Rethinking Health Systems
informal healthcare provision among Syrian refugees in Lebanon

Opinion Editorial

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While the ongoing conflict in Syria has had an enormous impact on the health needs of Syrian refugees, relatively little attention has been given to the effects the conflict has had on the health systems of refugee-hosting countries bordering Syria. Due to the scale of the refugee crisis, how these health systems function has dramatically altered in ways that are difficult to describe using current models. Indeed, this difficulty is often exacerbated by the interaction of outside organizations, as well as legal and socio-political factors that are generally not present in higher-income countries.

The present op-ed will attempt to highlight this disconnect by examining the effects of the current refugee crisis on Lebanon's health system. By evaluating the informal network of health provision among refugees, the present paper argues that this newly emerging sector does not easily subscribe to Western models of health systems. Traditional "pillars" (as outlined by the WHO's "Six Building Blocks" framework) such as governance and financing are not readily apparent, and furthermore, additional needs and services have developed.[1] There is therefore a requirement to contextually describe these systems in order to properly understand them.

As a country hosting an estimated 1.5 million refugees, representing just over 25% of the population, Lebanon has been severely affected by the refugee crisis.[2] Demand for healthcare within this refugee population is incredibly high; a report from John Hopkins[3] found 67% of adult refugees needed healthcare in the last year, and a further 70% of households reported their child needing healthcare over the same period. This has placed an enormous burden on the Lebanese healthcare system, with an overall increased demand of 40% on the hospital system.[4]

This increased pressure has created a health system that can best be characterized as fragmented and difficult to navigate for refugees.[5] Stewardship of health services for refugees falls under either the UNHCR or the private sector, and are delivered across a range of actors, including NGOs, public ser-vices, or the private sector.[5] Syrian refugees receive access to healthcare centers for a fee of US $2 to US $3 per consultation, and must pay a further 25% of hospital care costs, including medication.[5]

Given these financial and logistical barriers, many Syrian refugees are resorting to alternative methods for accessing healthcare. Research from the more established Palestinian refugee camps, as well as refugee popula-tions in similar countries, points to a large informal healthcare sector among the Syrian refugee population.[6] However, due to Lebanese labour laws prohibiting the rights of Syrian refugees to work in the country describing and documenting this informal net-work is difficult, largely due to the ethical concerns of conducting research in popula-tions working illegally.[7]

Despite this, there are some reports of Syri-an health professionals working outside the established health system. For example, the Multi Aid Programs (MAPS) is a grass-roots organization founded by Syrian refugees through the support of a virtual Lebanese board. The organization operates a clinic in the Anjar district, and employs 13 Syrian doctors who offer support to 150 patients

at a rate of US $2 for Syrian refugees, and US $6 for Lebanese.[8] Additionally, while authorities have stopped most Syrian doctors from opening clinics or working at hospitals, they have not stopped those who volunteer their services at clinics in border areas; states Abou Faour (the previous Minister of Health), "we cannot stop a physician from helping his compatriots".[9]

It is very likely that health professionals from Syria are adapting strategies established by Palestinian refugees, who are subject to similar labour laws, and have been residing in Lebanon since the 1950s.[10] Hanafi and Tiltnes[10] have documented a number of clever ways in which Palestinian health professionals have overcome these barriers. Palestinian medical doctors who are ineligible to write prescriptions for patients overcome legal restrictions by filling out prescription forms that have been signed and stamped by a Lebanese doctor. Some private insurance companies accept prescriptions from Palestinian doctors, provided their address is outside of a Palestinian refugee camp; one medical doctor residing in a refugee camp stated that he simply excludes the camp area from his address when signing prescriptions. Additional strategies include a Palestinian nurse who organized the Palestinian staff together to demand work permits, threatening that the hospital would "suffer the consequences" otherwise.[10] Other tactics include establishing a company in the name of a Lebanese national while Palestinian professionals do most of the work, or denying ones' Palestinian roots.

Informal networks among refugees are also used to overcome informational barriers to healthcare access. A study from Parkinson and Behrouzan[11] describes a situation where a Syrian refugee in labour is guided through the complex and fragmented Lebanese health system by a Palestinian refugee. The study also comments on how refugees rely on one another to find the cheapest pharmacy, best services, as well as other concerns, thereby overcoming the complex nature of the Lebanese health system.

These illustrations exemplify the intersectionality of two concepts - that of a substitutive informal institution, and therapeutic geographies. The former refers to a categorization of informal institutions by Helmke and Levitsky[12] based on the outcomes of the informal institution, and the effectiveness of corresponding formal institutions. A substitutive informal institution is one that arises because of an ineffective formal institution; in the case of Lebanon, the informal health sector exists because the formal health sector was not able to adequately address the health needs of refugees within the country. This inability arose from the second concept - that of therapeutic geographies, which refers to the reorganization of healthcare systems within and across borders under conditions of war.[13] Specifically, this refers to how the Syrian civil war has impacted the Lebanese healthcare system to the extent that parallel, informal institutions are arising as a substitution.

With protracted conflicts becoming more and more common, there is a need to better understand how health systems in low and middle-income countries adapt to these crises.[14] Western models of health systems are rapidly becoming obsolete when attempting to describe the changing concept of health within these countries. In regard to informal health provision, governance tends to be less prevalent, the workforce less regulated, and in general, the landscape is more complex and not easily categorized. As this article attempted to illustrate, more experiential research and a reconceptualization of health systems are required if we are to contextualize and address these situations properly.

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Fighting or Deepening Exclusions from Health Services?
social health protection program for the poor in India

Opinion Editorial

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India and Universal Health Coverage

The 2012 United Nations General Assembly Resolution on Global Health and Foreign Policy explicitly called for increasing efforts to provide high quality and affordable health services for all, acknowledging the role of good health in fostering international development.[1] This is all the more relevant given the reality of many developing countries where economic and social inequalities create severe health-related imbalances as a consequence.[2] Achieving universal health coverage (UHC), however, is highly dependent on national undertakings in the field of health systems strengthening, such as investing in infrastructure and workforce, establishing efficient health information systems, developing sustainable health financing mechanisms, ensuring access to medicines and health technologies, and assuring leadership and accountability arrangements.[3] India is no exception. Efforts are undertaken towards the achievement of UHC, however, the challenges of the national health system remain significant. In 2010, total government spending on health represented as little as almost 5%, which, what is more, accounted for only one-third of the expenditures on health. Out-of-pocket (OOP) payments for health services continue to constitute a barrier for health care utilization, amounting to 60% of spending for health.[4] In addition, as much as 86% of people residing in rural areas and 82% of those living in urban areas remained not covered by any health insurance, being reliant on their own savings.[5]

Rashthriya Swasthya Bima Yojana Scheme

Faced with the described situation, in 2008, the Government of India launched the Rashtriya Swasthya Bima Yojana (RSBY) health insurance scheme with the objectives of protecting below the poverty line (BPL) households from financial hardships associated with OOP spending and hospital treatment as well as increasing access to hospital services within the poorest population.[6] Next year's tenth anniversary of the scheme