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Discussion of "Health service utilization and access to medicines among Syrian refugee and host community children in Lebanon" by Lyles et al.

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Introduction

This editorial constitutes a discussion of the article "Health service utilization and access to medicines among Syrian refugee and host community children in Lebanon" published in the *Journal of International Humanitarian Action* in July 2016. The exchange has been initiated by El-Jardali et al. with a letter to the editors. After consultation with all involved parties, El-Jardali et al. and the original authors of the article, Lyles et al., agreed to engage in the form of this special discussion forum.

Initiation letter: lack of contextual knowledge leads to misinterpretation in primary healthcare cost estimates for Syrian refugees in Lebanon

We read with interest the paper by Lyles et al. (2016) entitled "Health service utilization and access to medicines among Syrian refugee and host community children in Lebanon" published in the *Journal of International Humanitarian Action*. The article is based on a report published in 2015 (Johns Hopkins University et al., 2015). Lyles et al. conducted a cross-sectional survey of Syrian refugees and Lebanese households to assess access to health services including out-of-pocket (OOP) costs at the level of primary healthcare (PHC). The cost estimates were based on findings from both the Primary Healthcare National Network and private for-profit providers of primary care. However, the study generalizes these findings to all primary care facilities when, in fact, they are more compatible with private for-profit providers. As such, we find the presentation of the cost estimates at the level of primary care in this study misleading.

As a matter of fact, the lack of contextual knowledge of the Lebanese healthcare system, particularly providers' characteristics and health services seeking behaviors of different socioeconomic groups of the population, leads to ill-designed studies and misinterpretations. Low socioeconomic groups of the Lebanese population and displaced Syrians are, with few exceptions, seeking care at the PHC centers (PHCCs) of the National Network supported by the Ministry of Public Health (MOPH), for nominal fees, whereas the well-to-do among both Lebanese and Syrians are more likely to seek private services.

The PHC National Network encompasses over 220 PHCCs spread across Lebanon (PHCU, 2015). A significant number of those centers are being accredited by Accreditation Canada International with positive impacts on quality and overall performance (El-Jardali et al. 2014). The MOPH caps the OOP contribution of any medical visit to the PHCC at a maximum of US$ 12. Additionally, the MOPH provides essential medications for acute illnesses free of charge and chronic medications for the dispensing fee of less than US$ 1. Refugees registered with the Office of the United Nations High Commissioner for Refugees (UNHCR), have access to subsidized PHC in PHCCs for a fee of approximately US$ 2 to US$ 3 (UNHCR, 2015). However, humanitarian subsidies for refugees are available at only approximately 100 PHCs countrywide.

The study concluded that OOP payments for child health care were considerable for both Syrian refugees and the host community. For example, the average total cost per visit among refugee families who sought care for child health at the PHCCs was reported at US$ 25.5. The majority of the OOP cost incurred at primary care level was linked to medications and cost was reported as

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the primary barrier to both care seeking and attaining medications.

In the study, the results included health centers outside of the PHC National Network which are private for-profit providers. Consultation costs at these facilities are higher and do not adhere to the price regulations set by the MOPH. In addition, these centers do not receive drugs from MOPH and do not dispense free drugs to beneficiaries. Instead, they prescribe drugs that beneficiaries purchase at pharmacies. As such, when calculating OOP expenses at the PHCC, the study not only included health centers outside of the PHC National Network, it included costs incurred at the level of the pharmacy, and attributed it to PHCCs. When presenting the study findings, the authors did not refer to these major contextual factors and as such conveyed an inaccurate representation of the current situation in Lebanon. As a result, the OOP estimates at the level of the PHCC are overly inflated and are not considered compatible with our observations at the PHC National Network.

The study design and sampling did not allow for stratification analysis to differentiate between the PHC centers of the National Network and the private for-profit providers in terms of service provision and cost. This resulted in misleading conclusions contradicting well-documented facts by the MOPH and UNHCR as mentioned above.

In conclusion, we acknowledge the contribution of the survey (Lyles et al. 2016; Johns Hopkins University et al., 2015) and previous other surveys conducted by UNHCR in providing information critical for program planning and evaluation (UNHCR, 2014). At the same time, we call for support from the international community to harmonize approaches to assessing health care services utilization and access to Syrian refugees, together with building on country-owned monitoring and evaluation platforms. This is critical given the growing recognition on the importance of supporting interventions targeted to building the national health system for addressing the health care needs of Syrian refugees.

Authors' response

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As Dr. El-Jardali and colleagues observe, the Lebanese health system is complex and in our study, we reported expenditures for care seeking at the primary level without disaggregating by type of facility. This limitation of the household survey methodology was identified during study design when it became apparent that respondents could not accurately distinguish between different types of facilities that provide primary care. In Lebanon, public sector primary health care facilities are operated by local NGOs under the umbrella of the Ministry of Public Health (MoPH) and the Ministry of Social Affairs (MoSA) also provides some health services. Additionally, humanitarian NGOs provide primary care through clinics and mobile medical units in addition to supporting public sector facilities; there is also a well-established private sector. Subsidized primary care for Syrian refugees is provided in approximately 100 primary health care centers, approximately half of which are in the MoPH network; however, some NGOs also provide subsidized care at a number of primary care facilities outside the MoPH network (Government of Lebanon et al., 2014). Despite extensive discussion and efforts to develop appropriate response categories for the different types of primary health care facilities, the study team was not confident in the reliability and validity of the question with more specific classification of facilities and it was excluded from the final version of the questionnaire. Study team members engaged in these discussions of appropriate response options included Health Sciences faculty from American University of Beirut and health technical staff from UNHCR and iNGOs, all of whom had contextual knowledge of the Lebanese Health System.[1] This approach is consistent with recent refugee surveys conducted that discuss health expenditures, but do not present out-of-pocket health expenditures by sector (WFP et al., 2015).

We observed out-of-pocket expenditures for the most recent health facility visit for both consultation (mean US$ 25.5, median US$ 3.3) and medications (mean $US 13.3, median US$ 17.2) with total expenditures averaging US$ 25.5 (median US$ 18.6) for care received by Syrian refugees at primary level facilities. These amounts reflect reported expenditures at primary health care centers in the public networks (MoPH and MOSA facilities) as well as those operated privately and by NGOs.

Subsidized primary care is available in approximately 100 primary health centers and about half of these are in the MoPH network. However, it is estimated that only 75% of refugees are aware of the availability of these low cost services and facilities offering subsidized care are not easily accessible to all refugees (WFP et al., 2015). While consultation fees may be low in MoPH network facilities (approximately US$ 2–3) (Government of Lebanon et al., 2014), not all diagnostic tests and medications are subsidized and if medications prescribed are not available in the facility or are not on the essential medicines list, they may be procured from private pharmacies where costs are higher. Thus, while in many cases refugees may be able to receive health services at highly subsidized levels at MoPH network facilities, they may incur out-of-pocket costs that are greater than the minimum payment amounts at these facilities; refugees

seeking care at private facilities are also likely to have higher out-of-pocket expenses. Given that the median out-of-pocket payment for consultation and diagnostic testing in primary health care clinics our study was US$ 3.3, findings are not inconsistent with the observation that subsidized care is available. In fact, this low median payment amount likely reflects that a significant proportion of refugees are accessing subsidized care at MoPH network facilities. Other recent national surveys of Syrian refugees in Lebanon report that only 12% of refugees could access free primary care, that 68% of households accessing primary care had an out-of-pocket payment, and that cost was the primary barrier to not receiving primary care services (reported by 46% of households) (WFP et al., 2015). UNHCR estimates that 93% of households [with a member that needed medical care in the preceding month] had to pay for healthcare and that the average cost of health care paid in the preceding month was US$ 136. This compares to average monthly health expenditures of US$ 127 (median US$ 66) reported among Syrian refugee households in our survey which accounted for 18% of total monthly household expenditures.

Dr. El-Jardali and colleagues are correct that our survey was not able to differentiate between out-of-pocket costs at primary health care centers in the MoPH network and other primary care facilities in Lebanon. While the study team hoped to be able to provide this disaggregation, it was deemed unfeasible because respondents could not correctly report whether or not the facility where they sought care was a MoPH network facility where costs were subsidized. It was not our intention to reflect that 53% of children's health visits occurred in MoPH primary health care centers or that the average out-of-pocket costs reported were incurred only in public sector facilities—rather, these figures represent out-of-pocket payments for all child care seeking visits at primary health facilities, regardless of whether they are operated by the MoPH, MOSA, NGOs, or privately (Government of Lebanon et al., 2014). Our findings are consistent with what is known about lower user fees in selected MoPH and NGO facilities but also with other reports of high health expenditures and cost as the primary barrier to care among Syrian refugee households (WFP et al., 2015).

While affordable access to health services for Syrian refugees in Lebanon remains a challenge, it is acknowledged in the MoPH Health Response Strategy, which aims to increase access to care for all population groups in Lebanon. As such, the MoPH and health sector have prioritized increasing access to primary health care through MoPH network and other primary level health facilities and expanding coverage of UNHCR and NGO partner programs for subsidized primary care for Syrian refugees. The increased burden of Syrian refugees on the Lebanese health system is immense and ensuring access to affordable care is likely to persist as a challenge, particularly in light of funding shortfalls.

Endnote

[1]We use the terms primary health care center or clinic to refer to primary level health facilities regardless of sector; private clinics generally provided secondary or tertiary care whereas hospitals provided tertiary care and also were not disaggregated by sector because subsidized care for refugees is provided by both private and public sector hospitals contracted by UNHCR.

Authors' contributions
The corresponding authors confirm that all co-authors read and approved this version of the manuscript.

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