brief

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The Impacts of Corruption on Lebanon's Public Health

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Introduction

Public health and medical inequalities have been an area of focus for states throughout the world for many decades. Adaptation to international legal frameworks, and investments in health and social services, access to clean water and sanitation, and education have led to improvements in global health indicators, notably increases in life expectancy and decreases in child mortality. However, such improvements have been uneven both between and within states, and some countries and socio-economic classes have fared better than others.[1] Much depends on a state's ability to cope with inadequate financial resources, health inequalities and disparities. Lebanon is one state that seems to have performed quite well at times. However, its weak state, financial situation and levels of corruption mean that a large proportion of its population struggles to access or afford healthcare services.

Lebanon has struggled financially and politically since its 1975–90 civil war. The privatisation of much of its system of healthcare was intended to improve the dysfunctional public provision. However, the healthcare system is still being criticised for its lack of quality and accessibility, at least to the poorer socio-economic classes.[2] [3] [4] [5] [6] This brief addresses the question of who has the right or is able to access good public healthcare. Accessibility in this case is a matter of both financial capacity and geographical distance.

Public health research suggests that bad governance and corruption have negative impacts on healthcare systems by diverting crucial resources.[7] Hence, this brief analyses how corruption in Lebanon affects public health and the healthcare system. The time frame is the 1990 to 2019, as many political and societal changes were made during this time, in particular to the healthcare system. The brief uses the 1948 World Health Organisation (WHO) definition of public health, which is still widely used today: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[8] [9] While there are other definitions of public health, this definition is chosen because it explains

[1] Skolnik, R. (2016). *Global health 101.* Third Edn. Jones & Bartlett Publishers.
[2] Méon, P.G. and L. Weill (*2010),* Is corruption an efficient grease? *World Development*, 38(3), 244-259.
[3] El-Jardali, F., Hemadeh, R., Jaafar, M., Sagherian, L., El-Skaff, R., Mdeihly, R., Ataya, N. (2014). The impact of accreditation of primary healthcare centers: successes, challenges and policy implications as perceived by healthcare providers and directors in Lebanon. *BMC Health Services Research*, 14(1), 86.
[4] Tawil, S., et al. (2020). Patients' perceptions regarding pharmacists' healthcare services: the case of Lebanon. *Journal of Pharmacy Practice and Research*, 50(2), 137-143.
[5] Deets, S. (2015). Networks and communal autonomy as practice: Health, education, and social welfare in Lebanon. *Ethnopolitics*, 14(4), 329-353.
[6] El-Jardali, F., Jaafar, M., Dimassi, H., Jamal, D., & Hamdan, R. (2010). The current state of patient safety culture in Lebanese hospitals: a study at baseline. *International Journal for Quality in Health Care*, 22(5), 386-395.
[7] Alnahdi, S. (2020). The impact of corruption on healthcare services: Empirical evidence from the MENA region. *International Journal of Economics and Financial Issues*, 10(5), 8-15.
[8] Skolnik, R. (2016). Global health 101. Third Edition. Jones & Bartlett Publishers.
[9] Leenders, R. (2012). Spoils of truce: Corruption and state-building in postwar Lebanon. Cornell University Press.

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simply and briefly how a state of well-being is different from an absence of illness. It also takes the definition one step further in committing to complete well-being, which everyone deserves.

Deserving good health, however, does not guarantee equal access for all, as is explained throughout this brief. Public health in Lebanon has become a class issue where only those who can afford to pay the necessary bribes or hidden expenditures, and who live in urban areas, are able to access quality healthcare. There has been a lack of focus in previous studies on corruption and its links to public health, which means that the consequences for the field are yet to be explored and pinpointing the exact causes is difficult.[10] [11] The analysis finds that Lebanon has good quality healthcare services, but these are not accessible to everyone. People in lower socio-economic classes, those living in poverty and stateless persons, such as Palestinian and Syrian refugees, struggle to access healthcare services. In recent decades, corruption in this area has not been tackled strongly enough by the state, and this is affecting the quality and accessibility of healthcare. There are both an urban-rural bias and issues over the high cost and low quality of healthcare. The result has been an increase in non-communicable diseases, and high rates of cancer and cardio-vascular disease in particular, compared to neighbouring countries.

The Case of Lebanon

Lebanon's uneven development, and its financial and political struggles have led to a large public sector debt and an unstable industrial base and economy. The main reason for this is political instability, as illustrated by events such as the assassination of Prime Minister Rafiq Hariri in 2005 and regular violent conflict and political turmoil, as well as the spillover from the Syrian Civil War and the related refugee crisis, high levels of corruption and more recently the effects of the COVID-19 pandemic.[12] [13] All this has led to increasing levels of poverty in recent years and high levels of inequality. Its Gini Index of 51 in 2017 ranked Lebanon 129th of 141 states on inequality.[14] Lebanon is also host to the highest number of refugees per capita in the world, but it has not signed the 1951 Refugee Convention. This means that an estimated 1.7 million people living in Lebanon have no legal right to access public services such as healthcare. Syrian refugees must pay out of their own pockets or receive cover from the United Nations High Commissioner for Refugees (UNHCR), while Palestinian

[10] Alnahdi, S. (2020). The impact of corruption on healthcare services: Empirical evidence from the MENA region. *International Journal of Economics and Financial Issues*, 10(5), 8-15.

[11] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon. Cornell University Press.*

[12] Vohra, A.,(2020) Foreign Policy.The Death of Lebanon's Middle Class. https://foreignpolicy.com/2020/05/21/lebanon-coronavirus-middle-class-poverty/.

[13] ESCWA, ESCWA warns: more than half of Lebanon's population trapped in poverty, https://www.unescwa.org/news/Lebanon-poverty-2020.

[14] Saliba, E., Sayegh, W. and Salman, T. F. (2017). *Assessing Labor Income Inequality in Lebanon's Private Sector: Findings, Comparative Analysis of Determinants, and Recommendations.* UNDP Fiscal Policy Advisory and Reform Project at the Lebanese Ministry of Finance Report.

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refugees are supposedly covered by the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) healthcare system. This creates an environment in which millions of people cannot get the healthcare they need and are not allowed to work in the same way as citizens can.[15]

However, many citizens also struggle financially with the cost of healthcare, even though they have full legal rights. The turmoil in Lebanon has led to rising unemployment and there is a large informal sector where people look for alternative job opportunities to make ends meet. Lebanon has tried to adopt a laissez-faire economic policy focused on the services sector. Tourism in particular has undergone great fluctuations due to the political instability and political violence. The economy has collapsed several times in recent decades, fuelling the vicious circle of rising inequality and poverty.[16] [17] [18] [19]

Political and Economic Developments in Lebanon

Lebanon's civil war (1975–1990) affected the economy, its industry, and its politics and policymaking. Lebanon's scarce natural resources and small domestic industry leave it heavily dependent on imports. The economy is mainly made up of the services sector, banking and finance, tourism and construction. As mentioned above, tourism has been a fragile industry since the end of the civil war, with fluctuations depending on the political and security situation in the country. Events such as the assassination of Hariri, the July War of 2005–2006, the ongoing Syrian Civil War and refugee crisis since 2011, and the "October Revolution" of 2019 have all called the stability of the country into question and led to contractions in sectors such as tourism. The Lebanese government has taken on several loans to make up the deficit created by imports exceeding exports. This has contributed to Lebanon's state-debt, which is estimated at 150% of GDP, being one of the highest in the world, and it is expected to increase further.[20] [21] The government has made several attempts to stimulate economic growth and reduce poverty, and these had relatively positive results in the post-war era of the 1990s until the assassination of Hariri.[22] [23] This type of cycle has been common for Lebanon, which seems to be stuck in a vicious circle of economic growth

[15] Janmyr, M. (2016) Precarity in exile: The legal status of Syrian refugees in Lebanon. Refugee Survey Quarterly, 35(4), 58-78.
[16] Chen, M.A. (2012). *The informal economy: Definitions, theories and policies (Vol. 1, No. 26, pp. 90141-4). WIEGO working Paper*
[17] Chen, M.A. (2005) *Rethinking the informal economy: linkages with the formal economy and the formal regulatory environment, WIDER Research Paper 2005/10.* United Nations University: World Institute for Development Economics Research (UNUWIDER), Helsinki.
[18] Tokman, V.e. (1992). *Beyond Regulation: The Informal Economy in Latin America.*
[19] Rossis, N.M. (2011). *The Informal Economy in Lebanon: Dangers and Benefits.* Durham theses, Durham University.
[20] Vohra, A.,(2020) Foreign Policy.The Death of Lebanon's Middle Class. https://foreignpolicy.com/2020/05/21/lebanon-coronavirus-middle-class-poverty/.
[21] World Bank, https://databank.worldbank.org/reports.aspx?source=2&country=LBN.
[22] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.
[23] Landguiden Libanon. https://www.ui.se/landguiden/lander-och-omraden/asien/libanon/

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followed by political instability and economic decline.

Unemployment levels have been increasing since 2015, and it is estimated that up to 40% of young people are currently unemployed. The COVID-19 pandemic has severely affected an already dire situation, and inflation has increased substantially. From a fixed rate of LBP 1500 to the US dollar, the currency lost over 60% of its value in the spring of 2020.[24] Scheduled blackouts are now normal all over Lebanon as the country has one of the least reliable electricity supply grids in the world, after Yemen, Haiti, and Nigeria.[25] There are also high levels of air pollution, which are often poorly monitored and reported in the larger coastal cities, especially Beirut. According to the WHO, Lebanon had the highest mortality rate linked to air pollution in the Middle East and North Africa (MENA) region in 2017. Certain regions of Lebanon also struggle with proper sanitation systems, resulting in 18.3 deaths per year due to inadequate water, sanitation, and hygiene provision.[26] [27]

Public Health and Healthcare in Lebanon

Historically, healthcare has been provided by religious organisations such as the Christian Maronite and Greek Orthodox churches, both of which receive financing from international communities. Citizens were therefore treated within their religious communities. Before the civil war, the state was able to administer, regulate and control the private sector quite well. After the war, however, it no longer had the same capacity. The private sector saw few restrictions being enforced and therefore took advantage of the weak state to make greater profits.[28] Public sector hospitals and other healthcare facilities at this time had been so severely damaged that many were unable to reopen. In response, the government through the Ministry of Public Health (MoPH) subsidised private healthcare for citizens so that quality healthcare services could still be provided while the public sector was being rebuilt. This was done through a reimbursement system, where private hospitals and clinics billed the MoPH for certain services. However, many overcharged due to the climate mentioned above and by 2001, 78% of the MoPH's budget was being spent on private sector healthcare. The ministry was not unaware of or innocent in this matter. In fact, there were several prosecutions for corruption, or avoiding and fabricating controls, but these did not lead to convictions.[29]

The system was supposed to be temporary but as the quality of care in public hospitals remained low – only 47 out of 128 hospitals met quality standards in 2000 – the contracts with private sector entities were extended despite the financial cost and the high levels

[24] Vohra, A.,(2020) Foreign Policy.The Death of Lebanon's Middle Class. https://foreignpolicy.com/2020/05/21/lebanon-coronavirus-middle-class-poverty/.

[25] Landguiden Libanon. https://www.ui.se/landguiden/lander-och-omraden/asien/libanon/

[26] Ibid.

[27] World Health Organization (2016). *Lebanon health profile 2015 (No. WHO-EM/HST/224/E).* World Health Organization. Regional Office for the Eastern Mediterranean.

[28] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.

[29] Ibid.

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of corruption.[30] In 2001 the MoPH adopted a hospital accreditation programme in order to improve the quality of care, reduce costs, deal with the issue of corruption and regain some control over the healthcare sector. Nonetheless, the private sector still represented about 90% of the healthcare sector in 2005.[31] [32] The public healthcare centres still have issues regarding administration today. Deets argues that this is because the government contracts with non-governmental organisations (NGOs) to run the centres rather than provide its own administration.[33] Lebanon's healthcare system is still 90% privatised and much of the remaining 10% public healthcare, although owned by the state, is managed by NGOs.

The high level of privatisation means that it is estimated that roughly 35% of hospitalisation costs and 65% of all healthcare expenses are paid for directly by the recipient.[34] Furthermore, economic and political insecurity means that roughly 40% of Lebanese citizens do not have any form of health insurance. In fact, 28% of the people residing in Lebanon in 2019 and 55% in 2020 were living in poverty.[35] Nonetheless, Lebanon performs quite well according to key health indicators, such as life expectancy at birth, and infant, maternal, neonatal and child mortality rates, especially compared to other low- and middle-income countries. It also has low levels of HIV, for which free treatment is provided by the state, and low levels of tuberculosis, while life expectancy has been steadily increasing since the 1990s. World Bank and WHO public health statistics rank Lebanon quite high on key measurements outside of the civil war years. Lebanon has seen steady increases in life expectancy and decreases in mortality rates since the end of the civil war.[36] While these statistics look promising, there are also high levels of non-communicable diseases, such as cancer, diabetes, and cardiovascular diseases, in contrast to the levels of communicable diseases that can spread from person to person, such as tuberculosis, HIV and measles.[37]

Lebanon had the highest levels of cancer in the MENA region in 2017, with an incidence of 242.8 per 100 000 inhabitants, followed by Syria at 169.9 per 100 000 inhabitants.[38] Lebanon has among the highest levels of non-communicable diseases among the MENA states but it is unclear why this is the case. Possible explanations could be the high

[30] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.
[31] Khalife, J., et al. (2017). Hospital contracting reforms: the Lebanese Ministry of Public Health experience. *Health Systems & Reform,* 3(1), 34-41.
[32] El-Jardali, F., Jaafar, M., Dimassi, H., Jamal, D., & Hamdan, R. (2010). The current state of patient safety culture in Lebanese hospitals: a study at baseline. *International Journal for Quality in Health Care*, 22(5), 386-395.
[33] Deets, S. (2015). Networks and communal autonomy as practice: Health, education, and social welfare in Lebanon. *Ethnopolitics,* 14(4), 329-353.
[34] Deets, S. (2015). Networks and communal autonomy as practice: Health, education, and social welfare in Lebanon. *Ethnopolitics,* 14(4), 329-353.
[35] ESCWA, ESCWA warns: more than half of Lebanon's population trapped in poverty https://www.unescwa.org/news/Lebanon-poverty-2020).
[36] Organization., W.H. (*2016). Lebanon health profile 2015 (No. WHO-EM/HST/224/E).* World Health Organization. Regional Office for the Eastern Mediterranean.
[37] Skolnik, R. (2016). *Global health 101.* Third Edition. Jones & Bartlett Publishers.
[38] Organisation, W.H., *Eastern Mediterranean Health Observatory* https://rho.emro.who.int/ThemeViz/TermID/130.

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levels of smoking and the lack of physical activity, as well as air pollution and poor waste management, although high levels of smoking are not unique to Lebanon. Another explanation might be inadequate healthcare, especially from the Primary Health Care Centres (PHCC).

PHCCs have seen improvements in quality since the adoption of the accreditation programme mentioned above, but Hemadeh et al. show that the PHCCs are still struggling to deliver care due to a lack of advanced medical equipment, and of written clinical guidelines on quality improvement, capacity building and resource provision.[39] Of the 188 PHCCs included in the study by Hemadeh et al., only 88.7% reported the availability of six types of basic equipment; 85.4% fulfilled all means of communication requirements; 48.5% fulfilled basic amenities requirements; 39.6% fully met infection control requirements; and 26.9% fulfilled all infrastructure requirements.[40] The PHCCs included in Hemadeh et al. were meant to be among the higher quality PHCCs in the country, since they had met accreditation requirements that not all have met.

From the beginning, the accreditation system was used by hospitals and PHCCs as a basis for contracting and determining reimbursement rates. However, as Leenders (2012) argues, this led costs to grow out of proportion, increased corruption and actually reduced quality. Hence, a reform programme was needed that involved hospitals and the PHCCs, and includes the development of an automated billing system, standardised admissions criteria, medical specialisation, patient care standards, staff competency testing and a system for implementing the new policies and procedures.[41] [42] The result, the accreditation programme. The fact that less than 40% of the PHCCs meet the requirements for infection control and infrastructure could be a reason for the increase in levels of noncommunicable diseases.

This raises the issue of accessibility: who can access the PHCCs and who has access to those PHCCs that have passed the requirements of the accreditation programme? The high levels of poverty and non-communicable disease make it important to examine the economic structure of healthcare in Lebanon, whether this encourages corruption, and how this ultimately affects public health. An understanding of how corruption works and adapts both generally and in the case of Lebanon is therefore central.

The Role of Corruption

A common definition of corruption used by Stiernstedt and Transparency International (TI) is: "the abuse of entrusted power for private gain".[43] This is similar to Leender's

[39] Hemadeh, R., et al. (2020). The primary health care network in Lebanon: a national facility assessment. *East Mediterranean Health Journal.*
[40] Ibid.
[41] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.
[42] Khalife, J., et al. (2017). Hospital contracting reforms: the Lebanese Ministry of Public Health experience. *Health Systems & Reform*, 3(1), 34-41.
[43] Stiernstedt, P. (2019). Some things are rarely discussed in public: On the discourse of corruption in healthcare, comment on 'we need to talk about

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definition of political corruption as "the use or abuse of public office for private gain".[44] A contrasting approach by Alnahdi uses two schools of thought from economic theory to define corruption. One refers to corruption as the *sand in the wheels* to suggest a negative impact of corruption while the second describes it as *greasing the wheels*, indicating a positive impact.[45] Alnahdi suggests that corruption can increase efficiency and encourage competition, and thus promote privatisation. According to this argument, corruption has the potential to increase the overall efficiency of and reduce a government's monopoly on healthcare.[46] [47] [48] This would suggest that Lebanon's healthcare system, 90% of which is provided by the private sector, would see competition between companies leading to lower prices, but this does not appear to be the case. By contrast, the *sand in the wheels* theory suggests that corruption puts healthcare out of reach of the poor, which would seem more applicable in the Lebanon case.[49] [50] This brief uses the definitions of TI, Stiernstedt, and Leenders as noted above, while keeping the theories of sand or grease in the wheels in mind.

Corruption operates in different ways and can take the shape of bribes or other hidden expenditures, forged documentation and avoiding regulations. The quantity of corruption in a society is strongly linked to the structure of its economy and the levels of economic resources, state power and trust in the state. Corruption in the healthcare system can severely impact the cost and quality of healthcare services, which is what has happened in Lebanon. In the 1990s, it was not uncommon for hospitals to keep patients for several extra days and undertake unnecessary tests in order to claim more money from the MoPH. Leenders also found that patients were receiving unnecessary surgery.[51] He explains that extensive surgical procedures were undertaken for conditions that could have been treated with other methods or minimally invasive surgery. The costs of the more extensive and higher risk surgeries were higher than the alternatives and the hospital was able to make more money from this surgery by overcharging the MoPH. Patients in the study were also reported to have been kept in hospital for in-patient treatment for more days than was necessary for similar reasons.[52] This probably had severe impacts on the health of the patients, but the studies did not provide

corruption in health systems'. *International journal of Health Policy and Management*, 8(9), 560; and Transparency International, https://www.transparency.org/en/what-is-corruption.

[44] Leenders, R. (*2012). Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.

[45] Alnahdi, S. (2020). The Impact of Corruption on Healthcare Services: Empirical Evidence from the MENA Region. *International Journal of Economics and Financial Issues*, 10(5), 8-15.

[46] Ibid.

[47] Méon, P.G. and L. Weill (*2010),* Is corruption an efficient grease? *World Development*, 38(3), 244-259.

[48] Clausen, B., A. Kraay, and Z. Nyiri (2011), Corruption and confidence in Public Institutions: Evidence from a Global Survey, World Bank Econ. Rev. 25, 212e249. EBRD, 2009. Life in Transition: After the Crisis. London: EBRD.

[49] Alnahdi, S. (*2020).* The impact of corruption on healthcare services: Empirical evidence from the MENA Region. *International Journal of Economics and Financial Issues*, 10(5), 8-15.

[50] Leenders, R. (*2012). Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.

[51] Ibid.

[52] Ibid.

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specific data on this aspect.[53] What was found, however, is that it made Lebanese healthcare extremely expensive and its treatments very long. A study by Information International in 1999 found that 75% of the respondents perceived Lebanese healthcare as materialistic rather than compassionate.[54] Corruption can also affect the quality of medicines as companies who import medicines want to avoid official testing and regulation. It was found that medicines were often imported into Lebanon without proper inspections and stored in warehouses that were below the required standards, which compromised their quality.[55]

Lebanon is not known for its transparency regarding statistics on issues such as corruption and poverty. Corruption is more likely to occur if there is financial insecurity, poverty, and unemployment. Where people struggle to make ends meet in the formal sector, they are more likely to engage in work in the informal sector. Data provided to the World Bank indicates a 0.1% poverty rate, which, as is obvious from independent studies, is false.[56] Lack of transparency is not synonymous with, but often indicates a certain level of, corruption.

As mentioned above, corruption takes many shapes, and can happen anywhere and involve anyone. It often takes place in the shadows but, more importantly, it also constantly adapts. This makes mapping corruption difficult, especially since writing about corruption and "outing" specific individuals can lead to legal action.[57] [58] Leenders writes of several cases where criminal charges were initiated in Lebanon in the post-war era regarding corruption in the healthcare sector, specifically between the MoPH and private sector actors. However, most if not all of the accusations were eventually dropped. Convictions and other hard facts are difficult to get as corruption is often hard to prove and testimony or confessions are rare. The methods of measuring corruption, such as those used by TI, are therefore based on citizens' perceptions rather than hard facts. The TI methodology has regularly been criticised as inaccurate or flawed.

Studies of Lebanese society, the healthcare system and public health have found high levels of corruption. According to Tawil et al.[59] many dispensaries do not meet MoPH quality guidelines and store out-of-date and illegal medicines. This is only possible due to corruption within the MoPH, where

[53] Leenders, R. (*2012). Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.
[54] International., I. (*2000). Corruption in Lebanon, Country Assessment Report 200: Preliminary Assessment and Feedback on the Corruption Study Pilot Study.* Beirut: Information International & Centre for International Crime Prevention, UN Interregional Crime and Justice Research Institute.
[55] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.
[56] World Bank, https://databank.worldbank.org/reports.aspx?source=2&country=LBN.
[57] Alnahdi, S. (2020). The impact of corruption on healthcare services: Empirical evidence from the MENA region. *International Journal of Economics and Financial Issues*, 10(5), 8-15
[58] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon.* Cornell University Press.
[59] Tawil, S., et al. (2020). Patients' perceptions regarding pharmacists' healthcare services: the case of Lebanon. *Journal of Pharmacy Practice and Research,* 50(2), 137-143.

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inspectors falsify forms or fail to perform quality inspections. As noted above, this leads to medical imports avoiding quality checks and being stored in unsafe conditions. This medicine is often sold in dispensaries at a lower price than regular medicines in pharmacies. Poverty therefore plays a role in whether patients can access quality medication.[60] [61]

Leenders further finds that there is money to be made not only by private sector companies, but also by politicians and public servants who assist companies with importing, restocking, and distribution, by forging documents and by faking quality checks.[62] These findings suggest that corruption was prominent in the post-war era and remains so today. The effects are shown in Tawil et al., which finds that only 34% of respondents trust the quality of products in dispensaries. Nonetheless, mainly for financial reasons, some still prefer to use dispensaries rather than pharmacies, which have much higher levels of trust (68%). Dispensaries and pharmacies fill a similar function of selling medication. However, in Lebanon pharmaceutical staff are made of trained pharmacists who can counsel the customer on medications. Dispensaries lack this kind of service and usually stock lower quality medications. This is still an option preferred by many Lebanese, due to the cheaper price. Hence, as mentioned above, people suffering from financial insecurities are more likely to obtain substandard medication. Returning to the question of accessibility, it is clear that it is more difficult to access quality medication and healthcare with fewer financial resources. This highlights another form of inequality that can prevent access to healthcare – class. Class differences can affect both status and financial resources, and the impact is often bigger where there are high levels of inequality.

Inequalities and the Public Health Divide

Lebanese society is highly unequal when it comes to access to public services, financial capital, and civil rights. Many cannot access the healthcare they need due to the high cost. In addition to Lebanon's Gini Index ranking, mentioned above, which is indicative of vast labour and health inequalities, the UN Development Programme has found that the top 2% in terms of earners account for 17% of total income while the bottom 59% accounts for just 22%.[63] Lebanon has adopted a minimum wage of US$ 450 per month, but this regulation does not apply to the informal sector where it is estimated that half the labour force works. Informal labour, as noted above, is a common occurrence in many states and operates outside of legislation and protocols. The people who engage in informal labour are often migrant workers, and this has long been common for Syrian

[60] Tawil, S., et al. (2020). Patients' perceptions regarding pharmacists' healthcare services: the case of Lebanon. *Journal of Pharmacy Practice and Research*, 50(2), 137-143.
[61] Leenders, R. (2012). *Spoils of truce: Corruption and state-building in postwar Lebanon. Cornell University Press.*
[62] Ibid.
[63] Saliba, E., W. Sayegh, and T.F. Salman (*2017). Assessing Labor Income Inequality in Lebanon's Private Sector: Findings, Comparative Analysis of Determinants, and Recommendations. UNDP Fiscal Policy Advisory and Reform Project at the Lebanese Ministry of Finance Report.*

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seasonal workers in Lebanon. However, refugees and asylum seekers are also likely to engage in informal labour due to restrictions on access to formal work and a lack of financial resources. The incentives for Lebanese citizens to engage, at least partially, in the informal sector have also increased recently due to the high levels of unemployment, increased poverty and the high cost of living in Lebanon, especially in urban areas. The informal sector drives wages down by not conforming to regulatory requirements, making it difficult for regular employers to compete with the low prices. However, the cost often comes in the form of lower wages for employees and unsafe working practices.[64] [65] [66] Informal labour that drives down costs continues a vicious circle of low prices and lower wages that affects the financial stability of the work force.

Two causes of the large informal sector in Lebanon are the legal restrictions on refugees undertaking waged labour and the high level of unemployment. Palestinian refugees are only allowed to work in certain sectors and Syrian refugees must agree to abstain from waged labour when they register with the UNHCR. Unregistered Syrian refugees are not allowed in the country and thus barred from formal employment. Policy and legislative changes on Syrian refugees in 2015 mean that it is very difficult and expensive for Syrians residing in Lebanon legally to be approved as refugees.[67] [68] [69] [70] It is estimated that the average salary of refugees in Lebanon is US$ 100–300 per month. Rents in cities such as Beirut are often around US$ 250–450 per month. It is therefore understandable that many people, especially refugees but also people earning close to the minimum wage, are struggling.

It is important to note that it is not only refugees who suffer poverty in Lebanon, but also many citizens. While refugees may be the most marginalised, unemployment rates and poverty are becoming more widespread.[71] This has arguably resulted in a further increase in the size of the informal sector. The country has experienced many turbulent times in the post-war era, from the assassination of Rafiq Hariri to mass protests, armed conflict, refugee crises, and political instability and deadlock.

The economic crisis reached new heights with the COVID-19 pandemic and the massive explosion in Beirut on 4 August 2020. Both put extra pressure on healthcare

[64] Saliba, E., W. Sayegh, and T.F. Salman (*2017). Assessing Labor Income Inequality in Lebanon's Private Sector: Findings, Comparative Analysis of Determinants, and Recommendations. UNDP Fiscal Policy Advisory and Reform Project at the Lebanese Ministry of Finance Report.*

[65] Tokman, V.e. (1992). *Beyond Regulation: The Informal Economy in Latin America.*

[66] Rossis, N.M. (2011). *The Informal Economy in Lebanon: Dangers and Benefits, Durham theses, Durham University.*

[67] Saliba, E., Sayegh, W. and Salman, T.F. (2017). *Assessing Labor Income Inequality in Lebanon's Private Sector: Findings, Comparative Analysis of Determinants, and Recommendations. UNDP Fiscal Policy Advisory and Reform Project at the Lebanese Ministry of Finance Report.*

[68] Janmyr, M. (2016) Precarity in exile: The legal status of Syrian refugees in Lebanon. *Refugee Survey Quarterly*, 35(4), 58-78.

[69] Rossis, N. M. (2011). *The Informal Economy in Lebanon: Dangers and Benefits, Durham theses, Durham University.*

[70] Alsharabati, C. and J. Nammour (2015). *Survey on Perceptions of Syrian Refugees in Lebanon: Full Report, Beirut,* Universite´ de Saint Joseph.

[71] Vohra, A.,(2020) Foreign Policy.The Death of Lebanon's Middle Class. https://foreignpolicy.com/2020/05/21/lebanon-coronavirus-middle-class-poverty/.

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facilities. It is therefore not surprising that there has been an increase in food and financial insecurity, pushing even more people into poverty. Some argue that the government is not doing enough to secure its people's public health.[72] There has been only limited government intervention apart from the accreditation system to improve public health.

In addition to wealth and labour inequalities, there are also inequalities related to geography. Physicians and nurses are supposed to be spread evenly throughout the country depending on population density, but there are a disproportionate number of medical centres in the cities, which causes understaffing of primary healthcare in the rural areas.[73] [74] There is also a general shortage of nurses in the PHCCs, at only 2.72 per 1000 population compared to 4.05 in Jordan, and most of these nurses work in the larger medical centres and hospitals.[75]

Most of the public hospitals were destroyed during the civil war, and many others were unable to reopen after the war was over. Public health measures were sparse and medical staff scarce, and there were just 22 physicians, 10 nurses and midwives, 26 hospital beds and 2.3 primary healthcare units or centres per 10 000 population.[76] [77] Alongside these constraints on and deficiencies in Lebanese healthcare, however, it is important to note that the country also has highly specialist and skilled healthcare providers. Lebanon, for instance, saw growth in medical tourism at an annual rate of 5.36% per year between 2007 and 2012. Roughly 90% of these tourists come from other MENA states, mostly Iraq, and the remaining 10% are mainly from Europe.[78]

It is arguable that the reimbursement system laid the ground for a highly corrupt healthcare system by creating a structure of underfunded public healthcare facilities and a dependency on private sector healthcare. Even though the reimbursement system was ended in the early 2000s, the decade in which it lasted made it possible for private companies, public officials, and even politicians to benefit financially from the provision of healthcare. While corruption may not be as prominent today as it was in the 1990s, as discussed above, rather than disappear it is adapting to new settings. As mentioned above, the informal market expands in times of turmoil and regression, and this drives down wages making it even harder for people to pay the high cost of

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healthcare. This vicious circle of inequality and poverty determines which public services it is possible to access.

Conclusions

As is discussed above, Lebanon's economic and political stability has fluctuated in recent decades. The economy has been plunged into crisis and the people who are feeling the worst effects are the poor and marginalised. They have been forced to turn to the informal sector for work that pays below the minimum wage, making Lebanon an even bigger breeding ground for corruption. This, along with the refugee crisis, has led to increased levels of poverty and financial insecurity for many Lebanese households, and made it exceedingly difficult for the poorer socio-economic classes to access healthcare.

This leads back to the original question in this brief: who is able to access and has the right to good quality public healthcare? Healthcare in Lebanon is only accessible to those who can afford it. Healthcare is also less accessible in rural areas, meaning that there is both a financial bias and a rural-urban bias. This confirms contemporary theories and findings on public health, where poorer people generally have worse health, partly because they usually eat less varied and less nutritious food, exercise less, and smoke and drink more, while also having more limited access to healthcare.[79]

All Lebanese citizens have the right to access health services, but refugees, asylum seekers and other people living or working informally cannot. The country has prioritised specialist healthcare and even medical tourism for those who can afford it. Thus, according to existing data, Lebanon's situation is in line with existing theories on health and poverty.

Geographical bias and a lack of nursing staff are real issues for Lebanese healthcare and the public health system and have the same effects as corruption.[80] It is corruption, however, that makes this kind of system possible: a system where only a few have access to good healthcare. Without good healthcare, public health often suffers. As noted above, Lebanon has among the highest numbers of smokers, lowest levels of physical activity, and highest levels of cancers and cardiovascular diseases in the MENA region. Unhealthy eating, smoking and other unhealthy behaviours are closely linked to the diseases mentioned above, and lack of accessible healthcare will make the situation worse in the future.[81] Poverty levels continue to rise, and the state does not seem to know how many people are living in poverty. Levels could in fact be much higher, which only increases the problem.

Given the rate at which the Lebanese economy grew in the post-war era and the early 2000s, the country should be further ahead than it is in the arena of healthcare quality and distribution. A number of

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[80] Hemadeh, R. et al. (2020). The primary health care network in Lebanon: a national facility assessment. *East Mediterr Health Journal.*
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political choices made by a wealthy few in the country, however, have favoured their own economic interests over those of the Lebanese public health, resulting in a high-cost healthcare system with many issues around quality and accessibility. Non-communicable diseases are increasing in the country, and these diseases require skilled, high quality healthcare services. If corruption persists in the way it has, more people will suffer poverty and increasing insecurity, and the healthcare system will not be able to take care of everyone. This will happen not because the healthcare personnel are not skilled enough, but because people cannot afford treatments or do not have any entitlement to treatment. As it stands, healthcare remains out of reach for people working informally or those living close to or below the poverty line.

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