TRANSATLANTIC
LEADERSHIP
NETWORK

HEALTH REFORM IN LIBYA

PREPARING FOR FUTURE EMERGENCIES

Monday, May 3, 2021
Washington, D.C.

Introduction

According to the World Health Organization's annual Libya report, over 50% of the country's healthcare facilities functioning in 2019 were forced to close in 2020. Those that remained open suffered frequent electricity cuts.

Moreover, critical vaccine shortages have inhibited immunization, putting children at risk of diseases in particular. The majority of primary healthcare centers faced shortages in medical supplies; many healthcare staff must wait long periods before receiving their salaries.

Per the WHO, there have been 179,193 confirmed cases of COVID-19 in Libya, with 3,059 deaths, between January 3, 2021, and May 2, 2021. As of May 7, 2021, Johns Hopkins reports 45.13 deaths per 100,000 population

This critical juncture for the Libyan health system set the tone of the Transatlantic Leadership Network's (TLN) discussion on Monday, May 3, 2021, on the state of Libya's health system and what reforms are needed for Libya to succeed in creating a quality and stable healthcare system for its citizens.

Participants included:

Dr. Haider El Saeh, lecturer of epidemiology, Faculty of Medicine, University of Tripoli and advisor to the Libya Ministry of Health

Dr. Taher Emahbes, professor at the Faculty of Medicine, University of Tripoli

Prof. Murad Grew, chair of the General Healthcare Council and health expert who contributed to Libya's Master Health Reform Strategy

Dr. Ghassan Karem, director of the Primary Health Care Institute

Dr. Samir Sagar, head of the National Centre for Health Systems Reform

Dr. Sasha Toperich (moderator), Senior Executive Vice President of the Transatlantic Leadership Network

Panel Conversation

Dr. Haider El Saeh

Faculty of Medicine, University of Tripoli;
Advisor, Ministry of Health

Dr. Haider El Saeh *began with a survey of the history of Libya's health system reform from 2011 onwards, and then turned to the necessity of reform in the present day.*

In the post-conflict environment, the health system certainly can play a major contribution to sustainable development goals, social stability and peace-building. It has been long recognized that the provision of public services enhance the government's performance, legitimacy and the perception of responsiveness, thereby reducing the societal susceptibility toward conflict. Moreover, an adequate health system is certainly a driver for economic growth, something that is at the forefront of the agenda of Mr. Abdelhamid Dbeiba and the Government of National Unity.

Improving the population's health and job creation are mutually supportive; good health has a sizable, significant effect on aggregate output. On the contrary, as we all know, poor health generates an economic burden to individuals and to countries. In particular, an unhealthy population generates higher healthcare costs and presents financial risks that hinder economic growth due to out-of-pocket expenses and high public expenditure.

Dr. Samir Sagar

Head, National Centre for Health Systems Reform

Dr. Samir Sagar *provided an overview of the findings and successes of the NCSHR in implementing health systems reform in Libya.*

We've found that there are a lot of problems with primary healthcare in Libya. While the importance of primary care has been around for quite some time, it has never been managed properly; there are all sorts of bodies that are responsible to run various areas of primary healthcare. Law 20 of 2010 clearly classifies that public health be funded by the government while family medicine be funded by health insurance. Therefore, it is important to have this clearly defined division to maintain proper health financing.

A robust health system ultimately depends on sufficient and sustainable financing. It shouldn't depend on one source, like how the availability and

funding of services now depend on the fluctuations of oil prices and production. Moreover, national health facility management should depend on an economic basis. Currently, they all depend on budgets that are spent as soon as they are received.

One success we have had with health financing is that we introduced a public health insurance fund. It is now legitimized and institutionalized. But issues remain, such as salaries. We've tried hard to establish a payment system based on performance. The current flat compensation is useless; without any incentives, proper performance toward a good outcome is not expected.

The NCHSR has put forward a three-year action plan whereby we should be able to start the "institutes," as I like to call them, as tools of changes, as well as change the legislation that needs to be changed. I would say we've had 70% success, despite all the problems that we face in the country.

We have also implemented projects that work to decentralize Libya's health services in its different municipalities. We created six integrated health regions, large enough to be viable but small enough to be manageable. This project, given the political and technical will necessary, can help facilitate access to quality health services to all Libyan residents.

One other concrete project that we have proposed is to pilot a new health system before taking it to scale. This would be funded by the Public Health Insurance Fund and initiated in the southern health region. From there, it can be scaled up to the rest of the country.

Dr. Taher Emahbes

Faculty of Medicine, University of Tripoli

Dr. Taher Emahbes *addressed several healthcare models and how they could apply to the Libyan context. He highlights the need for a holistic approach to health reform.*

The main aim of the health system is to improve the health of the people not only through curative treatment but also through protection and promotion of the public services.

The health system should be built to protect people against financial risk, as well as provide equitable access to modern health services all the while enabling people to make their own decisions regarding their health.

Considering this, I'd like to elaborate on the World Bank model, based on six building blocks for the health system:

service delivery, human resources, financing, health information, medical equipment, and drug supply. The second model is focused on financial issues--health system "control knobs" composed of financing, payment, organization, regulation, and behavior. One of the main challenges in Libya is a lack of data and a lack of health system research.

Thus, if we are to move towards reforming and strengthening the health system, we should know exactly where the problems are. For that, we need research that will provide real evidence of health system performance. Clearly, we will need health system reform following the Covid-19 pandemic, which demonstrated healthcare gaps not only in Libya but also all over the world. I believe a gradual reform approach would be best.

Prof. Murad Ghrew

Chair, General Healthcare Council

***Prof. Murad Ghrew**, who has been involved in Libyan Health system reform program over the last 9 years, explained that there have been multiple attempts to reform the health system in Libya over the last three decades. Some attempts were with support from international organizations like the WHO, The World Bank, and the European Union. Most of the attempts did not pass the analysis and recommendation/planning stages. However, the latest EU-sponsored LHSS program has now progressed to the implementation stage and the NCHSR is leading the process as Prof. Ghrew and his colleagues described.*

The reasons as to why attempts to reform the healthcare system have not been successful are complex but mainly traditional: intense resistance to change, bureaucracy and institutional corruption.

Resistance to change is strong because people prefer the status quo but also are fearful of loss of power and potential earnings. This meant there was no real change or quality improvement in the Health System since the 1970s.

The current health system reform program is very ambitious and some people feel it is too revolutionary. They prefer slow evolution. However, lack of system quality improvement and modernization over the last four decades left the existing system unfit for purpose and needs a revolutionary approach and a big jump to catch up with other counties in the MENA region. However any new system will need built-in program for consistent quality improvement to keep up to date and avoid this situation in the future.

The current health system fosters institutional corruption, inefficiency, and poor quality mainly through a lack of transparency, accountability, and lack of systems of quality assurance, which are the mechanisms intended to prevent corruption.

To promote transparency, accountability and ultimately improve quality and efficiency; we need to separate funding from service delivery and from regulation. Without separating these three components, the system will not be transparent. We should move towards a health financing system based on a social health insurance fund.

The main role of the Ministry of Health will be regulation of the services, setting up national standards and health policies. This will be facilitated through a network of regulatory bodies. It will also continue to be a key health service provider responsible for public health and selected tertiary services. Other MoH public hospitals and healthcare institutions will be managed using modern economic principles, competing with the private sector for funds from the Health Insurance Fund.

Competition will drive up quality and accountability. However, the Ministry of Health remains the body responsible for ensuring universal coverage, quality, and efficiency through its regulatory institutions.

Dr. Ghassan Karem

Director, Primary Healthcare Institute

Dr. Ghassan Karem *emphasized the importance of national ownership and national leadership in the health reform process.*

If the country does not have national leadership, they cannot lead reform projects, as they do not have the capacity to absorb all of the evidence of other countries systems, or even nationally-generated evidence to use in system development.

International aid brings experiences and supplies, but often policy enforcement and imposed priorities along with it. Since 2011, there has been frequent turnover of ministries, which was a main challenge for Libya because this is a barrier to implementing reform within the government. Because every government stays for a year or so, they look for quick fixes rather than long-term investment. Long-term reform is a project for four or eight years of a government, not a project that can be completed in one year. When national leaders do not engage in reform, nobody will, no matter how many international partners are advocating for reform.

A big part of reform is resource allocation. You can talk theoretically about reform and everyone will say it is good, but when it comes to resource allocation, there will be resistance. Nobody will think about adjusting the finances when it comes to service delivery or human resources. This is why it is important that the national leaders who control resource allocation believe in reform. There is a strong connection between the establishment of institutions and gaining the trust of the people. We need to gain back the trust of the people in the national health sector. This is why we need to work on mobilizing the people to use their power to influence decision makers to fix the system, not only providing services in the short-term, but also providing sustainable solutions for the health sector problems in Libya.

Open Discussion

Points from the Panelists

"We've got a project now – soon to be presented to the new government – to apply health system reforms to the South. We have a population of 500,000 there with 14 municipalities and practically no health services. The chances for this project to succeed are very high and if so, it can be a model for the larger health reform in the country."

"90% percent of the budget goes to human resources (salaries) where there are only two to three people working on development. The country still has a social welfare system (for health and education) where you can find municipalities with one doctor and two nurses and 80 or 90 administrative personnel, rather than the one or two truly needed. Many people receive salaries from the system because the system is still oriented towards social welfare. There are examples of schoolteachers on the government payroll who don't even know at which school they are supposed to teach. The health service sector had 125,000 employees, but now it stands at 250,000. The entire country seems to be employed either by healthcare or in the education system. This is the big elephant in the room."

"Reforms such as implementation of Law 59 providing local governments (municipalities) with more independence is too big a task for the current moment. Libya has more than 200 municipalities, some with no more than 10,000 people while others like Benghazi and Misrata have 500,000. This makes it a very difficult and complex model.

Covid-19 Response

Points from the Panelists

Libya experienced its first wave of Covid-19 in June-July 2020, later than most of the international community. The government responded by creating isolation centers, rather than utilizing and investing in existing hospitals and primary care units. This new and costly parallel system came with new payment contracts, new financing arrangements, new facilities, and new equipment. This was done partly due to lack of trust in the current old-fashion healthcare system, but also due to corruption.

Libya does not have an emergency preparedness plan for future disasters or pandemics. The earliest emergency department in the Ministry of Health was created in 2019. There are no clear division of responsibilities in the health system, often creating a doubling of effort, as no one knows who is responsible for a given task.

Libya procured more than five million vaccine doses, but does not yet have sustainable mechanisms for procurement such as protective gear, oxygen, and other important products to combat pandemic. However, in spire of all this, the estimated epidemiological indicators remain better in Libya compared to other countries.

Clockwise from top left: Dr. Taher Emahbes, Dr. Ghassan Karem, Dr. Murad Ghrew, Dr. Sasha Toperich, Dr. Samir Sagar, Dr. Haider El Saeh

About the Transatlantic Leadership Network

We are a nonpartisan international network of practitioners, private sector leaders and policy analysts dedicated to strengthening and reorienting transatlantic relations to the rapidly changing dynamics of a globalizing world. Through field activities, “policy rides,” foresight initiatives, futures scenarios, seminars, conferences, and policy briefs, we engage government officials, parliamentarians, journalists, business executives, scholars, and other thought leaders on contemporary challenges to the United States, Europe, the Middle East, and the Gulf.

The Transatlantic Leadership Network is a Washington, D.C. 501(c)3 nonprofit corporation.

About the "Next Generation: Emergent Leaders in Libya" Platform

The “Next Generation: Emergent Leaders in Libya” platform support efforts toward institution-building and reconciliation in Libya. It aims to inspire larger civic participation in Libyan communities and create a network of young emerging leaders committed to work to support, develop and promote: collective action and teamwork; reconciliation within the country; reparations for victims of war; and building of the Libyan national identity.

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