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SPECIAL REPORT

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Lebanon's essential health care benefit package: A gateway for universal health coverage

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Summary

Recent years have demonstrated the resurgence of a global commitment toward universal health coverage (UHC). The first step toward developing a sustainable primary health care (PHC)-oriented UHC program is the creation and service delivery of an explicit essential health care benefit package (EHCP). This paper aims to describe the development, features, and progress of the EHCP in Lebanon, in addition to outlining barriers, facilitators, and next steps. Building on the investments made in the PHC network, the ministry of public health in Lebanon piloted an essential PHC package program in 2016 targeting vulnerable Lebanese and was able to enroll over 87% of targeted population to date. In order to scale up the EHCP to the national level and achieve UHC, modifications need to be made to the package entitlements, provider payment mechanisms, and implementation arrangements. The paper also notes that further advocacy and lobbying are needed in order to place UHC and the EHCP on the national agenda and stimulate public demand.

KEYWORDS
health benefits package, health systems, primary health care, provider payment mechanisms, universal health coverage

1 | INTRODUCTION

Recent years have demonstrated the resurgence of a global commitment toward universal health coverage (UHC).[1,2] The concept of UHC is heavily based on the World Health Organization (WHO) constitution of 1948 declaring health a fundamental human right and on the Health for All Agenda set by the Alma Ata Declaration in 1978.[3,4] The

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United Nations (UN) has also caught up, where global commitment to UHC was explicitly stated as one of the health-related Sustainable Development Goals (SDGs) to be reached by 2030.[5] UHC was also inextricably linked to primary health care (PHC) in the Astana Declaration at the Global Conference on PHC.[6]

It has been widely established that achieving UHC in low- and middle-income countries requires a remarkable expansion of governmental investment in reinforcing PHC.[7-11] To this effect, it has been estimated that 80% of all health needs can be met at the PHC level and that PHC services have the capacity to reduce the global burden of disease by 70%.[12] Additionally, with equity at the forefront of the SDGs and at the heart of health planning, PHC has gained even more traction because of its unique ability to target the poor and thus reach the "furthest behind first."[13] PHC promotes health equity in rich as well as in poor countries, thus leading to human and national development.[14]

The first step toward developing a sustainable PHC-oriented UHC program is the creation and service delivery of an explicit EHCP.[15] EHCPs can be defined as the set of health services and products that can be feasibly financed and provided for everyone, given a particular country's actual circumstances.[15] Progress toward UHC has been linked with developing an explicit EHCP,[16] which is essnential in bridging the gap between the de jure set of treatments offered in theory and de facto services actually received by patients.[15]Countries starting their journey toward UHC develop a UHC funding pool and begin with prioritizing the worst off and targeting the poor.[15,17]

In Lebanon, the Ministry of Public Health explicitly expressed the commitment to UHC through its national health strategy, and in 2016, it took the first official step by delivering a package of essential health care services to the most vulnerable Lebanese through a project with the World Bank.[18] This project was considered a pilot and started in the midst of a chronic Syrian refugee crisis in Lebanon. It constituted an attempt by the MOPH to mitigate chronic crisis conditions while building toward system level reform, particularly considering that plans for scaling up the EHCP to a larger sector of the population were underway.[19] This paper aims to describe the development, features, and progress of the EHCP in Lebanon, in addition to outlining barriers, facilitators, and next steps.

1.1 | Overview of the health sector in Lebanon

Lebanon is a middle-income country characterized by a population of around 4.5 million Lebanese citizens and approximately 1.5 million refugees, predominantly fleeing from the ongoing armed conflict in neighboring Syria.[20] Lebanon has a long history of political conflict and instability, including a 15-year civil war and repeated Israeli aggressions, which has led to a fragile economy, weakened infrastructure, limited government capacity, and limited public services across all sectors.[21]

Despite economic and political instability, Lebanon has succeeded in improving health outcomes by maintaining and improving access and delivery of health care services.[22] Life expectancy at birth, infant mortality rates, and other health outcome indicators have seen improvements over the last 20 years. Life expectancy at birth for both sexes rose from 72.2 in 1995 to 79.4 in 2015.[23] Under 5 and infant mortality rates dropped to a third of their 1996 levels, making Lebanon one of the few countries to achieve the millennial development goals of reducing maternal and child mortality.[24] A series of health reforms in the late 90s resulted in lower out-of-pocket (OOP) expenditure on health care from 60% in 1998 to 34% in 2013 and lower percentage of gross domestic product (GDP) spent on health care (12.4% in 1998 lowered to 7.17%).[22,25]

In Lebanon, the health care system is geared toward hospitalization and secondary and tertiary care, which is reflected in insurance coverage schemes.[26] Almost half of the population is socially or privately insured, while the MOPH, which acts as the "insurer for last resort" covers around 53% of the population through a nonvoluntary tax-funded insurance scheme (Figure 1).[26] This makes the MOPH in Lebanon the main contractor of services at the hospital level. The MOPH contracts both private and public hospitals to provide curative services that take up the bulk of the MOPH budget (79%).[26] It also provides coverage for selected expensive outpatient services like kidney dialysis and chemotherapy in addition to full coverage for drugs of catastrophic illness (Figure 2).[26]

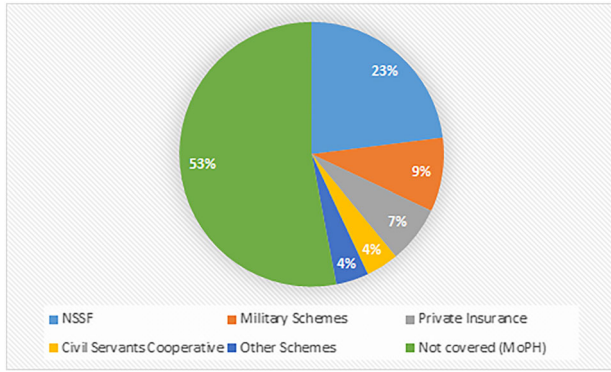

FIGURE 1 Insurance coverage in Lebanon by scheme

Box1: ***Implicit entitlements as per MoPH coverage***

- Subsidized inpatient care
- Subsidized selected expensive outpatient services
- Full coverage for drugs of catastrophic illness
- Provision of free vaccines as per national vaccination calendar
- Provision of free acute and chronic drugs as per the national essential drug list

FIGURE 2 Implicit entitlements as per Ministry of Public Health (MOPH) coverage

Despite the aforementioned decrease, the OOP rate in Lebanon remains high. One of the main drivers of OOP in Lebanon is outpatient care including both consultations and diagnostics.[27] The majority of these services are not covered by the MOPH coverage and are only partially covered by other schemes on a reimbursable basis.[26] This means that to access most outpatient services, beneficiaries still have to pay OOP at point of care that creates financial barriers to care.

1.2 | The PHCN in Lebanon

The development of the National PHC Network (PHCN) in Lebanon started in the 1990s (Figure 3).[26] As a result of the limited government capacities after the civil war, the number of nongovernmental agencies (NGAs) in the health care sector increased exponentially in all regions in Lebanon.[26] The civil society became a major player in health care and particularly in PHC. During this time, Lebanon had adopted the Alma Ata Declaration and aimed at integrating

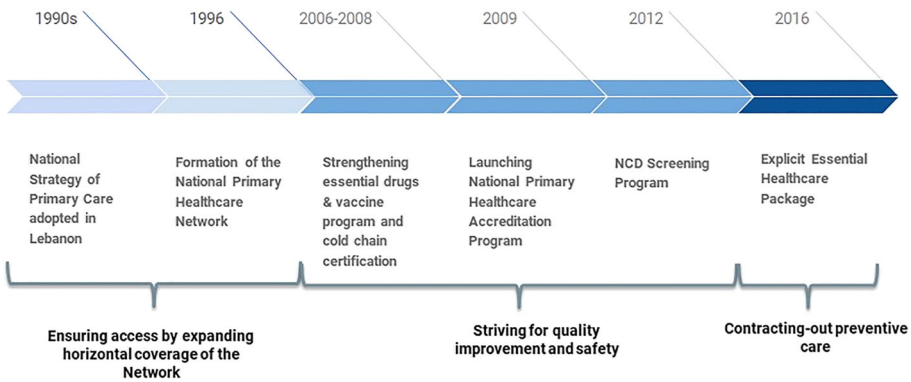

FIGURE 3 Timeline of the Primary Health Care Network

PHC in the health system reform.[26] Instead of building a parallel system to provide PHC services, the MOPH capitalized on existing resources and formed a National PHCN in collaboration with the local civil society. This allowed the MOPH to guide and regulate primary care provision rather than deliver services and saved the MOPH the start-up/operational costs of the primary health care centers (PHCCs).

As such, the National PHCN was established in 1996 with only 19 PHC Centers.[26] Today, the PHCN includes 229 centers distributed across Lebanon. It serves over 1 million beneficiaries annually including both Lebanese and Syrian refugee populations. The PHCCs are run by NGOs (67%), municipalities (20%), academia (1%), and governmental institutions (12%).[28] Each center provides basic PHC services (consultations and diagnostic testing) including family medicine, pediatrics, reproductive health, cardiology, and dental care for discounted rates.[29] While the Lebanese pay the discounted rates OOP, Syrian refugees benefit from United Nations High Commissioner for Refugees (UNHCR) subsidies and receive these services with limited copay.[30]

In terms of support to the network, the MOPH provides in-kind contribution to PHCCs in the form of free essential vaccines, essential drugs (acute and chronic), continuous capacity building, health information system, and technical support, medical supplies, and equipment.[29] In return, the contracted PHCs commit to providing the basic services required by the MOPH at discounted rates, adhering to the national immunization calendar and essential medication regulations and submitting monthly reports to the MOPH.

As for quality of services, in 2008, Lebanon become one of only five countries worldwide to have the cold chain certification for vaccination storage. The MOPH also initiated work on an accreditation mechanism for PHC centers, as a way to monitor and ensure quality at the PHCCs.[31] The MOPH selected Accreditation Canada as the accrediting body because of their extensive experience and standing as global leaders in primary care. The accreditation program is fully funded by the PHC Department at the MOPH. With the PHC accreditation program, Lebanon was the first to introduce an international accrediting entity in the region and was the first to have contextualized primary care standards in the region and translated to Arabic. In addition and in accordance with accreditation standards, the PHC Department launched new initiatives that focused on community needs such as the noncommunicable disease (NCD) program in 2012 and community outreach and awareness programs.[31] This helped shift the role of PHCCs from curative to preventive and enhanced their community outreach role. Moving forward after the investment in infrastructure and quality of care, the MOPH began piloting contracting out preventive PHC services in 2016 to be elaborated on in section 1.3.

1.3 | Essential health care benefit package in Lebanon

1.3.1 | Why the EHCP was needed

Despite the remarkable achievements of the Lebanese health care system, it has been described as pluralistic and fragmented. The health care system in Lebanon is the product of a partnership between the public and private sectors, with several sources of funding and channels for delivery of services.[22] This resulted in a multitude of insurance schemes with varying degrees of coverage (social security, private insurance, professional groups, government employees, military schemes, and so on).[26] As for the previously mentioned MOPH scheme, despite the breadth of the coverage (hospitalization, medication, chemotherapy, and so on), the benefit package itself remained implicit, and among the general public, the health entitlements of a Lebanese citizen remained vague. The multiplicity and ambiguity shrouding the health insurance schemes in Lebanon, in addition to the relatively high OOP health expenditures, and lack of coverage of outpatient services generated a sense of public dissatisfaction with the current state of the health care system.[32] The health care system in Lebanon also adversely affected the most low-income population; in that, the lowest quintiles had lower rates of insurance coverage and had to pay more frequent catastrophic payments, increasing their vulnerability.[33] Over the past 10 years, almost every minister of health and several parliamentarians have attempted to pass laws to merge the health insurance schemes, create a single funding pool, and standardize the package of services, but none of these laws were passed due to conflicting stakeholder

interests.[32,34,35] As a result, and in response to intermittent spurs of public demand, the issue of UHC and benefit packages has been passed over from one administration to the next.

Meanwhile, the MOPH had been making investments over the years in the PHCN as part of its post-civil war reforms.[26] There was a growing interest in PHC as the key to achieving people centered care and the SDGs, and there was a strategic decision to reorient the Lebanese health care system away from the curative and toward the preventive care.[34] In addition, the MOPH had a good working relationship with the NGOs in the civil society sector that owned and operated the PHCCs, which were considered natural allies.[36] Despite the in-kind support provided by the MOPH, the NGOs had never been financially compensated by the MOPH for the discounted services they deliver to the Lebanese as per MOPH regulations.[26] As such, following the success of the MOPH in performance contracting at the hospital level and the progress made with accreditation at the PHCC level, contracting out PHC services became a matter of time and opportunity.

In 2011, the onset of the Syrian crisis presented a considerable test for the Lebanese health care system. It placed a significant burden as the new refugees represented a 30% increase in Lebanon's precrisis population, resulting in the highest refugee density of any country worldwide since 1980.[37] Additionally, with the government's no camp policy, refugees were dispersed within Lebanese communities[38] and thereby integrated into the health care system where they accessed the same channels of care as the Lebanese at both the primary and secondary levels.[22] The new load of refugees caused crowding out of Lebanese especially at the primary care level where refugees were subsidized for care while the host population remained uncovered.[18,22] The proportion of Syrians accessing the PHCN increased from 12% in 2012 (precrisis) to 35% in 2014 and has now reached 46% in 2018.[18,39] This varied by region where in some PHCCs the proportion of Syrian refugees was as high as 90% of the total patient load.[18] This was especially alarming as the majority of Lebanese accessing care at the national network were vulnerable and their access had been compromised.[18] Subsequently and because of many accompanying circumstances, tensions were on the rise between host and refugee populations.[18]

At the same time, the World Bank had been working with the Lebanese Ministry of Social Affairs on a National Poverty Targeting Program (NPTP). Through this program, they developed a database of poor Lebanese and offered them a social package.[40] This prompted the World Bank to collaborate with the Lebanese Ministry of Public Health and target vulnerable Lebanese from their newly established database in order to enhance their access to PHC and mitigate the effects of conflict.[18] From the MOPH perspective, this presented an opportunity to mitigate the acute effects of crisis while carrying out the initial vision of advancing primary care and contracting-out services in the sector.[34]

Accordingly, the MOPH in Lebanon embarked with support from the World Bank on the emergency PHC restoration program, an essential health care benefits program targeting vulnerable Lebanese. The project was considered a pilot for a contributory insurance model rooted in PHC and was to be funded through a grant from the Multi-Donor Trust Fund.[18] In the short-term, the MOPH aimed to restore access of vulnerable Lebanese to primary care, in the long run, the MOPH aimed to pilot an explicit package of services that was fully subsidized for the vulnerable and will rely on contributions from the higher income quintiles once expanded to the entire population.[34]

Although the project had received approval at the World Bank level, it took over a year of advocacy and lobbying from the MOPH at the level of the government to get the project formally adopted. The acceptance of the grant by the government was influenced by several political determinants at the time including the Syrian crisis and conflicting stakeholder interests. The political factors were diluted and mitigated through intense lobbying via frequent meetings with the health, legal, and financial parliamentary committees.

1.3.2 | How the EHCP was developed

In Lebanon, the development of the explicit EHCP was planned as part of a wider health system reform that aimed to eventually reorient the health care financing and delivery models toward cost-effective primary care. This set a clear health system goal to operate within, and the resulting package took its initial shape based on both the

identified gaps in the existing MOPH implicit coverage scheme (which were mainly related to primary care) and subsequently the known capacities and strengths of the existing primary care system. As previously described, three of the major gaps in the existing MOPH coverage were outpatient consultations, screening, and diagnostic services whether for prevention, acute complaints, or chronic disease management purposes, all of which could be widely addressed in a primary care setting. As for primary care capacities, the PHCN had an existing essential immunization program fully subsidized by the MOPH and a reproductive health and NCD programs that were well implemented but financed mainly through OOP contributions.

Based on the above, a policy decision was made to develop preventive wellness packages for all, a maternal health package for women in reproductive age, and NCD-oriented package to follow up on two common chronic diseases: diabetes and hypertension (HTN). All of the above packages would capitalize on existing programs at the PHCN but will help arrange those programs and services within explicit entitlements that are subsidized by MOPH rather than paid for OOP. After setting the areas of focus, policy makers at the MOPH had several discussions in order to pinpoint the criteria with which to select services and interventions to be covered under every focus area. The following set of criteria were considered relevant to decision making (Table 1).

Next, MOPH approached the Family Medicine Department at the American University of Beirut Medical Center, a leading university hospital in Lebanon, and the region and a team of family medicine physicians were enlisted to develop the particularities of the packages. The team were briefed about the areas of focus and desired criteria. The MOPH expressed that the EHCP would comprise wellness, maternal health, and NCD packages that were evidence-based and cost-effective interventions. The team proceeded to collate existing national and international evidence in order to develop recommendations for further enhancement of the shape of the EHCP and the services to be included.

The team recommended wellness packages to be based on age and sex, namely, 0 to 18, 19+ females, and 19+ males. As such, wellness packages were arranged as life-time packages where services would be repeated according to a certain frequency as outlined in each package. The maternal health package, on the other hand, was arranged as an episodic antenatal package with services divided under three trimesters. Finally, the diabetes and HTN packages were arranged as annual disease management and follow-up protocols that require repetition every year.

As for services within the packages, these were arranged under immunization, health care worker consultation, lab services, other diagnostic tests, clinical encounter, education and counseling, and medications. In terms of what services to include, the maternal health, diabetes, and HTN packages were based on the existing national protocols that are also in-line with the WHO recommendations. As for wellness packages, the immunizations for 0 to 18 follow the national vaccination calendar that is set by a separate technical committee and reviewed on a regular basis. The rest of the services were based on existing international guidelines taking into account the above-listed criteria and in some cases, expert opinion. Finally, in terms of medication, the EHCP covered the existing essential drug list that is also developed by a separate medical and technical committee and reviewed on regular basis. It is important to note that because of the varying capacities of PHCCs in the PHCN, some selected services were not necessarily available in all the PHCCs; however, they were important for the purpose of the EHCP, for instance, mammography.

TABLE 1 Criteria to select services/interventions within the packages

Effectiveness
Maximizing the improvement of population health status
Cost-effectiveness
Budget Impact
Feasibility of scale-up to entire network after pilot phase
Wide availability at PHC level

Abbreviation: PHC, primary health care.

Such cost-effective services were included in the EHCP with the expectation that the implementation arrangements would require the PHCCs to contract an external entity to deliver the specific service to the patient.

To summarize, the below table (Table 2) highlights the overall skeleton of the resultant EHCP.

Following the development of the first draft of the EHCP, MOPH conducted a costing exercise for the EHCP with support from the World Bank. Based on the exercise, and considering that the MOPH had limited donation funds to implement the pilot project, a quick budget impact analysis was conducted, and some services were omitted. These were mainly expensive services that were known not to be available at the primary care level and would therefore cost providers a high amount to refer out. With these final revisions, the EHCP was complete and ready for implementation.

1.3.3 | EHCP governance and implementation arrangements

In 2016, the MOPH became the recipient of a US$15 million grant from the Multi-Donor Trust Fund, the "Lebanon Syrian Crisis Trust Fund" (LSCTF), which was managed through the World Bank. The funds were allocated for the "Emergency PHC Restoration Project" EPHRP, which aimed at restoring access to PHC services to vulnerable Lebanese through delivering an essential healthcare package of services in selected PHC centers in the national PHCN.[40] Project implementation extended for almost 4 years between May 2016 and December 2019.

A project management unit (PMU) was formed under the PHC Department at the MOPH to manage all project operations. The PMU was led by the head of the PHC Department at the MOPH, a civil servant.[41] In addition, a steering committee was formed to provide oversight and stewardship for the EPHRP project.[42] The project steering committee was chaired by the director general at the MOPH and included the EPHRP project coordinator and members of civil society and academia. The PMU comprised finance, procurement, and monitoring teams. The monitoring structure of the project included central officers and district level field coordinators who visited the PHCCs regularly

TABLE 2 Summary of the EHCP

Package No	Health Package Type	Age Subgroups, year	Group of Services
Package 1	Wellness package (0-18 y)	0-2 3–6 7-12 13-18	• Immunization • Health care worker consultations (Primary care physician, specialist, dietitian..) • Lab services • Other diagnostic services • Clinical encounter (details of what happens during the consultation • Patient counseling and education (Major counseling topics to be delivered) • Medications
Package 2	Wellness package female (19+ years)	19-39 40-49 50-64 65+	
Package 3	Wellness package male (19+ years)	19-39 40-49 50-64 65+	
Package 4	NCD package – diabetes mellitus	18+	
Package 5	NCD package – hypertension	18+	
Package 6	Maternal Health Package	Females in reproductive age	

Abbreviations: EHCP, essential health care benefit package; NCD, noncommunicable disease.

to follow up on project implementation. The project also contracted an external financial auditor and an external technical evaluator to ensure compliance with MOPH and World Bank regulations. To further strengthen accountability and transparency, the MOPH set up a comprehensive grievance redress mechanism for project beneficiaries with multiple uptake channels including a hotline, mobile app, and website.

The EPHRP project targeted 150 000 vulnerable Lebanese through 75 selected PHCCs in the national PHCN. An initial enrollment database was provided through a preexisting project, the NPTP under the Ministry of Social Affairs. The most vulnerable families were selected from the NPTP database and mapped across 75 PHCCs. The participating PHCCs were selected according to the following criteria: (a) participation in the PHCN and (b) geographical proximity to communities with high concentration of NPTP enrollees and those most affected by the influx of Syrian refugees.

Once contracted, the participating PHCCs underwent a preparation phase where they received intense capacity building on the different elements of the project. To encourage beneficiary enrollment in the EPHRP, the PHCCs conducted local and targeted outreach campaigns in their communities using promotional material provided by the MOPH. The campaigns included awareness sessions, home visits, and involvement of local community gatekeepers such as heads of municipalities, village mayors, and so on. Once enrolled, individuals and families were exempted from payment for EHCP services and had only to pay a loyalty fee of US$12/year. Below is a figure (Figure 4) that summarizes EPHRP implementation arrangements.

1.3.4 | EHCP financial arrangements

The EHCP package was costed with a bottom-up approach by estimating the full cost of delivering each package at the PHC center level from the purchaser perspective. The costing model took into account unit rates for each intervention within the packages. The unit rates were those of the National Social Security Fund (NSSF) discounted (30%) tariffs, which are widely used in Lebanon. After the packages were costed individually, an overall cost estimate for the project was developed taking into account the size of the target population, age and sex structure, prevalence of NCDs, and fertility rates. Accordingly, the cost of the EHCP over a period of two years was found to be $60 per

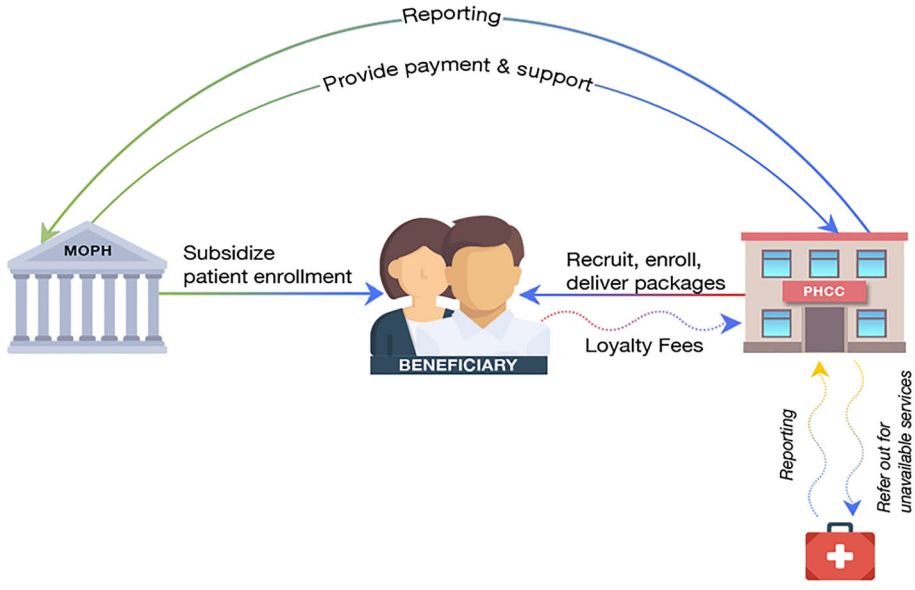

FIGURE 4 Emergency Primary Health Care Restoration Project implementation arrangements

capita. As such, PHCC contract ceilings were determined based on the number of assigned beneficiaries and the $60 per capita estimated cost over the 2-year period.

As for the provider payment mechanism (PPM), the MOPH opted for a mixed PPM, where a fixed $60 per capita rate was used regardless of package enrollment or age/sex disease status. The PPM included an advance, a bundled fee for service payment, and a performance payment. As such the $60 per capita was split into four parts according to Table 3.

The PHCCs received the 20% contract advance after contract signing, and the 40% and 30% payments after service delivery to the beneficiaries. Each of the six packages had different conditions for the first and second visit payments depending on the listed interventions. These conditions were built into the health information system and drew on patient medical records. Accordingly, every 3 months the PHCCs received a payment based on the number of beneficiaries receiving their first and second visits from the medical records. The final 10% performance payment linked to a patient satisfaction outcome was left to the end of the project in 2019.

1.3.5 | EHCP progress to targets

Since the launch of the EPHRP in May 2016, and by the end of March 2019, the project enrolled 131 409 beneficiaries (Figure 5). Overall project target is 150 000 beneficiaries, which is expected to be reached by end of 2019. As for utilization, 86% of enrollees accessed project services, with an average of 1.2 visits per user per year. Patient satisfaction was project services consistently high (above 96%).[29]

The project enrolled 14 % of adults in the diabetes mellitus (DM) package, 20 % of adult users in the HTN package, which are even higher than the overall prevalence of these NCDs in the general Lebanese population.[43,44]

Below is a table (Table 4) showing clinical package-specific utilization indicators.

Overall, the table shows that the project was successful in providing basic screening services to most of its target population and initiating management protocols for the NCD population. However, the project was not able to ensure adherence to NCD management guidelines and completion of package. For example, although 92% of

TABLE 3 EPHRP provider payment mechanism

Contract Advance (20%)	First Visit Payment (40%)	Second Visit Payment (30%)	Patient Satisfaction (10%)
	• First visit requirements including an initial consultation, screenings, and so on.	• Second visit requirements including a follow-up visit, diagnostic tests, and so on.	• % Patients satisfied (surveys by MOPH and external evaluator)

Abbreviation: MOPH, Ministry of Public Health.

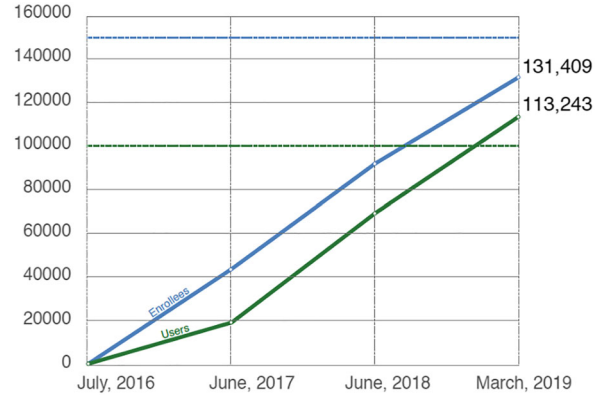

FIGURE 5 Enrollment and utilization in the Emergency Primary Health Care Restoration Project

TABLE 4 Selected clinical package indicators

Package	Indicator	Progress, %
Wellness adults	Percentage users screened for diabetes mellitus	90
	Percentage users screened for hypertension	99
	Percentage female users enrolled at least 1 year, screened for breast cancer as per guidelines (once within the past 2 years)	49
Noncommunicable diseases packages (diabetes mellitus/hypertension)	Percentage users enrolled at least one year, with Hba1c performed at least once throughout project lifetime (diabetes mellitus package)	92
	Percentage users enrolled at least 1 year, with Hba1c performed twice within the past year (diabetes mellitus package)	2
	Percentage users, enrolled at least 1 year, with microalbumin test in urine performed once throughout project lifetime (hypertension package)	77%
	Percentage users, enrolled at least 1 year, with microalbumin test in urine performed once in the past year (hypertension package)	13%
Antenatal care	Percentage users receiving at least four antenatal care visits (antenatal care package)	30%

beneficiaries enrolled in the DM package initiated their management protocols by getting their HBA1c tested, only 2% of those enrollees ended up continuing their management services as per guidelines and receiving two HBA1c tests in the past year.

As for the antenatal package, although the proportion of women enrolling in the package was close to that in the general population, only 30% of those enrolled received four antenatal visits as per guidelines. This shows that the project was successful at identifying pregnant women but not at retaining them during the course of their pregnancy.

2 | EHCP FACILITATORS, BARRIERS, AND THE WAY FORWARD

2.1 | EHCP facilitators

2.1.1 | Collaborative governance and strong public–private partnership

The delivery of the EHCP hinged on the contracting out of services to the PHCCs. Although the EPHRP marked the first time the MOPH contracted out PHC services from PHCCs, the new contracting arrangements built on the previous collaborative contract the MOPH had with the PHCCs in the network. The MOPH had been contracting the PHCCs which are mostly owned by NGOs for years to ensure the delivery of affordable quality PHC services. The EPHRP contracts added an element of financial reimbursement for services rather than just in-kind contribution of supplies and equipment. As such, the relationship between the MOPH and the PHCCs in the network was that rooted in shared values of mutual trust, public good, humanitarian work, transparency, and professionalism. This strong public–private partnership allowed the MOPH to smoothly transition into EPHRP, a pilot in performance contracting in primary care.

2.1.2 | Setting up accountability mechanisms

A main promoting factor in EHCP implementation was setting up effective accountability mechanisms. The monitoring and evaluation systems in place aided in supporting the PHCCs in optimal service delivery. Project

performance briefs were shared with providers on a quarterly basis where select indicators were presented along with benchmarking with other implementing PHCCs in their specific region and at the national level. This supported PHCCs in identifying key EHCP performance indicators, gauging their performance, and setting targets for improvements. Another monitoring exercise that the project introduced was the patient satisfaction phone calls which the MOPH conducted on a quarterly basis to project beneficiaries. This exercise served as a verification mechanism for services reported and as a way to hold PHCCs accountable to quality of services delivered. Patients felt empowered to speak up and submit grievances related to service delivery once reached out with a phone call. Another major citizen engagement and empowerment mechanism was the grievance redress systems in place. After the implementation of the EHCP, the MOPH promoted its existing hotline further as a way to submit comments or grievances. PHCCs were engaged in the effort, trained on basic protocols for grievance redress, and encouraged to promote a grievance redress culture in their own PHCCs. All of the above helped in trust building between MOPH, providers, and beneficiaries and promoted the existing partnership further.

2.1.3 | Mixed approach to beneficiary enrollment

At the beginning of EHCP implementation, the MOPH adopted the enrollment in the NPTP database as the sole criteria for beneficiary eligibility. Beneficiaries within the database were empaneled to different PHCCs based on geographical proximity, and PHCCs were encouraged to outreach those beneficiaries and recruit them into the project. As the project progressed, PHCCs began requesting that the MOPH allows open enrollment. They were approached by needy beneficiaries who were not necessarily part of the empaneled group. Moreover, because of inconsistencies and incomplete data in the database, they were not able to locate and recruit all the beneficiaries that were on their empanelment lists. As such, the MOPH allowed a margin of open enrollment where the PHCCs would recruit interested beneficiaries from within their catchment area based on certain criteria to ensure that they were indeed vulnerable and in need. This mixed approach to enrollment, which included both empaneled beneficiaries and a certain margin of open enrollment, proved to be a very successful approach in the Lebanese context. It enhanced both enrollment and utilization rates. The lists allowed the PHCCs to reach to marginalized people who do not usually seek care. It also gave PHCCs who are not very active within their communities a starting point for recruitment and outreach. On the other hand, well-established PHCCs were more familiar with the pockets of marginalized beneficiaries in their communities and an open enrollment approach allowed them to include those in need even if they were not part of the list. Moreover, open enrollment provided patients with a chance to choose their providers, which was translated into higher utilization rates among those who were recruited through the open enrollment method.

2.1.4 | Extensive capacity building and support

Project activities included a very strong and intense capacity building component that touched upon all dimensions of project service delivery including clinical packages, health information systems, communication for development, finance and procurement protocols, grievance mechanisms, key performance indicators, infection control, waste management, and many others. Project training modules were repeated for new staff to mitigate the effect of staff turnover during the course of the project. The training modules were complimented by on the job training by the MOPH field coordinators and MOPH HIS officers. The one-on-one support provided by the MOPH staff facilitated the change management process and helped ensure the adoption of project activities and new practices.

2.2 | EHCP barriers

2.2.1 | Shortcomings in the design of the EHCP

The design of the EHCP was conceptualized as a vehicle to reorient the health care delivery model toward preventive primary care. Through financing the EHCP, the MOPH aimed to attract patients to preventive care and incentivize providers to follow evidence-based guidelines and protocols. This resulted in a predominantly preventive package that in most cases was prescriptive in nature. Such a design had shortcomings that were apparent both at the beneficiary and provider level.

At the beneficiary level, the EHCP offered almost no coverage for the acute pressing needs of the target population. It did not fully address the existing coverage gaps in terms of outpatient curative care, mainly additional specialist consultations and diagnostic tests. As such, field reports and focus groups discussions showed that the MOPH offered an essentially preventive package to an already sick population. This was insufficient to meet client expectations, thereby compounding their trust issues with such initiatives and negatively impacting enrollment and utilization rates.

The lack of comprehensiveness in the package and its prescriptive and rigid nature created frustration at the provider level as well. Patients had a preidentified panel of tests that they should receive based on their age, sex, and health condition, and the package did not cover additional tests even if deemed necessary by the provider. This lack of control and autonomy over the care plan of their patients created resistance at the provider level. As a result, providers often treated the package as a onetime test panel rather than an integrated evidence-based care guide thereby reducing their adherence to guidelines and affecting quality of care.

2.2.2 | Weak enabling environment

While building on existing systems for EHCP implementation had many advantages, it also presented some drawbacks. Some systems that the EHCP built on were either immature or not strong enough to adequately support implementation. This created an overall weak enabling environment for the successful roll-out of the package. This included the existing referral mechanisms, the HHR mix and turnover rates at the PHCCs, the essential drug supply chain management, and the health information system.

Weak referral mechanisms between the PHCC and external health facilities negatively affected patient retention and continuity of care. While the project mandated the development of contracts between the PHCC and their selected external provider to provide diagnostic services, the PHCCs had low capacity in contract management and enforcement. As a result, in many instances, the burden of receiving feedback on test results was shifted to the beneficiary, and beneficiaries were lost to follow-up, thereby affecting the quality of service delivery.

In terms of HHR, the shortage of qualified nurses and certain physician specialties in some PHCCs acted as a barrier to the optimal service delivery of the EHCP. To aggravate the matter further, the high turnover rate across PHCCs hindered cumulative capacity building effects and added a significant training cost to the MOPH. Another hindrance was the disruption in the supply chain of the essential drugs program. This caused recurrent drug shortages which in turn compromised patient access to needed medications, negatively affected their satisfaction and caused a spike in reported grievances. Finally, while the newly developed health information system was created to support providers and enhance quality of care and documentation, internet connectivity issues compounded with staff shortages and extensive documentation demands burdened the PHCCs. In many instances, PHCCs had to duplicate efforts by using paper-based reporting at point of service and inputting electronic data at a later stage. This negatively affected quality of care and resulted in the HIS being used as a reporting system with limited documentation sufficient only for payment purposes.

2.2.3 | Inefficacious provider payment mechanisms

Because of the novelty of purchasing services in the primary care sector in Lebanon, when designing the PPMs for the EHCP, the main focus was on developing a simple, easy to understand mechanism that would tie payment to actual utilization. The result was as straight forward reimbursement scheme that did not create adequate incentives for desired provider behavior. The scheme consisted of a fixed per capita sum that did not recur on annual basis but instead was paid over project lifetime through an advance, two bundled fee for service payments, and a performance payment. The majority of the remuneration was tied to the bundled fee for service payments that were paid in full once the beneficiary conducted two visits to the PHCC. The scheme did not produce the desired utilization rates in packages that required frequent visits to the PHCC. This was particularly the case in the NCD and safe motherhood packages that contained numerous visits to the PHCC and recurred on an annual or episodic basis.

Accordingly, the scheme lacked incentives for package completion. Although the scheme included a performance payment, the low weight of the payment (10%) compounded with the deferred disbursement till project closing offset any intended effect on provider behavior. Additionally, the performance payment was not linked to any package completion or other quality indicators; instead, it was linked to patient satisfaction. Patient satisfaction was generally high across all PHCCs and regions and was not a reliable measure to assess real differences in quality and performance.

Finally, the per capita sum was fixed across populations and did not include any adjustments for age, sex, or disease conditions. As such, PHCCs with a more elderly and chronic populations who required costly services were at a financial disadvantage.

2.2.4 | Weak clinical governance

Clinical governance is defined as a system of steps and procedures to ensure that patients receive the highest quality care.[43] Despite the various attempts of the MOPH to ensure clinical governance in PHC such as the development of the PHC accreditation program and the presence of a dedicated monitoring team at the MOPH at the central and governorate level, the clinical governance remained deficient. A key feature of clinical governance at the institutional level is accountability and evidence-based practice that can only be enforced through practice audits and effective use of guidelines.[45] MOPH did not adopt these practices and focused less on outcomes and quality of clinical care and more on policies, structures, and documentation. This compromised its ability to ensure the quality of care delivered at PHCCs. Similarly, at the PHCC level, PHCC directors voiced their failure to control and monitor the quality of care delivered by physicians because of resistance. The low remuneration of physicians at the PHCC level shifted the power from their employer (PHCC director) to them. This power gradient and lack of incentive structure left the PHCC director unable to enforce clinical guidelines and fostered a culture of weak clinical governance and lack of accountability for medical practice. This in turn negatively impacted quality of care at PHCCs and the ability to deliver the EHCP according to clinical guidelines.

2.2.5 | Poor marketing and promotion of package

Empowering and engaging communities is essential in ensuring adequate utilization of services. Although the EHCP aimed to fill a gap and respond to community needs, the communication component of the project remained underdeveloped. Project communication did not include a national mass media campaign and was limited to local targeted activities implemented by PHCC staff. As a result, project messages were not standardized, and there was misalignment between beneficiary expectation and the reality of EHCP benefits. In addition, project design assumed that the subsidization (free coverage) of services would be sufficient to incentivize families to enroll in the EHCP. However, this did not account for the weakness in the culture of prevention in Lebanon and lack of awareness and

acceptability among the Lebanese to conduct preventive services. These gaps in the communication process led to delays in reaching enrollment targets, beneficiary opt out of the EHCP, and underutilization of preventive services.

2.2.6 | Fragmented external agency efforts

The Syrian refugee crisis led to an exponential increase in the number of active NGA, international organizations, and donors. Most of those actors implemented health related projects and programs at the national PHCN because of its capacity to reach refugee and host populations. As a result, there were several agencies with different agendas and projects, contracting the same providers (PHCCs in the network) to deliver health services to the same target populations. Instead of pooling funds and offering a harmonized and cohesive package to refugees and host populations through a single contracting platform, each of these agencies developed its own contracting arrangements, benefit packages, and payment mechanisms. Despite the formation of several coordination mechanisms (steering committees, working groups), the protracted fragmentation of efforts led to overlap of services and confusion among both beneficiaries and providers, which impaired the capacity for optimal service delivery in the EHCP.

2.3 | Moving forward

Lebanon's recent experience with the EHCP laid the groundwork for a UHC program that is rooted in PHC. The EHCP is now in its final year of implementation, and moving forward, the MOPH has secured a concessional financing loan of US$120 million from the World Bank to scale up EHCP for an additional 5 years, both in terms of breadth of coverage and size of the population.[19] The expansion will be under the Lebanon Health resilience project.[19] In this next phase, the MOPH will capitalize on the successes of the EHCP and lessons learned through providing a wider package that is more responsive to population needs. The MOPH is also costing the expanded package and developing a PPM that is more context specific. The upgraded PPM is expected to provide an incentive structure to induce the desired utilization outcomes and avoid the pitfalls of the previous one.

One of the main challenges that persist is the sustainability and the scalability of the EHCP. To date, all past and planned activities supporting the rollout of the EHCP rely on external funding. Although the MOPH envisioned the EHCP pilot as a precursor to a self-sustaining contributory insurance model, this has not been realized yet. Despite the success of the pilot, the ministry has not been able to mobilize domestic resources or secure public funds for project expansion. The national and sustainable scale-up of the EHCP is contingent on political commitment and citizen support. Further advocacy and lobbying is needed in order to place UHC and the EHCP on the national agenda and stimulate public demand.

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CONFLICT OF INTEREST

Authors R.H., R.H., and O.K. have affiliations to the Ministry of Public Health. The authors declare having no conflicts of interest.

AUTHOR CONTRIBUTIONS

R.H., R.H., and O.K. conceptualized the study objectives and hypothesis. R.H. and O.K. conducted the literature review and the analysis. R.H. and O.K. interpreted the data and drafted the study manuscript. All authors approved this version of the manuscript.

ETHICAL CONSIDERATIONS

Required administrative authorization to use the collected data for research was obtained from the concerned parties at the Lebanese Ministry of Public Health on January 10, 2019. Data included in this study were collected as part of the MOPH's routine monitoring activities and administrative service databases and part of unpublished reports. This article does not include primary data collection.

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