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Coverage Without Cost: Expanding Healthcare Access for Lebanon's Displaced

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STABILITY UNDER FIRE

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The current war has not only redrawn frontlines; it has redrawn the map of vulnerability across Lebanon. Displacement is no longer episodic or localized but widespread, fluid, and deeply destabilizing to already fragile systems of care. Thousands of households have been uprooted with little notice, severed from their usual providers, medications, and support networks. In such conditions, access to healthcare becomes both more urgent and more unequal: those with resources or connections navigate the system, while the displaced - often poorer, geographically dislocated, and administratively invisible - face delays, refusals, or prohibitive costs. Yet the central constraint facing the Lebanese Ministry of Public Health is stark: fiscal space is effectively nonexistent. The policy question, then, is not how to spend more, but how to govern better. This brief argues that through targeted regulatory adjustments, incentive design, and coordination mechanisms, the Ministry can mobilize substantial private and non-state healthcare capacity to expand coverage for displaced populations - without deploying public funds.

The key insight is that Lebanon's healthcare system, despite its fragmentation, retains significant latent capacity. Private hospitals, clinics, pharmacies, laboratories, NGOs, and professional networks continue to operate, even under wartime strain. The problem is not absolute scarcity, but misalignment: capacity exists, but it is unevenly distributed, poorly coordinated, and often inaccessible to those most in need. Governance - not spending - is the lever that can correct this. By lowering administrative barriers, aligning incentives, and improving information flows, the Ministry can reorient existing capacity toward displaced populations.

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A first and immediate measure is the fast-track accreditation of facilities willing to serve displaced patients. Many smaller clinics, NGO-run centers, and temporary facilities operate below full regulatory accreditation due to procedural delays rather than substantive deficiencies. The Ministry can introduce an emergency accreditation track that grants provisional status to facilities that meet core safety standards and commit to treating displaced individuals. This expands the effective supply of care without building new infrastructure or financing new providers. Accreditation, in this sense, becomes a tool of inclusion rather than exclusion.

Closely linked to this is the creation of a public recognition program for participating hospitals and providers. In a system where reputational capital matters, formal recognition by the Ministry - through published lists, media visibility, and professional acknowledgment - can serve as a powerful non-financial incentive. Hospitals that treat displaced patients under agreed terms can be designated as “priority humanitarian providers,” enhancing their public standing and potentially attracting future partnerships with international organizations. This leverages prestige as a substitute for payment.

Another critical instrument is priority access to imported medical supplies. While the Ministry may not finance procurement, it retains regulatory influence over import approvals, distribution channels, and administrative clearances. Facilities that demonstrably allocate a share of their services to displaced populations can be granted expedited processing for imported medicines, equipment, and consumables. In a context of scarcity and disruption, time is value. Faster access to supplies effectively reduces operational costs and creates a tangible incentive for participation.

> “THE PROBLEM IS NOT ABSOLUTE SCARCITY, BUT MISALIGNMENT”

Regulatory flexibility on staffing and licensing can further unlock capacity. Wartime conditions have disrupted the availability and geographic distribution of healthcare professionals. The Ministry can temporarily relax restrictions on practice locations, allow multi-site licensing, and recognize qualified retired professionals under supervised conditions. This enables doctors, nurses, and technicians to move where they are most needed, including into underserved areas hosting large displaced populations. Flexibility, carefully bounded by safety considerations, can transform rigid regulatory frameworks into adaptive tools.

To ensure that patients are matched efficiently with available services, a centralized patient referral system is essential. This does not require new infrastructure so much as coordination and digital integration. The Ministry can establish a simple, continuously updated platform - accessible via phone hotlines and online interfaces - that directs displaced patients to participating providers based on location, capacity, and specialization. By reducing search costs and uncertainty, such a system improves utilization of existing services and prevents overcrowding in a few visible facilities while others remain underused.

Malpractice protection assurances for emergency care represent another zero-cost but high-impact intervention. Providers may hesitate to treat unfamiliar or undocumented patients under crisis conditions due to legal exposure. The Ministry can issue temporary legal protections or clear guidelines that shield healthcare workers and institutions from liability when delivering good-faith emergency care to displaced individuals. This reduces perceived risk and encourages broader participation without compromising accountability.

Expedited approvals for mobile clinics can extend care into areas where displacement is concentrated and fixed facilities are absent or overwhelmed. NGOs and private actors often have the logistical capacity to deploy mobile units but face bureaucratic delays in authorization. A streamlined approval process - based on standardized criteria and rapid review - can accelerate deployment. Mobile clinics are particularly effective in bridging access gaps, providing primary care, vaccinations, and basic diagnostics directly within displaced communities.

Complementing this is the creation of a coordinated volunteer doctor registry. Lebanon possesses a large pool of qualified professionals, including diaspora physicians, recently graduated practitioners, and specialists willing to contribute time during the crisis. The Ministry, in collaboration with professional syndicates, can maintain a verified registry that matches volunteers with facilities and regions in need. By formalizing and coordinating volunteerism, the system avoids duplication, ensures quality, and directs effort where it is most impactful.

> **“Accreditation becomes a tool of inclusion rather than exclusion”**

Data-sharing platforms are equally critical. One of the defining features of the current war is information asymmetry: providers do not know where demand is highest, and patients do not know where capacity exists. The Ministry can mandate or facilitate real-time data sharing among hospitals, clinics, NGOs, and pharmacies regarding bed availability, service capacity, and critical shortages. Even a basic, regularly updated dashboard can dramatically improve system-wide efficiency. Transparency in data enables rational allocation without central command.

The transparent publication of participating providers ties these measures together. By maintaining and disseminating an official, frequently updated list of hospitals, clinics, pharmacies, and mobile units serving displaced populations - along with the services they offer - the Ministry empowers patients and creates accountability. Visibility reinforces incentives: providers that participate gain recognition and potentially greater patient inflow, while those that do not are implicitly differentiated. Transparency thus functions as both information and discipline.

Coordination with professional syndicates and NGOs is the backbone of implementation. The Orders of Physicians, Nurses, and Pharmacists possess regulatory authority, professional legitimacy, and communication channels that can rapidly mobilize their members. NGOs bring operational flexibility, field presence, and community trust. The Ministry's role is to convene, align, and authorize - establishing common frameworks, sharing data, and removing obstacles. Regular coordination meetings, joint task forces, and shared platforms can ensure that efforts are complementary rather than fragmented.

What emerges from this approach is a different conception of policy effectiveness under constraint. The absence of fiscal resources does not imply the absence of capacity to act. On the contrary, it forces a sharper focus on governance instruments: regulation, incentives, information, and coordination. Each measure outlined above operates by altering the behavior of existing actors - reducing their costs, increasing their benefits, or clarifying their roles - so that the system as a whole becomes more responsive to displaced populations.

> **Sovereignty in wartime is exercised through the ability to organize collective action**

Critically, these measures operate within binding political economy constraints that shape both feasibility and outcomes. Authority over healthcare provision in Lebanon is fragmented across ministries, syndicates, NGOs, and private providers, limiting the credibility of centralized enforcement and creating scope for uneven implementation. Providers respond not only to formal rules but to reputational incentives, access to scarce inputs, and expectations of future partnerships, which may lead to selective participation or cream-skimming of lower-cost patients. To mitigate these risks, equity safeguards must be embedded directly into the incentive structure: eligibility for fast-track accreditation, supply prioritization, and public recognition should be conditional on transparent service quotas for displaced patients, with simple reporting requirements and random verification. Public disclosure of provider performance can further discipline behavior where formal enforcement is weak. There is also a risk of informalization or resistance, as providers seek to bypass obligations or shift costs; here, minimizing administrative burdens and ensuring that participation yields tangible, immediate benefits is key to sustaining buy-in. At the implementation level, disparities in local capacity may generate uneven quality across facilities and regions, requiring light-touch monitoring and rapid feedback loops rather than rigid compliance. In this context, effective policy is not about eliminating constraints, but about aligning incentives so that participation, compliance, and equitable access become the least-cost strategy for providers operating under uncertainty.

There will be limits. No set of governance tools can fully offset the pressures of war, supply disruptions, and infrastructural damage. Yet the alternative - waiting for funding that may not arrive or allowing access gaps to widen - is far more costly in human terms. Well-designed regulatory interventions can unlock significant latent capacity during wartime, especially in mixed health systems like Lebanon's.

The deeper implication is that sovereignty during wartime is exercised not only through spending, but through the ability to organize collective action. The Ministry of Public Health, even under severe fiscal constraint, retains the authority to set rules, coordinate actors, and shape incentives. By using these tools decisively, it can transform a fragmented landscape into a more coherent system of care - one that responds to need rather than status.

In the end, the measure of policy is not the size of its budget, but the reach of its impact. Lebanon's displaced populations cannot wait for fiscal recovery or external assistance to secure basic healthcare. They require access now, under conditions of uncertainty and strain. The path forward is neither idealistic nor unattainable: it is grounded in the pragmatic use of governance to mobilize what already exists. If the current war has exposed the limits of systems built on fragmentation and exclusion, it also offers a stark opportunity to reconfigure them - quickly, intelligently, and without cost - toward greater equity and resilience.