional function but the focus of additional action in the period will be a consultation on the modernization of sub-national administrations in line with other developments in the sector.

It is worth mentioning that the MOPH has worked together with OMSAR and the Civil Service Board to develop a new organizational structure with particular emphasis on devolved units. The drafted law is still pending in the Council of Ministers since more than a decade.

1.3. Strengthening (sector level) information and systems

Given the limited personnel available to the MOPH, achievements in the production of basic sector information are significant. The MOPH has made considerable efforts to develop the information technology platforms to collect data from networks of both public and private (contracted) facilities. This forms the basis of both sector ("cold" data) statistical information (1.3), and ("hot" data) epidemiological surveillance systems (See Strategic Goal 4). A *Specific Objective* for the planning period is to continue to develop these systems to both collect and disseminate sector (-level) information (to both specialist and general 'stakeholder' audiences).

In terms of data collection, the (inter-operability) platform that allows the MOPH to collect (general facility based) data from networks of both public and private providers is to be developed further. Specific challenges also exist in terms of improving the quality of civil registration and vital statistics (CRVS) and particularly: death certification for purposes of mortality statistics, and maternal and neonatal notification (Ministry of Interior). A hospital based death notification system has been piloted that allows access to mortality and causes of deaths statistics at the same time overcomes the political and administrative bottle necks at the MOI, and would need to be further expanded pending a more developed e- government.

In terms of data dissemination for wider stakeholder consultation and dialogue the two basic data reporting documents for 'cold data' are: the Annual Statistical Report and the National Health Accounts can be continuously improved if additional resources can be found. Reporting systems for (hot) epidemiological surveillance systems are covered under Goal 4 (Specific Objective 4.2). A key indicator list for general epidemiologic reporting will be produced in the planning period and will support the simplification of data requests from external parties and partners.

1.4. Strengthening analytical, evidence, consensus and partnership formation capacity of MOPH

The Government of Lebanon, through the MOPH, is clearly not in a position to provide all health (care) services to all citizens of Lebanon but trying to manage the expectations of the population given the limited resources. Also for some collective public health activities also depends on building coalitions of stakeholders to ensure universal coverage. For this reason, it is vital that the MOPH can produce the analysis and evidence (based on robust input data, see above) to: engage wide stakeholder dialogue, and; support consensus and partnership building.

A key strategy, for example, and one of potentially of regional relevance in the longer-term, has been to build national coverage (and public health information) networks of hospital and primary care facilities combining both public and private interests. Maintaining these achievements requires broad stakeholder engagement, information and evidence for collaborative decision making. Without a policy and planning or similar unit, the MOPH has to rely to some extent on (external) partners, including domestic academic institutions and special/*ad hoc* committees to producing such material. In the longer term strengthening of a Medical Research Council (See above) should lead to improvement.

In the short to medium term this planning period covers improved evidence and consensus building activities in a number of specific topics: scoping unregistered professionals; a review of the existing 'blended' financing strategy of the sector and long-term options toward universal coverage; feasibility of a high-level consultation group on continuous medical education and human resources development.

Strategic Goal 2: Improve collective health and promotion across the life-cycle

Collective health and promotion concerns those (programmatic) 'public health' activities that are pursued and implemented at the population level. In many cases, this involves actions, and supporting actions, that are not implemented by the health or related professionals but by citizens, private sector and Lebanese society as a whole; and demand wide inter-sectoral action. For example: the cessation of smoking, food and work place safety measures, water and environmental controls, etc. The primary challenge is to translate well-established (health and medical) knowledge and evidence (1.4) into community action (*Specific Objectives 2.1., 2.2.*).

Collective public health activities also include a number of population level actions that are typically implemented by health professional networks; for example, screening and vaccination (so-called 'vertical') program. The continuous development of such programs is covered by *Specific Objective 2.3.*

Finally, a number of activities fall between community and professional contributions, and indeed between health and social services jurisdictions (Ministry of Social Affairs). This concerns particularly long-term (chronic) social and mental health services including care for the elderly (*Specific Objective 2.4.*).

The purpose of clustering collective public health activities – as opposed to (personal) medical services (Goal 3) - to become one (of just 4) fundamental pillars of the Strategy, is to

continue to build on recent success in vital inter-sector effort for population health. Progress in food safety is a good example. This focus then underlines the importance of such high impact, vital, community-wide, preventive and promotive contributions to health within the MOPH organization.

2.1. Improve public health promotion and behavior change

Healthy behaviors are vital at all stages of our life (cycle). To (pre-)school age, extensive programs and direct information and support exist through (particularly professional) primary care related services (*Specific Objective 2.3*).

From school age and above, and particularly with respect to combating non-communicable diseases, much depends on individuals having the information and incentives to embrace health promoting behaviors. Social marketing and mass communication methods to promote positive behavior change have developed considerably over the last decade. The *Specific Objective*, is to develop this capacity within the MOPH and indeed to promote as far as possible inter- and trans- sector efforts (i.e. across the whole of government and society) to promote the health and wellbeing of the people of Lebanon. A priority campaign during the coming period will be to promote health by targeting the big six health risk behaviors, particularly amongst the young. For post-adolescent groups a Health Promoting University (HPU) initiative was also developed and highlighted by the WHO that aims to integrate processes and structures for health promotion within the university's culture: http://www.who.int/healthy_settings/types/universities/en/.

2.2. Improved consumer and occupational safety, environmental, legal and human rights measures for human health

Beyond public information and involvement in their own health there are legal and regulatory measures that can be made and enforced to promote the health of people in Lebanon. The MOPH has recently, for example, had a number of successes in particularly the area of food safety. The MOPH plans to build on this success in the coming planning period.

The WHO (also in Lebanon) also proposed a Global Strategy on Occupational Health for all (http://www.who.int/occupational_health/globstrategy/en/). This stipulates the fundamental right of all people to the highest attainable standard of health. Furthermore, this strategy allows targeting the prevention of accidental injuries and the promotion of improvement of working conditions. Without additional funding operational activities are limited.

2.3. Increasing the efficacy and efficiency of population based (vertical) public health and communicable disease programs

Despite the many challenges that have and continue to face the health sector in Lebanon, the country has been very successful in continuing to protecting and implement a number of vital basic (communicable) disease control programs. Vaccination rates are high and need to be maintained. In addition, particularly through the creation of a national (public and private) network of primary care there is wide coverage of essential material and child care programs (*Specific Objective 3.1*). There are currently few population screening programs outside those for mothers and children. Maintaining, and where possible improving on, the success of these perhaps traditional, and to some extent routine, areas of public health continues to be a high priority for the MOPH and its sub-national branches (1.2).

The civil war in Syria and vast migrant and refugee population movements are one of a number of factors creating significant pressures not only on well-established population

disease control programs, but also introduce additional communicable disease and other health risks. The scale of these 'unknown' (and currently difficult to quantify) risks is such, that the current strategy includes a Strategic Goal targeted specifically at an attempt to: first understand, secondly provide emergency response to and, thirdly come to terms with and transition from emergency interventions (Strategic Goal 4). These are then distinct from on-going population programs while clearly there are risks of (unintended) impacts if not properly managed.

2.4. *Development of community health, mental, elderly and social services and partnerships*

The boundary between health and social care can be difficult to draw. Previously, as in some other countries, health and social affairs in Lebanon were covered by one Ministry. Cooperation in these areas remains important. Services at the border between health and social care are also typically long-term and cover 'chronic' conditions. Two areas at this border remain of particular importance: care for the elderly and (community) mental health care.

Aging is a clearly a natural process, but it is one that brings with it high burdens for health care systems. Available studies also indicate that as many as 50% of the elderly may have no form of health insurance (Kronfol 2009). Visit and prescription rates can be double those of the general population and burdens on particularly hospital services are currently high (MOPH 1998). Improving both primary care (3.1) and long-term extra- and trans- mural care for the elderly are therefore important strategic aims both in terms of bringing services closer to home and relieving pressures on the hospital sector.

In terms of mental health, the Syrian crisis was a leverage to initiate the integration of MH and psychosocial services at the level of PHC, aiming at improving access of MH services to the vulnerable populations. A national MH program was established at the MOPH funded through the Humanitarian partners.

Strategic Goal 3: Continue progress to Universal Health(care) Coverage:

Lebanon is an upper middle income country with a population of approximately 4.1 million Lebanese and some additional 2 million non-Lebanese (Syrian and Palestinian refugees and south east Asian workers). Socio economic disparities are observed, aggravated over the past few years by an escalating unemployment rate especially among the Lebanese. The health sector remains highly plural, and the MOPH is estimated to be 'insurer of the last resort' to approximately 52% of the population. The country receives external (humanitarian) aid that remains insufficient. The challenges of universal health care (medical) coverage under such circumstances are clearly significant. Despite the challenges, there have significant achievements both in terms of health and health care service indicators (See above). Universal Health Coverage also remains the overall ambition. At the same time, it is clear that the sustainability of achievements will depend on the further and continued development of the (unique) 'blended' finance and *Open Network* governance model that has emerged and continues to evolve.

The aim for the current planning period is to continue to build on existing achievements. First, ensuring a comprehensive national network of primary care facilities has been a fundamental component of universal access to essential services for many years (*Specific Objective 3.1.*). Maintaining the affordability of the hospital, specialist and emergency services available in the country, however vital, continues to present challenges (*Specific Objective 3.2.*). A primary instrument to steer improvements in medical services (supply) is the public/social

(medical) *insurer-of-the-last-resort* function (*Specific Objective 3.3.*). The MOPH will also continue to work with key stakeholder groups to improve the competences of medical and health professions throughout their careers (*Specific Objective 3.4.*). Finally, there is continuous effort to improve the efficiency of procurement and logistics support provided by the MOPH (*Specific Objective 3.5.*).

3.1. *Expanding access to (quality) primary care*

A national strategy for primary care was developed in 2004. Since that time, a large “national network” of 216 primary care providers (out of a total of approximately 1080 primary clinics and dispensaries) has been created. The majority are owned and managed by NGO. These are contracted by the MOPH to provide essential close-to-user services. Each has a catchment population of approximately 15,000 to 20,000. Activities in the planning period will focus on expanding the number, scope and quality of services provided by this (public-private or ‘blended’) network. With the support of external donors, this also includes services to refugees from whom proportions of visits have expanded from 14% (2012) to 35% (2014). Outside the publicly supported ‘national network’, primary providers are subject to general licensing and operating regulations (Section 1).

3.2. *Strengthen the public hospital network, emergency and ancillary services*

In 1996, the Government approved legislation to grant financial and administrative autonomy to all public hospitals. While under independent boards, the MOPH still provides some *tutelage* to these 27 hospitals (approx. 1750 bed total). To attract patients and reduce transfers, patients receiving subsidized MOPH ‘insurance-of-the-last-resort’ enjoy lower copayments in public hospitals. Admissions to public hospitals are estimated at approximately 30% of MOPH funded coverage. There remain actual and perceived challenges in improving the competitiveness of public hospitals against private sector counter-parts. The MOPH also faces long-term challenges in controlling the diffusion of medical high-technologies across all hospitals. High levels of diffusion of medical high-technology increase overall expenditure pressure and reduce affordability (See MTA initiatives, SP 1.1). Efforts at standardizing and reinforcing emergency medical services, both at pre- and in- hospital level have been made over the past few years and need to be further reinforced

Outside the direct contracting of providers through ‘insurance-of-the-last-resort’, all providers are subject to general licensing and operating regulations (Section 1). In the hospital sector this includes pricing and tariffs.

3.3. *Strengthen access through the ‘public social medical insurer’*

The challenging recent history of the health sector in Lebanon explains perhaps the unusual situation of the MOPH as both sector regulator, and also the direct operational manager of a large *insurer-of-the-last-resort*. Sector reform programs in the past have attempted to create a more conventional: purchaser, provider, regulator functional separation. Such reforms are complex both technically and politically. Radical reform measures are not foreseen in the current planning period.

3.4. *Improving health sector human resources and continuous medical education*

General medical education falls under the jurisdiction of the Ministry of Education. Despite numerous efforts over more than a decade, it has proven difficult to regulate entry into the medical education (upstream) and practice (downstream). As with difficulties in controlling the diffusion of medical high-technology, the bulk of international evidence would suggest this can be expected to increase pressures on total public and private expenditures. The focus with respect to human resources in the health sector has had to be shifted to professional safety and quality (of practice).

3.5. *Efficient procurement and logistics*

The MOPH manages its procurement activities through a dedicated unit. This unit cooperates in wider government initiatives in, for example, e-Government and e-Procurement. Efforts towards the efficiency and transparency of centralized procurement activities remaining, should insurer-of-the-last-resorts be contract, may need to be reviewed.

Strategic Goal 4: Develop and maintain emergency preparedness and health security:

Recent global health emergencies, particularly those involving new and little understood infectious diseases, have raised awareness of the importance of International Health Regulations (IHR). Lebanon has adopted these regulations to ensure the safety of its citizens, and stem the tide of any Public Health Emergency of International Concern (PHEIC). The MOPH is responsible for the implementation of these regulations and has been successful to date in handling potential crises and containing epidemics. The refugee crises confront Lebanon, and a number of other countries in the region, with new and significant risks that are difficult if not impossible to anticipate accurately.

Under current circumstances, and those like to prevail into the medium term, the vital importance of strengthening emergency preparedness only increases. A large part of preparedness is timely, reliable, robust and comprehensive epidemiological data and intelligence (*Specific Objective 4.1.*). This is a challenge facing all countries. These requirements are extensions, however, to underlying data and information system foundations at the sector level (*Specific Objective 1.2.*). There is therefore a critical path between *Specific Objectives 1.2* and *4.1.* The re-emergence of particularly infectious disease and epidemic risks as a (local and global) priority is also leading to the need to re-assess and re-enforce epidemic preparedness programs (*Specific Objective 4.3.*). Finally, the unique situation of Lebanon, where crises are leading to long-term, severe and numerous impacts on health systems as a whole, make it increasingly necessary to confront and manage these impacts and indeed post-emergency transition (*Specific Objective 4.4.*).

4.1. *Strengthen emergency preparedness*

Preparations have been made to respond to the full requirements of IHR. The legal framework has been developed and has been processed through ratification by parliament along with the implementation regulations. With support of WHO significant capacity building in terms of IHR requirements has been provided including reinforcing IHR monitoring capacity at Points of entry (Tripoli port, Beirut airport and Beirut port), establishing a HAZMAT (Hazards Management) team, development of facility based Contingency plans

and Mohafazats based contingency plans; monitoring and responding to radio-nuclear hazards is commissioned to the national Lebanese Center for radiation. National plans for pandemics and epidemics containment are elaborated and periodically updated. National laboratory functions are currently tendered to a number of public and private laboratories although long-term plans to create a national (public) central referral laboratory exist. The focus of the coming period is to fully implement the IHR framework and continue to develop and test emergency and epidemic plans.

A national disaster risk reduction program is established at the level of Cabinet of Prime minister, and has already developed a national framework of emergency preparedness and response plan. A national HAZMAT team (multidisciplinary) has been established and trained and fully equipped to respond to medical care for CBRN

4.2. Strengthen epidemiological surveillance program

Created in 1995, the Epidemiological Surveillance Program (ESP) unit is responsible for the surveillance system of communicable diseases and national cancer registry. The ESP uses surveillance data, screens epidemiological alerts, conducts field investigations and analytic epidemiological studies, provides feedback to health professionals, and trains them on surveillance tools. The need reported above to improve reporting from physicians in private cabinets, medical centers, and outpatient facilities is largely driven by the needs of (timely and robust) epidemiological surveillance (critical path from 1.3. and 'hot data' components to data collection).

Early warning is fundamental to population-wide collective public health functions. The indicators-based surveillance relies mainly on the classical surveillance system targeting forty (40) diseases to be reported by health facilities. In addition, the event-based surveillance relies on two major sources: community news and electronic epidemic intelligence. The epidemiological surveillance unit publishes its reports and figures on the MOPH website with weekly updates on the following website (<http://www.MOPH.gov.lb> (prevention, surveillance). Further development of anti-microbial resistance (AMR) monitoring is initiated.

Ensuring continuous training for health professionals is critical for an accurate surveillance system and current training programs do not currently have sufficient reach. One option is to explore advanced technology for a wider scope of training (including e-learning modules on specific communicable diseases surveillance). However, simplifying and strengthening facility level basic reporting requirements through an electronic platform is a more basic first requirement. The role of sub-national public health authorities is also to be re-evaluated in respect to training and capacity building and delegation of authority to analyses data available at subnational level and initiate response accordingly (1.2.).

4.3. Strengthen preparedness for epidemics

The dispersal of the Syrian refugees among the host communities across the country as well as the chaotic establishment of informal tented settlements with very poor sanitation and hygiene facilities increased the risk of outbreaks and prompted the intensive upgrade of the national Early Warning and Response function (EWAR). EWAR was expanded to include: schools, PHC, hospitals and private sector (sentinel), with provision of necessary equipment (faxes, training and updating and revision of reporting forms, response guidelines for the most common outbreak prone conditions).

The national contingency plans at central and Mafazat levels have been developed by the MOPH, including creating stockpiles of medications and supplies for immediate outbreak response. Support staff for polio monitoring is also available in the Qadas most at risk for possible outbreaks. Some Qada health units have also been re-enforced with additional staff. The District Health Information System (DHIS2) has been used to allow faster monitoring of and response to potential hazards and outbreaks (4.2).

A plan to support computerization of EWARS and creating a multi-level multi institutional IT platform that allows timely exchange of epidemiological alerts and facilitates prompt response with concerned health and non-health teams is under preparation with the WHO and would need additional support and resources

4.4. Crisis response and post-emergency transition management

Significant efforts were made to improve the capacity of the MOPH and related health stakeholders on emergency risk and crisis management, including a special cell established at The Prime Minister's Office for inter-ministerial coordination. However, the interventions remain fragmented and poorly coordinated. One main limitation is the absence of a dedicated team/unit at the MOPH for emergency risk and crisis management. Secondly, as emergency situations, particularly those related to refugees endure, it becomes increasingly necessary to develop transition management strategies to avoid unintended consequences of impact on the regular health systems of the country.

Nevertheless, a national master plan for emergency preparedness and response is developed through the inter-ministerial committee at the PM Office. The MOPH (with support of WHO) has already developed its health component within this master plan and a (Syria Response) health sector strategy. Contingency plans for health emergencies (man-made, outbreaks or natural disasters) are already developed at Mohafaza level with WHO support; drills and simulation exercises will be needed regularly

Moving from Planning to Operations

The approach taken in this Plan follows OMSAR guidelines which leave the substantive details of how these *Strategic Goals* and *Specific Objectives* will be achieved, to an Operating Plan. The Strategic Plan provides only an overview and indicates how plans submitted by departments and units early in the planning process are consolidated and fit together. The links between the Strategic and Operational Plans clearly are simply illustrated (Figure 6). The Operational Plan is then a management document based on the structure and plan set out above.

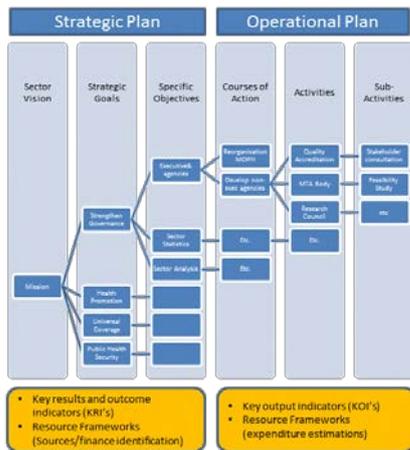


Figure1: Linking the Strategic and Operational Plans

6. Operational Plan Link to the Strategic Plan 2016-20

This Operational Plan accompanies the current medium-term Strategic Plan of the MOPH (2016-20). The Operational Plan provides the details of current (immediate and specific) activities towards the longer-term Goals and Objectives of the Strategic Plan. 'Activities' in a general budgeting and planning sense are further and formally specified in the OMSAR framework for strategic planning as: "*Courses of Action*" which in turn are made up of "Activities" (and potentially therefore also "sub-activities")

The Operational Plan part of the report is therefore structured in sections according to the Goals and Objectives as set out in the Strategic Plan. There are four main Strategic Goals. The descriptions in the Strategic Plan are not repeated (See Strategic Plan). Each section therefore lists only the *Courses of Action* and subsequent (sub-) activities relating to each Specific Objective.

The Operational Plan

The Operation Plan is structured according to the Strategic Goals and *Specific Objectives* of the MOPH Strategic Plan.

The Strategic Plan has been constructed (in accordance with OMSAR guidelines) as a cascading (or aggregating) structure of:

1. Strategic Goals (made up of)
 - 1.1. Specific Objectives (made up of)
 - 1.1.1. *Courses of Action* (made up of)
 - 1.1.1.1. Activities

The Strategic Plan proposes four strategic goals namely:

- 1. Modernize and strengthen Sector Governance:**
- 2. Strategic Goal 2: Improve collective health and promotion across the life-cycle**
- 3. Continue progress to Universal Health(care) Coverage:**
- 4. Develop and maintain (post-)emergency preparedness and (long-term) health security:**

The Operational Plan provides for each strategic Goal, specific objectives, under each the corresponding course of action with proposed activities for each course of action proposed

Operational Plan

In this section, the various Strategic Goals (SG) , Specific Objectives (SO) *Courses of Action* (CA)are listed and, where relevant, specific planned or requested activities specified (A).

SG1. Modernize and strengthen Sector Governance:

SO 1.1 Strengthen executive, quasi and self-regulatory bodies

CA 1.1.1 Re-organization of organogram of MOPH to include emergency and preparedness response unit and NCD program

A.1.1.1.1 Consultation within MOPH for revised organogram for final approval

A.1.1.1.2 Develop, elaborate a human resources plan for the MOPH

A.1.1.1.3 Establish selected critical Units/programs at the MOPH

CA 1.1.2 Develop and strengthen regulatory capacity related to:

A.1.1.2.1 Accreditation and Licensing

A.1.1.2.2 Pharmacovigilance and post-marketing systems establishments

A.1.1.2.3 Medical Technology Assessment Administration

A.1.1.2.4 Quality Assurance for Pharmaceutical Products initiative

A.1.1.2.5 Public Managed Care Provider Executive/Third Party Administrator for 'insurer-of-last-resort' functions

A.1.1.2.6 Good Storage Distribution & Packaging, Good Manufacturing Practices and Good Laboratory Practices Initiatives

A.1.1.2.7 Code of ethics for drug promotion

A.1.1.2.8 Generics use promotion at the national level

SO 1.2 Strengthen sub-national public health administrations

CA.1.2.1. Develop a decentralization plan at Qada level

A.1.2.1.1 Assessment of capacity of Qada health unit for monitoring health of population

A.1.2.1.2 Capacity building, training on population health monitoring

A.1.2.1.3 Staffing at Qada Level

SO 3. Strengthening (sector level) information systems and statistics:

CA 1.3.1 Improving information gathering and surveillance

A.1.3.1.1 Strengthening Civil Registration and Vital Statistics

A.1.3.1.2 A project for the nation-wide implementation of ICD 10

A.1.3.1.3 Development of an e-health strategy

A.1.3.1.4 (Further) development of the inter-operability platform for health facility and provider networks interfaces (Primary, Hospitals, and Pharmacies).

CA.1.3.2 Improving sector level data (for decision-making) reporting

A.1.3.2.1 Staffing

A.1.3.2.2 Issuing annual health statistics reports

A.1.3.2.3 Integrate National Health Accounts at government level

A.1.3.2.4 Develop a unique identifier for beneficiaries of MOPH public services (World Bank Project)

SO 1.4.Strengthening analytical, evidence, consensus and partnership formation capacity of MOPH

- CA 1.4.1 Improve regulatory capacity of MOPH in Health Research
 - A.1.4.1.1 A sector Finance and Governance Review and options towards Universal Health Coverage
 - A.1.4.1.2 National Consultation of Public Health Priority research areas
 - A.1.4.1.3 Update regulations related to clinical trials and expand regulations to clinical trials that include medical devices
 - A.1.4.1.4 Set up a clinical trial registry

- CA 1.4.2 Develop the open network governance approach to engage stakeholder networks and strengthen partnerships
 - A.1.4.2.1 Conduct assessment and feasibility study
 - A.1.4.2.2 Pilot the open net-work approach modeling

S G 2: Improve collective health and promotion across the life-cycle

SO 2.1 Improve public health promotion and behavior change

- CA 2.1.1. Non-communicable disease (NCD) promotion and risk-reduction
 - A.2.1.1.1 Behavior change campaigns developed for anti-smoking and (childhood) obesity (diet and exercise), breast cancer early detection, breastfeeding, injuries and violence, etc..
 - A.2.1.1.2 School health programs and improving the health of adolescents
 - A.2.1.1.3 Review standards related to food quality with regard to NCD risk factors

- CA 2.1.2 Promotion and monitoring of maternal, child and adolescence health at PHC level
 - A.2.1.2.1 Community outreach activities and initiatives related to maternal, reproductive, sexual health, neonatal, child health and youth health
 - A.2.1.2.2 implementation of global school health surveys

- CA 2.1.3. Reinforce the nutrition program
 - A.2.1.3.1 update the national guidebook for nutrition services at PHC (screening, awareness, and micronutrient replacement)
 - A.2.1.3.2 Assessment of malnutrition and selected micro-nutrient deficiencies
 - A.2.1.3.3. Capacity building on Nutrition (services provision at PHC level, management of malnutrition)

- CA.2.1.4 NCD Monitoring
 - A.2.1.4.1 Expand Cancer registry to include community data
 - A.2.1.4.2 Establish Diabetes Registry
 - A.2.1.4.3 Establish Cardiovascular Registry

SO2.2. Improved consumer safety, environmental and sanitation measures for human health

- CA 2.2.1. Consumer and occupational protection, health and safety
 - A.2.2.1.1 Reestablish occupational health program at MOPH
 - A.2.2.1.2 Establish an occupational health registry
 - A.2.2.1.3 Revise and introduce legislations to ensure human resources safety for health

A.2.2.1.4 Maintain and institutionalize food safety program

CA 2.2.2 Environmental safety

A.2.2.2.1 Link database of environmental health and sanitation program to MOPH-HIS

A.2.2.2.2 Review water quality and sanitation standards

A.2.2.2.3 Establish a standard environment health and sanitation surveillance system

A.2.2.2.4 Implement health care waste management standards in all health facilities (standards updates and training)

A.2.2.2.5 Piloting of health cities model in selected areas

SO.2.3. Increasing the efficacy and efficiency of population based (vertical) public health and communicable disease programs

CA 2.3.1. Control of communicable diseases; to maintaining and expand the following programs:

A.2.3.1.1 HIV/AIDs program

A.2.3.1.2 Hepatitis (all)

A.2.3.1.3 Tuberculosis

A.2.3.1. 4 Malaria

A.2.3.1.5 Neglected Tropical diseases

A.2.3.1.6 Establish and implement antimicrobial resistance program

CA 2.3.2 Reinforcement of National Surveillance System

A.2.3.2.1 Routine surveillance upgrade using IT system

A.2.3.2.2 Periodic issuing of bulletins on communicable diseases

CA.2.3.3 Vaccination Program

A.2.3.3.1 Expand capacity of EPI at PHC level

A.2.3.3.2 Procurement of vaccines

A.2.3.3.3 Introduction of new vaccines (Rota, hepatitis A, HPV, and others)

A.2.3.3.4 Develop an adult national vaccination calendar

A.2.3.3.5 Conduct monitoring surveys for coverage

SO 2.4. Development of community health, mental, elderly and social services and partnerships

CA 2.4.1. Expansion of mental health program

A.2.4.1.1 Integrate mental health services at PHC

A.2.4.1.2 Expand mental health registry

A.2.4.2.2 Implement mental health services in selected settings like prisons

A.2.4.2.3 Capacity building on emergency mental health care

CA 2.4.2. Development of long-term and elderly care program

A.2.4.2.1 Elaborate a palliative care package of services at MOPH

A.2.4.2.2 Integrate elderly health services at PHC

SG3. Continue progress to Universal Health (care) Coverage:

SO 3.1 Expanding access to (quality) primary care

CA 3.1.1. National PHC network facilitation and 'platform' development

A 3.1.1.1 Expand PHC network at a rate of 50 new centers per year

A.3.1.1.2 Expand PHC accreditation program

- A.3.1.1.3 Pilot open-network approach modeling as in 1.4.2.2
- CA 3.1.2. Expand the wellness packages
 - A. 3.1.2.1 Develop additional wellness packages (for elderly, people with special needs,.)
 - A.3.1.2.2 Capacity building training on new wellness packages

SO3.2. Strengthen the public hospital network, emergency and ancillary services

- CA 3.2.1 Developed public hospital governance and management:
 - A.3.2.1.1 Training programs focusing on hospital management
- CA 3.2.2. Develop internal financial management and ('business operations') performance systems
 - A.3.2.2.1 Development and implementation of management systems for 'public' (i.e. private non-profit) hospital management [under development]
- CA 3.2.3. Improve referral systems to public hospitals
 - A.3.2.3.1 Develop a strategy to improve cooperation and referral between primary and hospital providers
- CA 3.2.4. Review emergency services systems
 - A.3.2.4.1 Establish a sentinel system for information on emergency services
 - A.3.2.4.2 Develop standards on quality of emergency care
 - A. 3.2.4.3 Training on Standards of Emergency care

SO 3.3. Strengthen access through the 'public social medical insurer'

- CA.3.3.1 Assess administration options for the MOPH 'insurer-of-the-last-resort' function
 - A.3.3.1.1 Performance contracting trials
 - A.3.3.1.2 Contracting 'insurer-of-last- resort' functions to a Third Party Administrator (TPA)
- CA 3.3.2. Develop a clearer branding strategy of the social/public funded 'insurer-of-the-last-resort' function
 - A.3.3.2.1 Upgrade beneficiary databases and management
 - A.3.3.2.2 Development and implementation of a compatible communication strategy
- CA. 3.3.3. Institutionalize the National Health Accounts
 - A. 3.3.3.1. Training relevant institutions on NHA
 - A. 3.3.3.2, Generate yearly NHA report

SO3.4. Improving health sector human resources and continuous medical education

- CA 3.4.1. High level public-private consultation forum on long-term human resource for health development
 - A.3.4.1.1 Organize at least every 2 years a national conference to discuss human resources plan for the country
- CA 3.4.2. Update of Continuous Medical Education (CME) process with professional orders
 - A.3.4.2.1 Organize conferences/workshops to update CME content and set standards for validation of professional licenses
 - A.3.4.2.2 Update the national licensing requirements and process for medical professionals
- CA 3.4.3 Training programs (short courses) to develop health professionals' performance at work (in public facilities)

- A.3.4.3.1 Develop modular course on performance improvement
- A.3.4.3.2 Organize trainings

SO3.5. Efficient procurement and logistics

CA 3.5.1. Cooperation in e-procurement strategy and systems developments

No current planning. This section is included for purposes of comprehensiveness and use in future up-dates of this document for next strategy cycle.

CA 3.5.2 Maintain Chronic NCD program with YMCA

- A.3.5.2.1 Review Essential Drug List
- A.3.5.2.2 Procurement of medications

CA 3.5.3 Access to catastrophic illnesses medications

- A.3.5.3.1 Update list of medications to be covered and mechanism for access
- A.3.5.3.2 Include efficiency and cost-effectiveness studies when adding new medications to the list
- A.3.5.3.3 Continue procurement

SG4 .Develop and maintain (post-) emergency preparedness and (long-term) health security (All):

SO4.1. Strengthen emergency preparedness

CA 4.1.1 Implement the 2015 International Health Regulations framework

- A.4.1.1.1 Expand health units at boarder areas
- A.4.1.1.2 Expand Hazmat Team at Mohafaza level
- A.4.1.1.3 Conduct simulation exercises in selected areas
- A.4.1.1.4 Develop contingency planning at Qada Level
- A.4.1.1.5 Update pandemic plans periodically

CA 4.1.2. Reestablish the national central public health lab full functions

- A.4.1.2.1 Update functions of central referral lab
- A.4.1.2.2 Select and capacity build labs to implement the functions of central referral public health lab

SO4.2. Strengthen epidemiological surveillance program

CA 4.2.1. Establish a comprehensive surveillance and response system modules in epidemiological and surveillance information systems

- A.4.2.1.1 Develop an IT platform to allow flow of information to and from epidemiological and surveillance unit

SO 4.3. Strengthen preparedness for epidemics

CA 4.3.1. Expand EWARS and event management system using IT network

- A 4.3.1.1 Training on event based management
- A.4.3.1.2 Periodical alerts monitoring system linked to other partners

CA 4.3.2. Audit and asses registry of EWARS stock(s)

- A.4.3.2.1 Procurement of PPEs and reagents
- A.4.3.2.2 Periodic stock monitoring

SO 4.4 Develop crisis response and post-emergency transition management within context of Syrian crisis response strategy

CA 4.4.1. Transition management and post-emergency strategy

A.4.4.1.1 Update yearly the 5 year humanitarian response strategy

A 4.4.1.2 Lead coordination activities within humanitarian response

CA. 4.4. 2 Enhance the role of media and academia in emergency preparedness and response

A.4.4.2.1 organize sensitization meetings with the media

A 4.4.2.2. Organize sensitization meetings with academia

Performance monitoring and management

The mission of the MOPH is both ambitious and complex. Maintaining and pursuing the health of every individual in Lebanon, irrespective of his or her personal circumstances, is a continuous and formidable challenge. The aim of this Strategic Plan is to provide a clear and relatively easily understood structure to guide and coordinate the execution of therefore a very extensive range of operational activities across a wide range of specialized and often highly technical areas. In the case of the MOPH, coordination is therefore also needed across a large number of departments and fields of expertise; and indeed across a much wider context of stakeholder groups and interests in the health sector and health systems. In this section, a summary is provided of how the MOPH proposes to monitor on-going performance against the plan and ultimately evaluate success in the future.

In the attached operational plan-spreadsheet, is set out to give clear indicators and measures of what is to be produced under each of various *Strategic Goals* and *Specific Objectives* that make up the plan. It is clear that any plan requires large numbers of assumptions about future events. Issues in estimating such risks in the light of the background discussion on the background, and contingency measures against such risks, are discussed in the final section of the chapter.

Budgeting

In terms of the budget and revenue and expenditure projections a number of constraints exist. First, it is clear that as there has been no formal state budget for Lebanon since 2005 there is no base for calculations. Secondly, the absence of any formal budgeting process over such a long period has left the MOPH with no effective capacity in this area. This continuing constraint is therefore beyond the control of the MOPH. Thus, estimating budgets were not possible.

Risks and contingencies

The primary risks identified in the formulation of the plan are as follows:

1. Government funding does not increase
2. The Syrian crisis continues with constrained international help
3. Employment constraints and low salaries (particularly for high-skill mobile labor requirements) in the public sector continue
4. Negative public perception of government health care services
5. Expanding sector infrastructure will lead to scarce resources and pressure on (working capital) operating budgets.

The perceived extent, nature and likelihood of these risks are not estimated or discussed further in this report beyond the background analysis. It should be clear however that the operations of the MOPH are subject to considerable uncertainty and detailed multi-annual operational planning is unlikely to be either motivating or realistic. Operational Planning is then prepared one year at a time but with an overview of all possible activities foreseeable over a medium-term time horizon and to fulfill the ambitions of the Strategic Plan (see Operational Plan). Because the risks facing the MOPH are beyond its control, the following mitigating measures are taken against them, respectively:

1. The Strategic Plan clearly distinguishes between different functions and roles that the MOPH might perform and hence also between areas that must be publicly funded and areas that might be funded through other means;

2. The Strategic Plan includes a high-level Strategic Goal specifically focused on emergency (and indeed post-emergency transition) management;
3. The Strategic Plan (and specified in the Operation Plan) identifies a number of distinct projects and areas of operations of the MOPH where it should be possible to continue to develop project and programmatic areas of support to the MOPH administration while it is subject to the constraints affecting the public administration as a whole.
4. The Strategic Plan includes a number of measures on both the financing/purchasing and provision sides of public health care services and insurance (administration) aimed at improving the efficiency and quality of public health care service providers and their staff;
5. The Strategic Plan includes a number of measures aimed at strengthening both: non-executive bodies and 'self-regulation' and; the evidence formation and consultation capacity of the MOPH to continue to build and develop partnerships towards both individual organizational and collective sector goals

7. Conclusion

The Strategic Plan started with an extensive consultation across departments of the MOPH and amongst stakeholders to result in just four ambitious over-arching goals:

1. Modernize and strengthen Sector Governance
2. Improve collective Public Health and Promotion
3. Continue progress to Universal health(care) Coverage
4. Develop and maintain emergency preparedness and health security

Each of these Goals reflects areas of functional operations within the MOPH that are sufficiently independent to stand alone. Each also includes many activities across the entire MOPH organization and amongst its wide partner and wider stakeholder networks. But taken together, and with partners, networks, and activities progressing together, it is possible to continuously strive towards the vision of the MOPH:

An equitable health system that: identifies and addresses the key determinants of health, and; promotes and sustains the highest attainable health status of all Lebanese, and turns its ambitious mission into reality:

To build an effective, high impact organization that can develop partnerships across Lebanese society to achieve the vision of promoting health and improving the quality of life of even the poorest and most vulnerable of Lebanese society thereby contributing to the social and economic development of the country.

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