



Access to Healthcare for Syrian Refugees.

*The Impact of Fragmented Service Provision
on Syrians' Daily Lives*

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Abstract

This report aims to explore the fragmented organisation of healthcare services in Lebanon, for Syrian refugees. Although it is not an assessment of the Lebanese healthcare system, this report does nevertheless reflect on the challenges and underlying dynamics of the current Lebanese system, which are reproduced in the healthcare provision for Syrian refugees. In this sense, the report highlights the privatised, rather *ad hoc*, and irregular provision of healthcare in Lebanon, notably for Syrian refugees, which tends to take on a more curative rather than preventive approach, resulting in significant costs on the patients. Consequently, a great number of vulnerable Lebanese and non-Lebanese residing in Lebanon, notably Syrian refugees, are unable to access health services.

Key words

Syria

Refugees

Access to Healthcare

Healthcare Privatisation

Public Healthcare Services

Social Protection

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Challenges inherent to the public healthcare system in Lebanon, notably for specialised care, prompt the country's residents to resort to private health services, resulting in significant costs for the patients. Consequently, a great number of people with limited resources are denied access to health services. In this context – even prior to the Syrian refugee crisis – several NGOs, religious organisations, and charities have taken over certain realms of healthcare, leading to a highly fragmented provision of medical aid. Since 2011, over one million¹ Syrian refugees have registered in Lebanon, adding more strain on Lebanon's already fragile provision of healthcare. This report seeks to highlight the challenges faced by Syrian refugees in order to secure access to healthcare services. This is the third of a series of reports seeking to analyse the impact of Lebanese government policies on Syrian refugees' daily lives.

¹ At the time of writing, (October 2016,) a total of 1,033,5113 Syrian refugees in Lebanon are registered at the UNHCR.

Methodology

This report is based on desk research and fieldwork. Fieldwork consisted of a total of 26 interviews with Syrian refugees, conducted between July and August 2016. Lebanon Support used its extensive network of Syrian refugees, humanitarian workers, civil society activists, medical doctors and researchers, as well as workers working in primary, secondary, and tertiary healthcare, to identify who has access to healthcare in Lebanon, and to what extent. Interviews followed a semi-structured interview guide, and Lebanon Support did not provide incentives. All interlocutors provided oral informed consent to participate, and were assured that their identity would remain anonymous, unless the interviewees explicitly agreed to the public use of their name. Most interviews took place in person in Beirut and other regions in Lebanon. Interviews took place in private settings and were conducted in either Arabic or English. Our group of interlocutors consisted of Syrian men and women aged between 18 and 60. Preliminary findings of this study have been discussed in a multi-stakeholder meeting in October 2016, and feedback has been incorporated into the analysis.

2 The healthcare system in Lebanon

- 2 Marie-Noëlle AbiYaghi, "The Social Protection System," Beirut, Arab NGO Network for Development, 2014, p.189.
- 3 Wim Van Lerbergue, Walid Ammar, and Abdelhai Mechal, "De l'impasse à la réforme : la crise du secteur de santé au Liban," *Studies in Health Services Organisation & Policies*, No 2, 1997.
- 4 Karam Karam, *Le mouvement civil au Liban : revendications, protestations et mobilisations associatives dans l'après-guerre*, Paris, Karthala, 2006.
- 5 This can be explained by the fact that, until the eruption of the Civil War in 1975, "the MoPH provided free healthcare in public hospitals for the poor, and paid for their care in private hospitals only for services not available in the public hospitals. During the Civil War, all the victims of the war could be treated in the private hospitals at the expense of the MoPH. As government hospitals could not be properly funded or administered, the MoPH extended its coverage of all healthcare services to all citizens in private hospitals, and became the primary financing agency of these hospitals." As of then, government expenditures rose to more than 80% (compared to 10% before 1975) being spent on healthcare services in private hospitals. As a result – and with the army also starting to pay for services in private hospitals – the private sector in healthcare expanded to a great extent. After the war, the government continued to pay for private services, and "effectively lost power to regulate the system, and a fragmented, chaotic, uncontrolled, and unregulated system emerged." Roger Sfeir, "Strategy for National Health Care Reform in Lebanon," Université Saint Joseph, 2007, p.8-9, available at: <http://www.fgm.usj.edu.lb/pdf/a62007.pdf> [last accessed 28 September 2016].
- 6 See: Vincent Geisser, "'État' de santé au Liban : une médecine à deux vitesses?," IFPO, 2014, available at: <http://ifpo.hypotheses.org/5836> [last accessed 3 August 2016]. As such, the Lebanese healthcare system accounts for 6.4% of Lebanon's GDP. See: Total expenditure on health as a percentage of gross domestic product (US\$), as of 20th of June 2016. World Health Organisation, "Total expenditure on health as a percentage of gross domestic product (US\$)," 2016, available at http://www.who.int/gho/health_financing/total_expenditure/en/ [last accessed 7 September 2016]. United Nations High Commissioner for Refugees, "Health Chapter," Inter-Agency Multi-Sector Needs Assessment (MSNA) Phase One Report, Secondary Data Review and Analysis, UNHCR, 2014, p.10, available at: <https://data.unhcr.org/syrianrefugees/download.php?id=6241> [last accessed 17 August 2016].

When Lebanon gained independence in 1943, the Lebanese state set out to develop a healthcare policy in order to provide better healthcare access for low-income families and communities in regions lacking adequate sanitation infrastructure. These attempts were reinforced in the 1950s and 1960s when President Fouad Chehab (1958-1964) founded public institutions, such as the Ministries of Planning and Social Development, in order to develop social protection systems in Lebanon. His attempts, however, as well as those of his successors, proved to have limited success. The outbreak of the Lebanese Civil War (1975-1990) put a definite end to creating some kind of state-directed social protection in Lebanon.² In addition, most public hospital structures were destroyed by the time the war had ended in 1990; the private sector, meanwhile, remained rather dynamic.³

During the Civil War, Lebanon also witnessed a surge in the number of civil society organisations⁴ that contributed to the setup of a network of healthcare centres, clinics, hospitals, and dispensaries across the country. These services were – and remain – provided by secular, religious, national, and international organisations, as well as non-governmental organisations (NGOs). Although these organisations provide private health services, many of them rely on the government for funding,⁵ which has led researchers to describe this system as "public funding for private healthcare."⁶

The healthcare system in Lebanon thus seems not only fragmented between the many different providers, but also between different social protection schemes that do not contribute to ensuring universal healthcare access to citizens and residents. This means that access to healthcare is mainly determined by wealth and/or position in the labour market. As a result, the rather limited intervention of the state, through the Ministry of Public Health, leaves many vulnerable Lebanese and non-Lebanese residing in Lebanon without any access to healthcare.

A FRAGMENTED SOCIAL PROTECTION SYSTEM

Unlike other countries, the Lebanese social protection system protection is based on the relationship between the citizen and the labour force, rather than on criteria for residency or citizenship belonging to the state.⁷ As such, Lebanese citizens can rely on several institutions – often linked to institutions they work for – to cover part of their medical expenses, some of which are public, and others private.⁸

The first is the Cooperative of Government Employees, which is available to employees of the public sector, depending on the governmental institutions they work for, given that various departments of Ministries allocate funds differently. In general, these types of insurances have high coverage and reimburse beneficiaries quickly.⁹ In addition to the Cooperative of Government Employees, five smaller funds are part of the financing schemes for civil servants: the Security Forces' fund, the Army's fund, the Internal Security Forces' fund, the General Security's fund, and the State Security's fund.¹⁰

The second public financing agent in the healthcare system is the state-run National Social Security Fund (NSSF),¹¹ which provides Lebanese citizens working in the private sector with an insurance plan.¹² However, any public sector employer whose institution is not covered by the Cooperative of Government Employees can register with the NSSF to provide insurance to his or her employees. Employees and students that do not have insurance access through their employer or university are also eligible to the NSSF. It is important to note, here, that the NSSF only covers hospitalisation, ambulatory care, and medication. It is also known for delayed reimbursements.¹³ Due to its debt, the NSSF was not able to pay workers back for years, making it the employers' responsibility to reimburse their employees.¹⁴

A third medical coverage option is through private insurance companies providing coverage for private firms, or, fourthly, through companies giving coverage for households.¹⁵ It is estimated that private hospitalisation insurance companies cover roughly 400,000 beneficiaries, which corresponds to 8% of the Lebanese population.¹⁶ This number not only reflects the number of subscribers but some of their family members as well, as they may also be covered by a subscriber's plan. According to a 2012 WHO report, options for coverage vary from partial to full coverage. It is worth noting that only 27% of Lebanese can afford full coverage, which secures them with a bed in a "better hospital."¹⁷ Nevertheless, even with the highest type of coverage, insurance companies do not provide full reimbursement for specific types of healthcare, such as dental care, optical care, or prostheses. Furthermore, in general, ambulatory care and medicines remain very expensive for families, as such care is reimbursed less.¹⁸

Still, healthcare is not easily accessible for a significant number of Lebanese citizens, as 52% of them do not enjoy any kind of medical coverage, and only 27% of them can afford full insurance coverage. For them, access to healthcare remains at the expense of their own revenues, or at the expense of the Ministry of Public Health (MoPH).¹⁹ In the latter case, patients are admitted to public hospitals or contracted private hospitals, for which the MoPH "covers 85% of hospital care costs and 100% of medication costs for chronic and high-risk diseases."²⁰

7 Marie-Noëlle AbiYaghi, *op.cit.*, p.184.

8 Roger Nasnas, *Le Liban de demain, vers une vision économique et sociale*, Beirut, Dar an-Nahar, 2007, p.356; Alef, "Right to health, greater access to healthcare for a healthier population," *The Human Rights Violations Monitoring Unit*, 2009, p.6; Roger Melki, "La protection sociale au Liban entre réflexe d'assistance et logique d'assurance," UNDP conference on linking economic growth and social development, Beirut, UNDP, 2000, p.189.

9 Marie-Noëlle AbiYaghi, *op.cit.*, 2014, p.185.

10 Roger Nasnas, *op.cit.*, 2007, p.356.

11 The NSSF is made up of four branches: family allowances, retirement allowances, illnesses and maternity, and professional illnesses and work accidents.

12 See: Roger Melki, *op.cit.*, 2000, p.194, 196.

13 Marie-Noëlle AbiYaghi, *op.cit.*, 2014, p.181.

14 Roger Melki, *op.cit.*, 2000, p.198.

15 *Ibid.*

16 Marie-Noëlle AbiYaghi, *op.cit.*, 2014, p.181; Roger Nasnas, *op.cit.*, 2007, p.358-368; Ministère de la Santé Publique "Recueil national des statistiques sanitaires au Liban," Beirut, 1999; Ministère de la Santé Publique "Recueil national des statistiques sanitaires au Liban," Beirut, 2004; Ministère de la Santé Publique "Recueil national des statistiques sanitaires au Liban," Beirut, 2012. After reviewing the last three sanitary statistics reports available, it can be noted that the percentage of the population (8%) covered by a private insurance is the same across all three reports. However, this number does include a small portion (about 0,7%) that is also covered by the NSSF.

17 Regional Health Systems Observatory, Health System Profile "Lebanon," World Health Organisation, 2012, available at: <http://apps.who.int/medicinedocs/documents/s17301e/s17301e.pdf> [last accessed 6 September 2016].

18 Roger Melki, *op.cit.*, 2000, p.196, 199.

19 Roger Nasnas, *op.cit.*, 2007, p.358. The expenses of the MoPH on hospitalisations and ambulatory care in 2012 was about 301 billion LBP which represents an amount of USD 123 per year and per person of coverage of healthcare costs. In comparison, the average spending on hospitalisation and ambulatory care of the NSSF is about USD 323. See: Ministère de la Santé Publique, *op.cit.*, 2012, p.120.

20 *Ibid.*

3 The main healthcare providers for refugees and barriers to accessing them

21 It should be noted that Lebanon is not a signatory of the Convention Relating to the Status of Refugees, nor of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families. As such, the Lebanese state is not bound to abide by these conventions. Still – according to the preamble of the Lebanese constitution – Lebanon is “a founding and active member of the United Nations Organisation” that abides by the Universal Declaration of Human Rights. In addition, Lebanon has signed and ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR). Thus, the problem lies not necessarily in the content of the legislations, but in their application, as well.

22 The UNHCR offers health assistance to all “people of concern”: a term that corresponds to the term “refugees” in countries that signed the 1951 Convention on the Status of Refugees, or its 1967 protocol (which Lebanon did not). Concretely, “people of concern” are “(a) those who fall under the Statute/1951 Convention definition and thus are entitled to benefit from the full range of the Office’s functions; (b) those who belong to a broader category but have been recognised by States as being entitled to both the protection and assistance of the Office [this can also be Lebanese citizens]; (c) those to whom the High Commissioner extends her «good offices,» mainly but not exclusively to facilitate humanitarian assistance; (d) returning refugees, for whom the High Commissioner may provide reintegration assistance and a certain protection; and (e) non-refugee stateless persons whom UNHCR has a limited mandate to assist.” UNHCR, “Protection of persons of concern to UNHCR who fall outside the 1951 Convention: a discussion note,” 1992, available at: <http://www.unhcr.org/excom/scip/3ae68cc518/protection-persons-concern-unhcr-fall-outside-1951-convention-discussion.html> [last accessed 28 September 2016]. The Lebanese government has requested the UNHCR to suspend the registration of Syrian refugees as “displaced people” as of May 2015. Those wishing to register after this period could only be recorded (not registered) as a “person of concern.” Moreover, the classification “person of concern” also includes Syrians refugees who are not yet registered/recorded, but fulfill the criteria for that recognition. In addition, the UNHCR cleans up its database by inactivating the files of deceased people, people who are no longer in the country, or people who – according to the UNHCR’s criteria – are no longer a “person of concern.” The Country Director of one of the leading NGOs in the health sector informed us that it is virtually impossible for them to reactivate a file once it has been inactivated. For those who are not registered but who are in urgent medical need, a fast track assessment exists, in which the UNHCR can determine that, despite not being registered, a person can still be regarded as a “person of concern,” entitled to coverage from MediVisa – the third party contractor of UNHCR (see footnote 44). However, he also informed us that once unregistered/unrecorded persons of concern are discharged from the hospital, they are obliged to formally record themselves. Still, there are many Syrians who – considering the potential consequences of being recorded while also being persecuted by the Syrian regime – deliberately do not register. For them, registering (and thus, coverage by MediVisa) is not an option.

23 Palestinian refugees can turn to the United Nations Relief and Works Agency for Palestine Refugees (UNRWA) for assistance and protection. Due to the nationality-based criteria for beneficiaries, Palestinian Refugees from Syria (PRS) seem to be eligible for UN protection from either UNRWA or the UNHCR. In practice, however, they do not enjoy any protection. This seems to be confirmed by our interlocutors.

The current healthcare system poses a series of challenges for refugee populations in Lebanon. Our research shows that a fragmented healthcare system has left most refugee – and vulnerable Lebanese – populations without easy access to health services. This section seeks to highlight the main challenges indicated by our fieldwork. The main identified barriers are internal and include a lack of clarity, mistrust, and perceived discrimination; another set of identified barriers and challenges are more structural, and include affordability, limited and fragmented service provision, and healthcare for urgent care only.

SOME INTERNATIONAL INSTRUMENTS PROTECTING THE RIGHTS OF MIGRANTS, REFUGEES, AND ASYLUM SEEKERS

Article 25 of the “Universal Declaration of Human Rights” states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care and necessary social services.

The “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” is also laid down in the 1966 “International Covenant on Economic, Social, and Cultural Rights” (ICESCR). The 156 countries that have ratified the Covenant must “refrain from denying or limiting equal access for all persons” to preventive, curative, and palliative health services, including “asylum-seekers and illegal immigrants.”

The 1951 “Convention Relating to the Status of Refugees” states that “refugees shall be accorded the same treatment” as nationals in relation to maternity, sickness, disability, and old age.

The 2003 “International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families” has set out the rights of migrant workers to health care (although it fails to address their rights to preventive measures and early treatment).²¹

3.1 The UNHCR

The leading institution affiliated with providing both registered and unregistered Syrian refugees²² with access to healthcare in Lebanon at the primary, secondary, and tertiary levels, is the United Nations High Commissioner for Refugees (UNHCR). The UNHCR is the UN agency responsible for the assistance and protection of (non-Palestinian)²³ refugees.

A wide range of services: primary, secondary, and tertiary healthcare

Primary healthcare (PHC) refers to an individual's initial contact with the healthcare system when seeking treatment. If a patient requires further care that cannot be provided at the PHC level, a primary care provider will refer the patient for more specialised care, either at the secondary or tertiary levels. Secondary health care (SHC) refers to care from a specialist in a facility with more advanced medical investigation capabilities, while tertiary health care (THC) is even more specialised care that takes place in a hospital and usually includes surgical care. The UNHCR refers to both SHC and THC as "referral care."²⁴

The UNHCR provides Syrian refugees with access to 28 primary healthcare centres across Lebanon, primarily run by the UNHCR's NGO partners and the Ministry of Social Affairs (MoSA).²⁵ Syrian refugees who are registered or recorded with the UNHCR can access primary healthcare in these centres for a fee that ranges between LBP 3,000 and 5,000 per consultation, whereas Lebanese are charged between LBP 10,000 and 15,000. The UNHCR also provides acute medication, vaccines, and two ultrasounds for pregnant women²⁶ free of charge, while chronic illness medications (diabetes, cardiac conditions, hypertension, asthma, epilepsy, etc.) are provided for a handling fee of LBP 1,000 per visit.²⁷ In a 2015 survey, however, 71% of Syrian refugees who reported stopping the use of chronic disease medication did so because they could not afford medication or handling fees.²⁸ For children under 5 years old and adults over 60, along with other vulnerable individuals such as pregnant women and persons with disabilities, the UNHCR subsidises 85% of the cost of laboratory and diagnostic tests; all other refugees must pay 100% of test costs.²⁹ Yet, despite the fact that the UNHCR provides some services free of charge, these services are not always sufficient.³⁰ Moreover, many people fall outside of the UNHCR's scope of assistance for primary healthcare, thus leading to significant healthcare costs that Syrian refugees are unable to pay, as many have informed us that even the consultation costs are too high.

With regards to secondary and tertiary healthcare, the UNHCR covers 75%³¹ of refugees' medical costs, but only in the case of life-threatening emergencies.³² For most eco-

24 United Nations High Commissioner for Refugees, "Guidelines for Referral Health Care in Lebanon: Standard Operating Procedures," UNHCR, 2016, p.2.

25 Amnesty International, "Agonizing Choices: Syrian Refugees in Need of Healthcare in Lebanon," London, Amnesty International Ltd, 2014, p.9, available at: <https://www.amnesty.org/en/documents/MDE18/001/2014/en/> [last accessed 3 August 2016].

26 The UNHCR recommends a total of four ultrasounds during the course of a woman's pregnancy. It subsidises 85% of the cost of the last two of these ultrasounds.

27 United Nations High Commissioner for Refugees, "Health Services for Syrian Refugees in Beqaa," UNHCR, 2016, p.4, available at: <http://reliefweb.int/report/lebanon/health-services-syrian-refugees-bekaa> [last accessed 15 September 2016].

28 Emily Lyles and Shannon Doocy, "Syrian Refugee and Affected Host Population Health Access Survey in Lebanon: July 2015," The Centre for Refugee and Disaster Response at Johns Hopkins University Bloomberg School of Public Health and Médecins du Monde, 2015, p.26, available at: <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0a hUKEwjf2a7pDPAhUsDcAKHai1DIQQFggeMAA&url=https%3A%2F%2Fdata.unhcr.org%2Fsyrianrefugees%2Fdownload.php%3Fid%3D9550&usg=AFQjCNHo1y40cVgvSrIxsGFclPk-NQDd8g> [last accessed 14 September 2016].

29 *Ibid.*

30 For example, interviewed medical doctors have informed us that pregnant women need at least four ultrasounds, rather than two. Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016.

31 The most marginalised Syrian refugees can receive up to 90% coverage of medical costs – and in very rare cases, even up to 100% coverage – after a vulnerability assessment by the UNHCR.

32 Until April 2013, UNHCR coverage of medical costs for Syrian refugees was 100%, eventually going down to 85%, and then to 75% by mid-2014. United Nations High Commissioner for Refugees, "UNHCR Lebanon Health Update: September 2014," UNHCR, 2014, [last accessed 3 August 2016].

- 33 United Nations High Commissioner for Refugees, “Guidelines for Referral Health Care in Lebanon: Standard Operating Procedures,” *op.cit.*, p.3.
- 34 Interview with the director of a local NGO in tertiary healthcare, Beirut, August 2016.
- 35 Interview with a Syrian mother, Beirut, August 2016.
- 36 UNHCR, “Q&A on Emergency Health Assistance Provided to Refugees and Asylum Seekers by UNHCR and Partner Organizations in Lebanon” available at: <https://www.refugees-lebanon.org/news/104/qa-on-emergency-health-assistance-provided-to-refugees-and-asylum-seekers-by-unhcr-and-partner-organizations-in-lebanon>, 31 August 2016, [last accessed 31 October 2016]; Interview with a doctor working for a local NGO, Beirut, August 2016; Interview with a Red Cross representative, Beirut, August 2016; Interview with an NGO worker from a local NGO that supports underprivileged populations in Lebanon, Beirut, August 2016.
- 37 Michelle Kuepper, “Does Germany need to rethink its policies on healthcare for refugees?” ResearchGate, 2016, available at: <https://www.researchgate.net/blog/post/does-germany-need-to-rethink-its-policies-on-healthcare-for-refugees> [last accessed 26 September 2016].

nomically vulnerable refugees, the UNHCR provides targeted assistance of up to 90% of the total cost, funds permitting.³³ Interlocutors repeatedly emphasised that one of the central challenges they face is that this criteria is, first of all, narrow. A respondent of an NGO working with children who have cancer explains that “even the definition of what is ‘life-threatening’ is unclear: the UNHCR has never paid for a life-saving operation in childhood cancer treatment, for example.”³⁴ Second, the UNHCR’s targeted assistance for life-threatening emergencies excludes many patients who do need help, but whose life is not yet at risk. Humanitarian workers emphasise that this deprives many people from their basic right to proper healthcare. A Syrian mother illustrates the difficulties this poses for common accidents:

“ Seven months ago, one of my children accidentally swallowed a coin. We are still not sure if his body has discharged it, or not. We went to the hospital and they told me they needed to perform X-rays, but the UNHCR wouldn’t cover it because it wasn’t urgent. And we can’t afford to pay for it ourselves. He’s been in pain for weeks now, but we don’t know where to go or what to do.”³⁵

UNHCR coverage

Health workers, humanitarian workers, and Syrian refugees stressed that car or work accidents requiring medical care should be covered by the car owner or employer, and are not covered by the UNHCR.³⁶ In addition, Syrian refugees are not entitled to medical referral care with regards to chronic diseases. This, despite the fact that the most common health issues among refugees are those to which all human beings are susceptible to, which are mainly determined by sex, age and socio-economic position.³⁷ Still, the UNHCR only covers for acute aggravation or exacerbation of medical conditions. A doctor working in an NGO explains:

“ The UNHCR only provides coverage for life-saving operations – the removal of malignant tumours, for example. But some tumours are non-malignant at first, and would only require a small surgery to be extracted at this stage. If you don’t operate on it early on, it can grow and turn into a cancerous tumour after one or two

years. Still, the UNHCR does not cover the costs of small surgeries for non-malignant tumours. The long-term perspective is very bad for Syrian refugees.³⁸

Furthermore, many Syrian refugees explained that the UNHCR does not cover the entire course of their treatment, stressing that as soon as their conditions are no longer life-threatening, the UNHCR suspends payments:

“ I have a kidney disease, and few months ago I got very sick. I went to the hospital three times with my UNHCR registration card and the hospital staff refused to admit me, saying that they have not received the go-ahead from the UNHCR. Once they saw that my kidney was completely blocked, they admitted me into the hospital and gave me the necessary treatment. I was admitted for treatment twice. The the third time I went there, the staff told me I could not be admitted, that the UNHCR can only cover the costs of treatment twice.³⁹

Thus, not only is the criteria determined by the UNHCR in order for refugees to receive the 75% of financial coverage too narrow, but that same percentage does not cover the portion of the treatment that it claims to. Moreover, the UNHCR does not cover the additional costs of consultation, diagnostic fees, health products (such as diapers), medication, or even burials. In addition, many interlocutors emphasised that, while treatment itself may be covered, complications that arise from this treatment are often not.

More importantly, Syrian refugees still face significant out-of-pocket payments with the remaining patient share of 25%, which the UNHCR will not cover.⁴⁰ However, most Syrian patients are unable to pay for transportation to the hospital, or phone credit to call for test results. It comes as no surprise, then, that most Syrian refugees are unable to pay their patient share.⁴¹ An NGO worker argues:

“ First of all, Syrian refugees have to pay rent. The cheapest studio in Shatila is about USD 300. Second, most of people can't find a job, either because it's too difficult to find one, or because they've signed the pledge not to work. And if someone could find a

³⁸ Interview with a medical doctor working in a humanitarian NGO, Beirut, August 2016.

³⁹ Interview with two Syrian workers, Beirut, June 2016.

⁴⁰ In a June 2015 survey, Syrian refugees reported an average household expense of USD 105 on healthcare in the month preceding the survey. This expense amounted to an average of 17.7% of their monthly income. Emily Lyles and Shannon Doocy, *op.cit.*, 2015, p.26.

⁴¹ “Um Fares gave birth through a caesarean section last month. But the baby was sick and had to stay in the hospital for four days. I sold my stuff in my house and borrowed the rest to cover the costs of the hospital, which amounted to USD 1000, after the coverage provided by the UNHCR. In the end, the baby did not survive.” Interview with two Syrian workers, Beirut, June 2016.

- 42 Interview with an NGO worker of a local NGO, Beirut, August 2016.
- 43 When a patient requires hospitalisation, which is included as part of both SHC and THC, the UNHCR “contracts a third party administrator (TPA) to contact a network of hospitals where refugees can access care.” United Nations High Commissioner for Refugees, “Guidelines for Referral Health Care in Lebanon: Standard Operating Procedures,” *op.cit.*, p.2. In Beirut, Mount Lebanon, Beqaa and the North, MediVisa functions as the TPA for Syrian refugees registered with the UNHCR. “Health Services for Syrian Refugees in Beqaa,” *op.cit.*, p.5. TPA medical consultants approve cases that are below USD 1,500; if a case exceeds this amount, the TPA submits it to the UNHCR for approval, for which the upper ceiling is USD 10,000. United Nations High Commissioner for Refugees, “Guidelines for Referral Health Care in Lebanon: Standard Operating Procedures,” *op.cit.*, p.3-4.
- 44 Interview with the fundraising manager of an NGO affiliated with congenital heart disease, Beirut, August 2016.
- 45 Interview with the Head of Public Relations of a hospital in Beirut, Beirut, August 2016.
- 46 Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016.
- 47 Interview with a paediatrician, Beirut.
- 48 Interview with a Red Cross representative, Beirut, August 2016.

job, they wouldn't get paid more than USD 400-500. Even then, people can't really move as they used to before, because they don't have residencies anymore. The cheapest surgery costs USD 600. How can they afford to pay this?⁴²

Heavy bureaucracy constrained by an upper ceiling

Healthcare providers have informed us more than once of the time-consuming procedures that need to be undergone before treatment is approved by all parties.⁴³ But time is not always on the patients' side. As one NGO worker explains, “Sometimes, surgery needs to go faster than the paperwork.”⁴⁴ The upper ceiling of USD 10,000 is more often than not, insufficient. A medical representative from an important hospital in Beirut states:

“ I think for most patients, USD 10,000 is not enough. For small, one-day surgeries, like deliveries, USD 10,000 is a reasonable amount. But some surgeries are more costly, especially if we're talking about chronic diseases, or orthopaedic surgeries. And of course, if post-op complications occur, patients might need to stay for a longer period of time in (Cardiac) Intensive Care. And this can be even more costly.”⁴⁵

The upper ceiling adds to the feeling of powerlessness among humanitarian workers as well as medical staff.⁴⁶ A paediatrician explains:

“ I had two patients who still needed treatment, but they'd already reached their financial ceiling, so we had to tell them, 'sorry, we can't pay for you anymore.' Today, too, I've had to tell a patient, 'sorry, your money's finished, I don't know if I'll have more funds for you in two weeks.’”⁴⁷

Despite the fact that the UNHCR is the leading organisation concerned with healthcare provision for Syrian refugees, our interlocutors unanimously agreed there are still too many health-related costs that remain uncovered. And since the UNHCR is the main health actor, addressing complaints about the UN becomes difficult for them.⁴⁸

3.2 *Other healthcare providers*

Looking at the healthcare system in Lebanon, one of the most important challenges appears to be directly linked to the privatisation of the healthcare system. Although there are public hospitals and healthcare centres in Lebanon, and despite the fact that the Ministry of Public Health offers some coverage in the realm of healthcare, fieldwork accounts have stressed that public health institutions are not always able to offer the same services as private health institutions, as specialised treatment or even equipment are not always available. Moreover, the quality of these public services⁴⁹ (in terms of both care and funding) appears to be highly debatable, and people resort to them as a “very, very last option.”⁵⁰ A humanitarian affairs advisor explained that this common belief may be based on the actual quality of public healthcare. Another explanation could be that this belief is “a reflection of people’s mistrust towards public institutions, especially given the historical symptoms of state unaccountability.”⁵¹ As she explained, the widespread privatisation of health and education services is the product of the neoliberal reconstruction that the Hariri mandate pursued after the Civil War had ended: “Developing an excessive and negative attitude towards the state and its services – already aggravated during the war – delivered a further blow to people’s trust in public institutions.”⁵² As such, privatisation expanded during the Civil War and the subsequent reconstruction phase in the 1990s.⁵³

As a result, most people in Lebanon rely on private healthcare, i.e. private hospitals, private insurances, and NGO/charity provisions. Yet, for Syrian refugees, private hospitals and private insurances are, in most cases, not affordable. Not only has the protracted crisis forced them to deplete their savings, they also have very restricted access to the Lebanese labour market, leaving them with very few means to secure their livelihoods.⁵⁴

“ *The problem is Syrian refugees’ socioeconomic conditions, not access to healthcare services, per se – it’s access to all services in a country where everything is privatised and you need a high income to pay for everything. This is why you need NGOs to provide services to Syrian refugees, so that healthcare becomes*

49 According to a doctor working for an international NGO in health realms: “A lot of these clinics are not in their best of shape. Doctors are not trained in, what we believe, are the adequate or good medical schools. Some of them, or a lot of them, are trained in Eastern Europe, Russia, Ukraine. But the medical education there is not top-notch, especially when people there buy their medical degrees. But these are the people working in these primary care clinics. But other clinics do have adequate care.” Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016.

50 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016; Interview with a researcher in health services from an international NGO, Beirut, August 2016.

51 Interview with a humanitarian affairs advisor and postdoctoral research associate, Beirut, September 2016.

52 Interview with a humanitarian affairs advisor and postdoctoral research associate, Beirut, September 2016.

53 Marie-Noëlle AbiYaghi, *op.cit.*, 2014, p.181.

54 See Lebanon Support, “Syrian Refugees’ Livelihoods: The Impact of Constraining Legislations and Increased Informality on Syrians’ Daily Lives,” Beirut, *Civil Society Knowledge Centre*, 2016.

- 55 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.
- 56 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.
- 57 For minor healthcare problems, pharmacists offer medical advice free of charge. In this vein – although it is officially required – medication is often distributed without prescription.
- 58 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.
- 59 Roger Nasnas, *op.cit.*, 2007, p.381.
- 60 Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016. This is also confirmed by literature, see Roger Nasnas, *op.cit.*, 2007, p.392.
- 61 See: Roger Nasnas, *op.cit.*, 2007, p.379. Secondary and tertiary care appeared to be lucrative investments in the private sector.
- 62 As constituted in the 1925 Decree No. 15 on Lebanese Nationality, the Lebanese nationality can only be transmitted by paternity. Thus, children from Lebanese mothers and foreign fathers are regarded as foreigners by the Lebanese government. As such, they are not per se eligible for the Ministry of Public Health's help. Available at: <http://www.refworld.org/pdfid/44a24c6c4.pdf> [last accessed 26 September 2016].

accessible, because they can't afford the private sector. Or you can look at it the other way: the public sector needs to be stronger in order to cope with populations that have very low income.⁵⁵

As described above, the UNHCR's intervention is limited in terms of scope as well as in terms of the actual amount of coverage (only 75%). Therefore, most interlocutors we talked to are dependent on provisions of different NGOs and charity organisations. Those existed prior to the Syrian crisis, or have emerged as a response to the influx of Syrian refugees into Lebanon.

3.2.1 NGOs and charities

Already prior to the crisis, primary healthcare provision in Lebanon has been predominantly offered by NGOs,⁵⁶ which are not only covering medical treatment in private and public hospitals, but also run their own primary healthcare centres.⁵⁷ As one humanitarian worker explained, "NGOs are managing PHCs for a very good reason: there is a need for it."⁵⁸ But even though a great number of primary healthcare centres is available, the impact that these centres have is limited.⁵⁹ That is, there is a general perception that patients prefer to turn to secondary, rather than primary, healthcare centres.⁶⁰ Yet, despite the fact that secondary and tertiary care and services in Lebanon – which are essentially provided by the private sector – are known for their high quality level,⁶¹ this care is not accessible to everyone, as it requires financial contributions that not only refugees but even large numbers of Lebanese citizens are unable to meet. While Lebanese citizens without insurance can rely on financial support from the Ministry of Public Health,⁶² Syrian refugees cannot. And since neither the Lebanese government nor the UNHCR guarantees extensive or long-term treatment, it is again NGOs and religious organisations that take up important realms of healthcare by providing either healthcare services or financial assistance. Though this is predominantly the case in the primary healthcare sector, it is drastically reinforced within secondary and tertiary healthcare sectors, where NGOs are often the only accessible support for refugees, serving as the UNHCR's main collaborators.

A fragmented system

Whereas UNHCR assistance is available to both registered and unregistered Syrian refugees, some NGOs do require refugees receiving assistance to be registered, thus, excluding unregistered Syrians from their services. NGOs that do not require UNHCR registration, however, apply less strict criteria for assistance in general, and focus on specific diseases (cancer, heart, or kidney diseases), which facilitates a specialised approach to the medical treatment of these diseases. As the director of a small NGO in tertiary healthcare states: “for us, an important criterion is that a disease is life-threatening, when no treatment is given.”⁶³

But this rather niche approach of different NGOs that are active in supporting the access of deprived segments of the population (among them refugees) is not without its challenges. First of all, NGOs are required to comply with the government’s health policy: “By law, the Ministry of Public Health is the Planner, Supervisor, Regulator, and Evaluator of health, healthcare, and the health system. Yet, the scarcity of financial and human resources made it impossible for the MoPH to perform its role.”⁶⁴ As stated by a researcher in health services:

“ This is a very unusual response, because on the one hand, the government wants to keep calling the shots. On the other, it has very weak infrastructure. Usually, in a humanitarian response, the health organisations would just go and set up field hospitals and provide their own services. But in Lebanon, you can’t just do that. You still need to coordinate with the ministry.

Moreover, the fragmented and highly bureaucratic healthcare system, which consists of many different NGOs, charities, and religious organisations, does not include a clear and systematic referral system, making the distribution of healthcare services not clear, but also hindering proper follow-up on patients. Although the first years of the crisis have been explicitly described as the most challenging due to this system, doctors and humanitarian workers explained that the more protracted the crisis is, the more people are being able to find their way in health services.⁶⁵ Still, too many ambiguities remain:

⁶³ Interview with the director of a small, local NGO in tertiary healthcare, Beirut, August 2016.

⁶⁴ Roger Sfeir, *op.cit.*, 2007, p.9.

⁶⁵ Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016; Interview with Red Cross representative, Beirut, August 2016.

66 Interview with a researcher in health services from an international NGO, Beirut, August 2016.

67 Interview with a Red Cross representative, Beirut, August 2016.

68 Interview with the director of a local NGO in tertiary healthcare, Beirut, August 2016.

69 Interview with Red Cross representative, Beirut, August 2016.

“ I think the most confusing thing is the system itself. No one can understand what is covered and what is not, which NGOs cover what, if being registered or not makes a difference. And it’s changing constantly, all the time. People just don’t know where to go when they get sick.”⁶⁶

The director of a small NGO working in tertiary healthcare adds that “Everyone states that there is a problem, while also refusing to solve it, blaming donors or other NGOs for this problem.” Thus lack of clarity eventually lead to an *ad hoc* referral system. While Syrian patients have described feelings of being sent back and forth “from pillar to post,” NGO workers emphasise that ambiguity is a challenge for them, too. As a result, some institutions “misuse”⁶⁷ this vagueness to reject patients. A member of an NGO covering treatment of vulnerable diseased children explains:

“ I have seen many families who asked many NGOs for help, and all NGOs say they will check the case, but then they refuse it. From my experience, I could already tell families from the beginning that there is not even sense in trying, they will get refused by every NGO. Yesterday, I dealt with a difficult case and had to tell the patient’s brother that our NGO cannot help them much anymore. Then, he said he’d spoken to a big international NGO, and they wanted to talk to me to see how they can help. I talked to the woman and she just wanted to ask which NGO she can refer the case to. So basically, she just gave me back the question.”⁶⁸

Such referrals are time-consuming, and some interlocutors stress that patients are often left without any help at all in the end. Most of our respondents, in fact, plea for an approach in which the patient, rather than finance-based policies, is the focus.

Interlocutors also stress the importance of health education and awareness among Syrian refugees.⁶⁹ A UNHCR representative explains: “refugees don’t know where to go when they are sick. More importantly, they don’t know when it’s time to visit a doctor – and when not to. So the UNHCR distributes mass information brochures and leaflets

that include the [...] health care facilities where services are subsidised and contracted [...] as well as the number of the Red Cross for emergency transportation, don't seek help too late. But at the same time, you don't want them to call the Red Cross for minor problems, such as a sore throat, either."⁷⁰ Interviewees argue that, although refugees might be aware when it's time to seek medical aid, they still face a grim financial situation, which forces them to prioritise things differently.

“ You need to understand what their living conditions are, what their priorities are. People may not show up at appointments because they have other things on their mind: their family is stuck in Syria, someone they know just died, they couldn't find someone to watch their children during their appointment. As a doctor, you have to find out what their daily struggles are and try to work around them.”⁷¹

Scarcity of funding

The second challenge for NGOs is that they rely on donor revenues. Donors often explicitly specify which purposes or target groups will benefit from their donations; donations are “earmarked,”⁷² and funding differs per region: “some funds only cover certain diseases until the funds change, and these diseases are not covered at all in some regions anymore.”⁷³ In addition, funding is often still emergency-focused,⁷⁴ and many NGO workers we have interviewed emphasise that emergency aid should evolve more towards development aid: “Refugees have been in Lebanon for five years, now, but they're still not considered as residents who must receive the necessary aid.”⁷⁵

Yet this very protraction – coupled with the fact that health-care is more expensive in Lebanon than in other countries due to its privatised system – has led to a donor fatigue. As a result, “funding is decreasing, while the needs continue to increase.”⁷⁶ Adding to this is the fact that health problems have a consistent character. An NGO worker explains:

“ Health isn't like a protection project that you can stop for a while and then restart. You can't suddenly stop providing healthcare and say, 'Sorry, next month if you're still sick, you can't come back.' But this

⁷⁰ Interview with UNHCR representative, Beirut, August 2016.

⁷¹ Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016.

⁷² When donations are earmarked, donors explicitly specify which medical purposes or which target groups will benefit from their donation.

⁷³ Interview with an NGO worker of a local NGO, Beirut, August 2016.

⁷⁴ People prefer giving blankets or emergency supplies. Interview with the General Coordinator of an international NGO concerned with providing healthcare, Beirut, August 2016.

⁷⁵ Interview with a researcher in health services from an international NGO, Beirut, August 2016.

⁷⁶ Interview with the Head of Public Relations of a hospital in Beirut, Beirut, August 2016.

- 77 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.
- 78 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.
- 79 Interview with a researcher in conflict sensitivity of health services for an international peace-building organisation, Beirut, August 2016.
- 80 Before the UNDP launched its ART GOLD Lebanon Project, for example, which aims to empower local authorities and communities to participate in the planning and implementation of development processes, there was a training of health staff in Haret Hreik. See: http://www.lb.undp.org/content/lebanon/en/home/operations/projects/poverty_reduction/-art-gold-lebanon.html [last accessed 26 September 2016].
- 81 Interview with a researcher in health services from an international NGO, Beirut, August 2016.
- 82 Interview with the director of a small, local NGO in tertiary healthcare, Beirut, August 2016.
- 83 Interview with a doctor working for a local NGO; Interview with the Head of Public Relations of a hospital in Beirut, Beirut, August 2016.

***is what's often happening to our organisation; there's a gap of two months in our funding.*⁷⁷**

Furthermore, resources are inefficiently spent, as local and national NGOs as well as the ministry and hospitals do not optimally and exhaustively coordinate the provision of healthcare. For example, new centres and programmes were set-up, although they did not offer any additional value to already existing ones.⁷⁸ Interlocutors have also informed us that decisions made on a political level do not always correspond to the needs in the field.

“ The Ministry of Health decided to set up certain laboratories in public hospitals, so they ordered very expensive equipment, which the UNHCR paid for. When work started, the implementers realised that hospitals are either not aware of the need, or don't recognise the need for such a laboratory. They might not even have the right to set up such a laboratory. So money is spent on things that are purchased, but they're not being set up, or not being used. The equipment is just rotting somewhere, collecting dust. And the next year, such a lab will probably turn into something else, as it is not responding to a need.⁷⁹

For this reason, healthcare education needs to be elaborated “prior to introducing renovated infrastructure and technological progress.”⁸⁰ In order to sustain enough income to continue to exist, healthcare providers are often forced to take decisions based on business interests.⁸¹ Researchers working in healthcare maintained that, although some organisations try to save money by being fully organised by volunteers,⁸² other organisations spend significant amounts of money on human resources.⁸³ They also emphasised the negative consequences this has for Syrian refugees:

“ What we have seen with basic assistance is that the less money is available, the more rigorous funding criteria are applied. So if agencies had less funding, they would either have to cover the cost of people who were selected with a very rigid methodology, which is often problematic, or they decreased the general per-

centage of subsidies and people pay out-of-pocket. Either way, it would be more difficult for Syrians to access health care.⁸⁴

Confessions and politics as additional challenges

In addition to one's financial situation, confession and political orientation can also serve as an obstacle in accessing healthcare. Since the Civil War, many dispensaries, care centres, and hospitals owned by religious communities provided – and often continue to provide – free care for members of their communities, while also prioritising these members when it comes to treatment. Despite these providers' official mission statement, some health services are designed for and provided to specific ethnic groups, or *tawa'ef*. Although there are no organisations that explicitly provide services on an ethnic or confessional basis, in practice, all of them operate in specific geographic areas that are often demographically marked as “Muslim” or “Christian.”⁸⁵ Unfortunately, in the case of an emergency, some patients may be sent to another care centre because of their confession, meaning that such confessional discrimination may have fatal consequences. As a result, not all health services are accessible for Syrian refugees or other vulnerable populations.

3.2.2 Public and private hospitals

Hospitals are one of the main healthcare service providers in Lebanon. Since doctors' fees in private clinics are not covered by private healthcare providers, most people rely on hospital care, making hospitals the first focal point for most of our interlocutors when they face health problems. Lebanon hosts a total of 130 hospitals spread throughout the Lebanese territories, 80% of which fall under the private sector.⁸⁶ However, hospitals charge amounts that Syrian refugees often do not own. After five years of crisis, many Syrian refugees have depleted their savings,⁸⁷ while having little-to-no access to the labour market⁸⁸.

Expensive treatments and lack of livelihoods

The financial situation of Syrian refugees makes hospitals face increasing challenges in terms of financial coverage for medical treatment for Syrian patients, sometimes leading to detrimental coping strategies in order to secure payment. First of all, hospitals that are not contracted with the UNHCR are refusing Syrian refugees. A Red Cross representative

⁸⁴ Interview with a researcher in conflict sensitivity of health services for an international peace-building organisation, Beirut, August 2016.

⁸⁵ Interview with a humanitarian affairs advisor and postdoctoral research associate, Beirut, September 2016.

⁸⁶ Council for Development and Reconstruction, “Public Health, Social Infrastructure,” Government of Lebanon, 2013, available at: http://www.cdr.gov.lb/eng/progress_reports/pr102013/Epub.pdf [last accessed 27 September 2016].

⁸⁷ Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.

⁸⁸ Lebanon Support, “Syrian Refugees' Livelihoods. The Impact of Constraining Legislations and Increased Informality on Syrians' Daily Lives,” *op.cit.*

89 Interview with a Red Cross representative, Beirut, August 2016.

90 Interview with an NGO worker of a local NGO, Beirut, August 2016.

91 Interview with an NGO worker of a local NGO, Beirut, August 2016.

92 Interview with a Red Cross representative, Beirut, August 2016.

93 Interview with a doctor working for a local NGO, Beirut, August 2016.

94 Interview with a Syrian father, Beirut, August 2016.

confirmed that this prevents ambulances from transporting Syrian patients to health establishments.⁸⁹ An NGO worker adds that Syrian refugees being excluded from hospital care affects humanitarian and medical workers, as well:

“ Once, a woman called after midnight. She was giving birth right in front of the hospital, but they wouldn't let her in. So I took a taxi and went there, but unfortunately, the woman was without her husband or family. She delivered her baby on the street and the baby fell on the floor and died. I was depressed for a very long time after that night.”⁹⁰

Second, hospitals that are contracted with the UNHCR are facing challenges in finding the financial support for non-covered medical treatment. Interlocutors have stated that some hospitals wait for a guarantee that the UNHCR, or other organisations, will pay their share before admitting patients.⁹¹ But even when such a guarantee is provided, many public hospitals ask for a private insurance or a deposit prior to providing a patient with medical care.⁹² Syrian refugees and humanitarian workers also confirm that most hospitals require them to pay their patient share of 25% before undergoing treatment.⁹³ According to a Syrian father:

“ My daughter is 9 years old. Once, we came back home and we found her hanging on the wall with a scarf around her neck. We didn't know how if she was playing or if she was trying to kill herself. Maybe someone else did this to her. We took her to the emergency room, but the office of UNHCR made us wait for hours before they agreed to let her in. She's been in the Intensive Care Unit for five days. Now, the hospital is threatening to discharge her if we don't pay. The UNHCR covers only 75%, so we need to pay the remaining 25%, which already amounts to 5 million LBP. How can we pay this amount of money? I can't even pay 10%.”⁹⁴

Over-crowdedness

Many hospitals often refuse patients due to lack of space and over-crowdedness. Humanitarian workers emphasise that such rejection is not uncommon, although there is no

data documenting the consequences.⁹⁵ This situation also applies to all vulnerable populations in Lebanon – lower-class Lebanese citizens, other refugee populations, and Syrian refugees, even though hospitals are legally required to provide help when it comes to life-threatening issues. But Syrian refugees have been forced to hand over their IDs or passports in order to guarantee payment.⁹⁶ Some hospitals have even been reported to be unwilling to discharge patients – or even deceased bodies – until payment took place:

“ A young mother had problems during delivery, so they put the baby in an incubator. However, the UNHCR didn’t agree to pay for the incubator costs, and the parents couldn’t afford to do so. So they discharged the mother, but kept the baby in the hospital. They told the mother she was not allowed to visit her newborn until she paid the bill. I went to the hospital and took the baby out secretly; his name was written on a band around his wrist. But these kinds of things happen sometimes. You even hear stories about people who pass away. They keep their dead bodies, until someone pays. And on top of that, they charge for the time during which they kept the dead body in the morgue.”⁹⁷

Rising tensions between the lebanese community and Syrian refugees

Fieldwork shows that hospitals also have to cope with rising mutual discrimination and tensions between Lebanese and Syrians. An underlying factor of these rising tensions can be related to the fact that 85% of registered refugees are living in areas in which 67% of the host population is living below the poverty line.⁹⁸ In these areas, the financial situation of Lebanese is comparable to the financial situation of Syrian refugees, 70% of whom live under the poverty line.⁹⁹ However, especially in the beginning of the crisis, the international community was focusing exclusively on Syrian refugees and neglected vulnerable Lebanese communities. As such, health services were only subsidised for Syrians, and required higher contributions from Lebanese using the same services.¹⁰⁰

In addition, health services have been described as “overstretched and underfunded,” even prior to the crisis.¹⁰¹

⁹⁵ An NGO worker explained that: “A few months ago, a child was referred to a hospital. The child was very sick and had high temperature, but the hospital didn’t have any rooms available. They told us to give the child some pills to lower the temperature and that’s it. The parents called me during the night to say that the child passed away.” Interview with an NGO worker of a local NGO, Beirut, August 2016.

⁹⁶ Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016.

⁹⁷ Interview with an NGO worker of a local NGO, Beirut, August 2016.

⁹⁸ World Health Organisation, “Donor Snapshot - Lebanon. July - September 2014,” available at: http://www.who.int/hac/donorinfo/who_donor_snapshot_lebanon_english_oct14.pdf [last accessed 4 September 2016] in International Alert, “Understanding the Use of Segregation measures in primary Healthcare settings in Lebanon,” unpublished, 2015. The World Bank estimates that the national average of Lebanese living below the poverty line accounts to 27%. World Bank, “Lebanon / Data,” 2012, available at: <http://data.worldbank.org/country/lebanon> [last accessed 28 September 2016].

⁹⁹ “Situation report Lebanon: Syria crisis response,” World Food Programme, January 2016, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/WFP%20Lebanon%20Situation%20Report_December%202015_English.pdf [last accessed 14 September 2016].

¹⁰⁰ “Une ONG suisse soigne les réfugiés syriens au Liban,” 24H, available at: <http://www.24heures.ch/monde/moyen-orient/ong-suisse-soigne-refugies-syriens-liban/story/25322377> [last accessed 16 August 2016]. For example, this can be seen in the difference in fees for primary health centres “which can be up to five times higher [for Lebanese] than the subsidised fee [for Syrians].” United Nations High Commissioner for Refugees, “UNHCR Lebanon Operational Update: April-June 2016,” UNHCR, 2016.

- 101 International Alert, *op.cit.*, 2015, p.1.
- 102 Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016; Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016.
- 103 International Alert, *op.cit.*, 2015, p.1.
- 104 International Alert, "The costs of Lebanese patients' withdrawal from primary healthcare centres in Lebanon," unpublished, 2015.
- 105 Interview with a researcher in conflict sensitivity of health services for an international peace-building organisation, Beirut, August 2016.
- 106 Interview with the Head of Medical Activities working for an international NGO, Beirut, August 2016; Interview with a Red Cross representative, Beirut, August 2016.
- 107 International Alert, *op.cit.*, 2015, p.3.
- 108 Interview with a researcher in conflict sensitivity of health services for an international peace-building organisation, Beirut, August 2016.
- 109 International Alert, "Understanding the Use of Segregation measures in primary Healthcare settings in Lebanon," unpublished, 2015.

Researchers working in healthcare explained that the increased number of Syrian patients led to longer waiting lines for Lebanese. Coupled with a fear of contagious outbreaks, especially since Syrians in tented settlements lack proper hygiene services,¹⁰² this has led to a rise in tensions between Lebanese and Syrians,¹⁰³ prompting Lebanese patients to withdraw from some health services.¹⁰⁴ On top of this, there were disturbing examples of the provision of medication through different channels, especially at the outset of the crisis:

“ At the beginning of the crisis, the Ministry of Public Health would provide medication for chronically ill people, as it’s supposed to, but there would be delays due to administrative complications. Meanwhile, the UNHCR/UNICEF would provide medication for the Syrians on time. So medication would often be available, but would not always be accessible to the Lebanese and this was naturally a source of tension.¹⁰⁵

As a result, hospitals and primary healthcare centres use various coping strategies, such as applying a quota of beds available to Lebanese or Syrians,¹⁰⁶ fast-tracking Lebanese patients, separating Lebanese and Syrian patients in different waiting rooms, or scheduling them on different periods of the day or even completely different days.¹⁰⁷ A researcher in healthcare explained that such coping strategies were “worrying, because they reinforce stereotypes and prejudices.”¹⁰⁸ Consequently, although they were not always aware of segregation measures and were generally satisfied with the quality of services, sources of tension for Syrian patients evolved around experiencing longer waiting lines than Lebanese and less attention by healthcare staff.¹⁰⁹ A researcher on conflict in health realms explained:

“ By June 2015, health providers were already more accustomed to the new way of work, so the initial wave of dissatisfaction and anxiousness and tension started to subside. Health care workers got used to new requirements on how they needed to take note on Syrian patients differently from Lebanese patients. They were getting more used to having different patients in the waiting room, more comfortable dealing with everyday

conflicts that may emerge, and as a result, the patients themselves became more accustomed. During the first years, tensions were mainly erupting as a result of misunderstanding the system.¹¹⁰

At the same time, not all NGO workers recognise this discourse, as there are many Lebanese and Syrians who, despite political or religious differences, “try to make the best of the situation.”¹¹¹ One positive aspect of the crisis is that international aid has led to a better distribution of health services, thus also has improved Lebanese people’s access to them.¹¹² Moreover, tensions between refugee and host populations led to the realisation that the needs of locals need to be addressed, too, encouraging the evolvement of *ad hoc* assistance towards long-term development.¹¹³

¹¹⁰ Interview with a researcher in conflict sensitivity of health services for an international peace-building organisation, Beirut, August 2016.

¹¹¹ Interview with the director of a local NGO in tertiary healthcare, Beirut, August 2016.

¹¹² See: Dalia Atallah and Dana Sleiman, “With Syria refugee crisis, Lebanese health services improve,” UNHCR, 6 September 2016, available at: <http://www.unhcr.org/en-us/news/stories/2016/9/57ce7e7d4/syria-refugee-crisis-lebanese-health-services-improve>. [last accessed 14 September 2016]. For example, this can be seen in the fact that in 2016, there are 230 primary health care centres across Lebanon, a significant increase from the number that existed prior to the Syrian crisis (180 centres). Dalia Atallah and Dana Sleiman, *op.cit.*, 2016.

¹¹³ Interview with a humanitarian affairs advisor and postdoctoral research associate, Beirut, September 2016.

4 Varying coping mechanisms among refugees

- 114 Medical conditions allow for entry and residency under category 8, as a “displaced person,” or for a medical visit (category 9). See: Lebanon Support, “Formal Informality, Brokering Mechanisms, and Illegality. The Impact of the Lebanese State’s Policies on Syrian Refugees’ Daily Lives,” Beirut, *Civil Society Knowledge Centre*, 2016, p.10.
- 115 That is, private hospitals are more present in Beirut and Mount-Lebanon, whereas public hospitals are more present in the Beqaa Valley or in the South. The North remains relatively neglected. See Roger Nasnas, *op.cit.*, 2007, p.373.
- 116 Interview with a Syrian janitor, Beirut, July 2016.
- 117 Interview with a Red Cross representative, Beirut, August 2016.
- 118 However, although health institutions in general do not require legal residency as a prerequisite in order to receive help, some organisations only offer their services to refugees who are registered or recorded at the UNHCR. For more information, see footnote 22.
- 119 For example, in Wadi Khaled, medical products such as reproductive health kits, or a supply of sanitary pads were distributed. See United Nations Population Fund, “Meeting Syrian Refugees Needs in Reproductive Health,” 2012, available at <http://www.unfpa.org.lb/News/Refugees-RH.aspx> [last accessed 27 September 2016].

Although in theory, medical conditions allow for Syrian refugees to obtain legal residency in Lebanon,¹¹⁴ most of our interlocutors have stated that they were unable to do so. As a result, most Syrians in need of medical care are still illegal.

Illegality and accessibility

The fear of crossing checkpoints due to an illegal status leaves many Syrian refugees with no choice but to resort to undesirable or harmful ways to navigate in these circumstances (“negative coping mechanisms”) and still access healthcare, especially during nighttime. Adding to this is the fact that there is an unequal distribution of private and public hospitals in different areas, which further complicates the issue of accessibility.¹¹⁵

In order to overcome such challenges, a Syrian father described having to always carry the medical file of his sick child with him when he leaves the house. Should the father be stopped at a checkpoint, he would show the officers the file, in a plea for mercy.¹¹⁶ A representative of the UNHCR informed us that crossing checkpoints can be avoided if patients ride in Red Cross ambulances. But a spokesperson from the Red Cross informed us that Red Cross ambulances are technically obliged to transport Syrians to the nearest hospital, which may or may not be contracted with the UNHCR, and which therefore is (un)willing to admit them.¹¹⁷ While illegality does not seem to influence patients’ admission to the hospital, it still influences free movement within the country.¹¹⁸ As such, moving around illegally does affect the way sick people can access medical institutions, especially in emergency cases.

Transborder medical aid

Other coping strategies described by our informants include crossing borders to seek medical aid. In the first years following the eruption of the Syrian crisis, Syrians would access healthcare in both Syria and Lebanon. Most Syrians resided in Syria, and – especially those living close to the Syrian-Lebanese border – entered Lebanon from time to time to access services and receive medical products.¹¹⁹ Meanwhile, Syrians already residing in Lebanon would return to Syria for treatment. Yet, due to the so-called “October policies” adopted by the Lebanese government in October 2014 and the *de-facto* closing of the borders, it has been

increasingly difficult to leave or (re-)enter Lebanon, as we have previously shown in another report:¹²⁰

“ The (international) response to the Syrian crisis covered only emergencies. So chronically ill patients, up until the last moment when borders were open, would cross the border to access their medication or health services in Syria. Since January 5, 2015, the borders were essentially sealed off. But even since October 2014, it was already becoming more difficult for Syrians to move back and forth between Syria and Lebanon, so people had no access to chronic services for chronic diseases.”¹²¹

The closing of borders, in addition to the high costs and complex bureaucratic procedures of the healthcare system in Lebanon, has prompted many Syrian patients to return to Syria for treatment. Though Syrian refugees try to avoid going back to Syria due to security reasons, NGO workers often advise to do so.¹²² As several Syrian refugees have explained, “it’s an absolute death to go to Syria.”¹²³

“ A doctor in the Beqaa asked me to go to Syria for treatment, but this is very difficult. I am from Homs; our house is destroyed. The whole city is destroyed. You cannot reach hospitals, even if they were still open and functioning...”¹²⁴

An NGO worker confirms:

“ I often hear from other workers in the field that people sometimes go back to Syria for certain medical interventions because they’re free of charge there. So basically, they would rather risk their lives to access the treatment, than stay here where they can’t afford it. And then of course, for those who can’t go back, their health situation would deteriorate.”¹²⁵

Paving the way for informality

Many Syrians in need of medical care are thus excluded from healthcare services, which adds to feelings of stress and anxiety and sometimes even leads to aggression towards health actors:¹²⁶ “They’re worried that they have to wait for

¹²⁰ Lebanon Support, “Formal Informality, Brokering Mechanisms, and Illegality. The Impact of the Lebanese State’s Policies on Syrian Refugees’ Daily Lives,” *op.cit.*

¹²¹ Interview with a researcher in conflict sensitivity of health services for an international peace-building organisation, Beirut, August 2016.

¹²² Amnesty International, *op.cit.*, 2014, p.16.

¹²³ Interview with a Syrian mother, Beirut, August 2016.

¹²⁴ Interview with a Syrian mother, Beirut, August 2016.

¹²⁵ Interview with an NGO worker from a local NGO concerned with supporting underprivileged populations in Lebanon, Beirut, August 2016.

¹²⁶ Interview with a Syrian humanitarian activist, Beirut, August 2016.

- 127 Interview with a researcher in health services from an international NGO, Beirut, August 2016.
- 128 Interview with a Syrian mother, May 2016.
- 129 A Syrian humanitarian activist informed us that these informal health facilities were initially established to help wounded Syrians.
- 130 Interview with a Syrian humanitarian activist, Beirut, August 2016.
- 131 Interview with a Syrian humanitarian activist, Beirut, August 2016.
- 132 Emily Lyles and Shannon Doocy, *op.cit.*, 2015, p.70.

a long time before they get approval for financial aid, or that public services are not good enough. And they always fear that they will be mistreated, or that they will have to pay after all.”¹²⁷ Moreover, being barred from medical aid is leading Syrians to hope for resettlement,¹²⁸ or taking the risk to leave Lebanon. As a result, these options leave many Syrian refugees without any perspective. In this context, unofficial health facilities are emerging for those who do stay. Since the beginning of the conflict, different networks of Syrian activists – political opponents of the Syrian regime – were established in Aaley and the Beqaa Valley, for those who, whether legally or illegally, entered Lebanon and were in need of help.¹²⁹ Thus, paradoxically, illegality becomes the only possible – and logical – way to access health services:

“ We established an apartment in the Beqaa Valley in early 2012, so it could be used as a recovery centre. We equipped it with all the necessary medical supplies. We had hospital beds, a pharmacy, and even hired a nurse. Then Syrians in Lebanon who needed various medical care came to know us. They started calling me and asking for help, as the UNHCR is giving close to no services. We were an informal network consisting of only a few people; we would get our funding through individual donations and some NGOs. But despite this, we helped many people. We had a lot of different cases and different diseases, like heart disorders, chronic diseases, and people who got injured... All this urgent health care is not covered by the UNHCR. We were able to save many lives. But we also lost many. The needs are huge. We took the risk and did all of this work because no one else is doing it.”¹³⁰

A Syrian activist informed us that lately that the Lebanese government has cracked down nearly all informal facilities.¹³¹ As a result, a sizable number of Syrian refugees end up not seeking care when they need it.¹³²

“ I think if people see these patients, they would see that they are human, that they are not cases or just numbers. I think that would make a lot of difference. If you hear that ‘a patient is sick and he needs money,’ you won’t be motivated. But when you see him, when you listen to him, when you listen to his aspirations, when you listen to his hopes, then it’s completely different. That’s when you think: maybe what we’re doing is not enough.¹³³

This report adopts an anthropological and human rights perspective in order to analyse the extent to which the Syrian refugee population in Lebanon is able to access healthcare.

The leading institution concerned with access to healthcare for Syrian refugees is the UNHCR. Although their assistance and support is significant, many Syrian refugees are left with rising costs that they are unable to meet. As a consequence, NGOs, charities, and religious organisations are affiliated with providing health services or financial support. But dependency on such a highly fragmented and bureaucratic system which lacks clarity or a systematic referral or follow up system leads to an *ad hoc*, irregular, and insecure approach in healthcare. Above all, healthcare for Syrian refugees in Lebanon seems focused on merely alleviating the symptoms of the health problems in question, rather than actually addressing their underlying cause. As such, the system is more curative than preventive.¹³⁴ In addition, previously mentioned organisations are highly dependent on funding, which not only prohibits a steady stream of revenues or services, but also forces them to focus on specific target groups or diseases. As a result, many Syrian refugees are not provided with access to healthcare. This creates difficulties for NGOs and hospitals, and especially for Syrian patients, most of whom depleted their savings, are in debt,¹³⁵ and have very minimal access to the labour market.¹³⁶

Given the enormous influx of refugees since the eruption of the Syrian crisis, the Lebanese government has been forced to respond to an increased number of needs, access to healthcare being one of them. Although the country has been able to implement a range of health services with the help of international donors, it also has suffered from the consequences of not only the Syrian refugee crisis, but

¹³³ Interview with a paediatrician, Beirut, August 2016.

¹³⁴ Some researchers even argue that social policy in Lebanon remained focused more on palliative care – which provides patients with relief from symptoms, pain, or stress in order to improve the quality of life for both patients and their families – rather than solutions for the underlying problems. In contrast to curative care, palliative occurs when curing is not an option anymore. Therefore, palliative care is often associated with end-of-life care. See Rana Jawad, “Religion and Social Welfare in the Lebanon: Treating the Causes or Symptoms of Poverty?”, *Journal of Social Policy*, Vol. 38 (01), Cambridge, Cambridge University Press, 2009, p.141-156.

¹³⁵ Lebanon Support, “Syrian Refugees’ Livelihoods. The Impact of Constraining Legislations and Increased Informality on Syrians’ daily lives,” *op.cit.*

¹³⁶ *Ibid.*

137 Dalia Atallah and Dana Sleiman, *op.cit.*, 2016.

138 Interview with a humanitarian affairs advisor and postdoctoral research associate, Beirut, September 2016.

139 Michelle Kuepper, *op.cit.*, 2016.

also the protracted Palestinian refugee crisis.¹³⁷ As such, an increasing number of inhabitants “have simply unearthed the pre-existing structural deficiency of the local healthcare system, whose reform actually depends, in turn, on political decision making.”¹³⁸

Fieldwork indicates inefficiency of aid as one of the main challenges. However, more importantly, challenges seem to be inherent to the lack of effective coordination and common strategy between health actors, be it the state, UNHCR, hospitals, NGOs, but also donors. All parties involved describe funding as the most important challenge, as most medical treatments involve high costs, while the healthcare sector in general is left underfunded.

We can thus conclude that the Syrian refugee crisis has, to a large extent, not only magnified, but also reproduced already existing challenges and shortcomings of a highly privatised, fragmented, and inefficient healthcare system that is unable to provide a sustainable pathway for provision of healthcare to patients, whether citizens or refugees. This results in many Syrian refugees not being able to enjoy their basic human right to proper healthcare, thus relying on informal and illegal structures of health service provision, and sometimes, not being able to access medical aid at all. This, in fact, proves to be a more fundamental problem than any of the practical or financial challenges of providing such care.¹³⁹

