Can Lebanon conjure a public health phoenix from the ashes?

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The recent bombing of Lebanon destroyed much of the country's largely high tech health infrastructure. As services are rebuilt their focus should be orientated towards primary care to meet the needs of the poor and uninsured

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Lebanon is currently struggling with the aftermath of the most devastating conflict in its history. The south, where the population was already disadvantaged, was worst affected by Israel's bombardment over the 34 day war that started on 12 July. Over one million people, about a quarter of the population, were displaced. The Higher Relief Council put the overall death toll at 1183, nearly all of them civilians, and over 5000 were wounded. Two government hospitals were completely destroyed along with countless health and social centres.

Before the war Lebanon had one of the highest gross domestic products in the region, with 12% spent on health.[1] However, health provision was already inadequate in the south because of a system dominated by private providers with little interest in the needs of people who are poor or have long term disabilities or chronic illnesses. We describe how healthcare provision developed and argue that the postwar climate ought to compel the government to reconsider the prevailing market led structure.

Development of health services

After independence in 1943, the state built a network of district and rural hospitals that focused on serving the underprivileged. Patients were required to prove hardship in order to be admitted for care, creating a legacy of stigma associated with public provision that remains today.

The frequent civil wars, Israeli incursions, occupation, and bombing that ravaged the country from 1975 until 1991 weakened the institutional and financial capacity of the government.[2] As a result, the country had no clear health policy, no means to implement it, no information database to work from, and no health workers.[3] The public sector shrank dramatically in quantity and quality.[4] The few public health programmes available, such as vaccinations and healthcare for mothers and children, were driven by donors and pushed further into the hands of local and international non-governmental organisations.

After 1991, government provision became limited to some secondary and tertiary care for civil servants plus some targeting of the most disadvantaged groups. But since most public hospitals had been either destroyed or closed, the state had to buy services from private hospitals.[5] The private sector continued to expand and became the main secondary and tertiary provider, with primary care largely relegated to non-governmental organisations. Modern diagnostic techniques, equipment, and high technology services proliferated disproportionately to the size of the population Lebanon's rate of cardiac catheterisation, for example, is the second highest in the world.[6] Thus even before the war, the health sector in Lebanon was facing a major crisis, with inefficient services of uneven quality and large inequality in distribution and access to care despite high cost and substantial public funding.[4]

MATT DUNHAM/AP/EMPICS

Bombing in Lebanon destroyed health facilities

Public health funding

Around half the population have no insurance.[7] The ministry acts as the insurer of last resort, financing the hospital costs for any citizen who is not covered by insurance. However, the nature and organisation of health services means that as much as 84% of health expenditure goes on curative care, with hardly any support for preventive public health activities.[7]

An opportunity moving forward

As Lebanon moves to meet the needs of its population in the aftermath of the most recent war, it has an opportunity to challenge its predominantly market led health system and begin anew, with a vision for radical change. Any government planning of health services should follow the lead of local non-governmental organisations. This means moving away from high tech care and focusing on providing expanded access to primary care and community health centres for the poor and uninsured populations in the more remote regions.

Expanding public coverage through partnership with trusted local providers and civil society groups needs to be a priority. Similarly, donors and

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international non-governmental organisations providing emergency relief in Lebanon should work closely with local health providers to rebuild services and plan for longer term care. Working in partnership with local communities will help expand affordable health care coverage, encourage retention of the workforce, promote resiliency, and begin a healing process to a hugely traumatised and dispossessed population.

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Reproductive health of Arab young people

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Cultural taboos are limiting young people's access to sexual and reproductive services and information

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The Arab region, though diverse, is characterised by patriarchal social systems and family structures that give prominence to the role of men in both public and private spheres. Only recently has this situation been challenged by public policies and reforms in family laws. Since the international conference on population and development in Cairo in 1994, governments have pledged to improve the sexual and reproductive health of adolescents by providing integrated health services including contraception for sexually active adolescents and health education. Most regions of the world still fall well short of these recommendations, especially for unmarried young people, but those in Arab countries are particularly underserved.[1 2]

Demographic changes affecting young people

Focus on the high percentage of young people in the population has tended to sideline other demographic trends in the region with important implications for young people. These include the large recent rise in the average age at marriage for both sexes (nearing 30 in parts of North Africa[3]) and the rising proportions of young unmarried women in many Arab countries.[4] These trends have occurred in a cultural context where marriage is universally expected and sexuality outside marriage, particularly for women, heavily sanctioned and thus have important ramifications for reproductive health. Although research is very limited, premarital sexual relations are reported; in Jordan, 7% of college students admitted to non-marital sex in a study in 1994, as did 4% of the general population aged 15-30 in 1999.[5] Among university students in Egypt, 26% of men and 3% of women reported having sexual intercourse at least once.[6]

Major changes in the institution of marriage in the region are almost completely unexplored. There has been a resurgence of customary ('*urfi*) marriage, whereby young people obtain a clandestine marriage certificate to engage in sexual relations but are unprotected legally or in terms of health services, in countries such as Egypt.[7] Other forms of temporary marriage such as "summer marriages" in Egypt or "business related marriage" in the Gulf countries are increasingly discussed in the Arabic media, but their prevalence is unknown.

Lack of information

Family life in the region is changing because of migration, urbanisation, busy lives, and new lifestyles brought by the mass media and consumerism.[1] A rapid increase in access to education and exposure to the global media has widened generational gaps between parents and their children[8] and altered the ways in which young people receive information. Although studies show that young people would prefer to learn about puberty and their health from their parents, many parents are reluctant or ill equipped to provide this information. A nationally representative survey of young people and their parents in Egypt in the late 1990s found that, although 42% of fathers reported talking to their adolescent sons about pubertal changes, only 7% of boys reported learning about puberty from their fathers.[9]

The lack of accurate information about sexuality and reproduction reflects a wider public policy reluctance to provide sex education in schools. Although sex education is increasingly included on curriculums, teachers are often too embarrassed to teach it.

Absence of appropriate health services

Government health services generally do not recognise the special needs of young people or foster a climate that supports them. As a result, private health services are often the only place where young people can seek help on sexual and reproductive health issues,

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