Aid cuts and health system resilience in Lebanon

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Key messages

Lebanon's experience of aid cuts underscores the need for a deliberate and context-sensitive approach to donor transition. The timing and mechanism are critical determinants of system stability. Priorities identified by this study include:

Closer coordination between donors and national authorities to ensure continuity of essential services, particularly for populations highly dependent on externally-financed care.

Protection and strengthening of primary healthcare, particularly through stronger prioritization of PHC by the Ministry of Public Health (MoPH), alongside a rebalancing of health financing away from hospital-centric models toward prevention and early intervention.

Safeguarded programme quality during transition processes. Transition strategies should go beyond financial substitution and address the full ecosystem of programme delivery.

Strengthened governance and institutional capacity. Enhancing transparency in health financing, consolidating expenditure tracking, and progressively aligning external funding with national systems are critical to restoring government ownership.

Expanded pooled financing mechanisms and reduced reliance on out-of-pocket payments are essential to a sustainable transition.

Sustained investments in health system strengthening alongside humanitarian assistance. A balanced approach that maintains currently externally-funded critical functions while transitioning service delivery financing is essential.

Transition strategies should go beyond financial substitution and address the full ecosystem of programme delivery.

Background

Lebanon's health system has long been characterized by a mixed public–private model in which private providers and non-governmental organizations (NGOs) play a dominant role in service delivery. Approximately 80% of hospitals are privately owned, and nearly 68% of primary healthcare (PHC) centres are managed by NGOs, a structure that has historically been associated with flexibility but has also entrenched fragmentation and reliance on private actors [1]. Health financing has similarly been fragmented, with households bearing a substantial share of costs through out-of-pocket (OOP) payments and insurance premiums [1].

Since 2019, this model has been severely destabilized by economic collapse, currency devaluation and erosion of financial protection mechanisms. Private insurers increasingly shifted toward dollar-based payments, exposing households to catastrophic expenditures [2]. National Health Accounts data for 2019-21 illustrate a rapid reconfiguration of financing, with the public share of health spending declining sharply while donor contributions expanded significantly, rising from 3.4% to 26.9% [3].

This shift reflects the growing importance of external funding to compensate for declining domestic resources. At the same time, humanitarian funding has fluctuated in response to overlapping crises, including COVID-19 and the Beirut port explosion, while remaining insufficient. Although the share allocated to health increased over time, reaching 14.9% in 2025, coverage remains below sectoral requirements under the Lebanon Response Plan [4,5]. Lebanon's large refugee population, including c.1.5 million Syrian and > 200,000 Palestinian refugees, also place sustained pressure on service delivery and financing systems [6,7].

Methods

This case study is part of a multi-country study examining the impact of aid cuts on health systems in fragile and shock-prone settings. The study combined a targeted document review (national policies, operational reports, peer-reviewed literature, and secondary datasets such as National Health Accounts and humanitarian financing data from United Nations Office for the Coordination of Humanitarian Affairs) [4] and key informant interviews with representatives from the Ministry of Public Health (MoPH), a parliamentarian, United Nations (UN) agencies, an international NGO, and a PHC centre.

Main findings

Impact of funding cuts

Lebanon is entering a phase of donor contraction and transition, marked by the withdrawal of support from the United Nations High Commissioner for Refugees (UNHCR) for secondary and hospital care and anticipated reductions in services funded by the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), raising critical questions regarding sustainability, equity, and resilience.

The effects of funding contraction are visible across all levels of the health system, reaching to core system functions, service delivery, and population-level outcomes. While the system has not experienced uniform collapse, evidence points to a progressive erosion of critical buffers that have historically sustained performance.

Institutional level: the MoPH remains heavily dependent on donor financing, particularly for PHC services, e.g. medication, staffing, and outreach activities, as well as key enabling functions, e.g. digitalization and data systems. This dependence is structural, with large segments of MoPH staff – at national and sub-national levels – funded by international agencies. Ongoing hiring restrictions introduced in 2019, limit the government's capacity to replace these positions [8].

Service delivery level: PHC centres operate and absorb increasing demand but are dependent on donor-funded medications and subsidies. Informants consistently emphasized that uptake of PHC services are contingent on these inputs, and any reduction in pharmaceutical support is likely to trigger a decline in service use, undermining one of the system's primary access points for vulnerable populations.

Programme level: funding contractions are producing uneven but significant effects, with specialized services and development-oriented programmes particularly vulnerable. Mental health, epidemiological surveillance, and maternal and child health programmes are approaching the end of donor funding cycles without clear transition pathways, and are at risk of abrupt discontinuation rather than gradual phase-out. This reflects a broader shift in donor priorities towards short-term, life-saving interventions. HIV and tuberculosis programmes have entered a sensitive transition phase amidst reduced eligibility to external financing as well as broader reduced funding, with the government assuming partial responsibility for commodity financing.

While this has prevented immediate disruptions in medication availability, the broader programme components, e.g. training, supervision, and community outreach, have weakened. The merger of HIV and tuberculosis programmes, implemented as a cost-containment measure, illustrates the reactive nature of current adaptations. Although framed as an efficiency gain, this risks diluting specialized expertise and undermining service quality, particularly given the distinct needs of key populations and the central role of community-based approaches.

Public hospitals: humanitarian funding for high-cost care has been temporary and limited in scope. As major actors withdraw from health financing, hospitals are under growing pressure to absorb costs or transfer them to patients, raising concerns about access to essential secondary and tertiary care.

Household level: the impact of funding cuts is both immediate and profound. As external support narrows, financial risk is progressively shifted onto individuals. Patients are increasingly required to navigate fragmented networks of NGOs and charitable organizations to secure care, often facing delays, financial hardship, and difficult trade-offs between health and other basic needs. This dynamic is particularly severe for chronic and high-cost conditions, where continuity of care is essential.

These effects are not evenly distributed across populations. Syrian refugees are disproportionately affected by the withdrawal of hospitalization support, while Palestinian refugees face growing gaps in access to specialized care following reductions in UNRWA funding. At the same time, vulnerable Lebanese households are experiencing increased exposure to OOP expenditures. Overall, funding contraction is contributing to widening inequities and a systemic shift of risk from institutions to individuals.

Government and donor response

The government and donors have initiated measures aimed at maintaining system functionality under conditions of constrained resources. However, these responses remain largely partial, non-systemic and are shaped by the broader context of fiscal and institutional fragility.

Coordination mechanisms have evolved in response to shrinking resources, becoming more tightly structured and operationally aligned. The health sector coordination platform, led by the World Health Organization and co-led by the MoPH, has played a central role in harmonizing interventions and reducing duplication. The adoption of shared tools, such as unified vulnerability assessments, reflects a shift toward more targeted and efficient resource allocation.

At the same time, there are early indications of increased domestic financial engagement. The government has increased its budgetary allocation for health, and the MoPH has begun to assume partial responsibility for selected programme costs, e.g. HIV and tuberculosis medications. Pilot financing reforms, e.g. capitation-based models supported by World Bank loans, signal an effort to explore more sustainable financing approaches, although their long-term viability remains uncertain.

Efficiency gains have also been pursued through digitalization and regulatory reforms. The introduction of the MediTrack pharmaceutical traceability system has improved transparency in medication flows and generated cost savings that have been reinvested in service delivery. Similarly, clinical protocol revisions aimed at prioritizing cost-effective therapies reflect attempts to maximize coverage within limited budgets.

Several other reforms remain under discussion but have yet to be operationalized. These include strategies to address critical MoPH human resource shortages, primarily through capacity-building of existing staff in a context where public sector recruitment remains restricted. However, concerns persist regarding the feasibility of this approach, given low staff motivation, limited incentives, and the continued outflow of skilled personnel to better-paying opportunities in international organizations.

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Discussions are ongoing regarding a potential redefinition of the state's role, with greater delegation of operational responsibilities to private sector actors. While this shift is framed as a means to improve efficiency, it raises important questions about the current capacity of public institutions to regulate, supervise, and ensure equitable access within an increasingly market-driven system.

Looking ahead, the proposed Universal Health Coverage (UHC) law is positioned as a central pillar of longer-term reform. By shifting the system towards prevention, pooled financing, and more equitable access, there is potential for transformative change. Proposed measures, e.g. introduction of tobacco taxes, aim to expand fiscal space and support more sustainable health financing. In parallel, discussions around the establishment of a national drug agency seek to address pharmaceutical regulation and reduce

dependency on imports. However, these reforms remain largely theoretical, with implementation pathways, financing mechanisms, and institutional arrangements still under development.

Taken together, current responses reflect a pattern of partial adaptation rather than comprehensive transformation.

Challenges and bottlenecks

Persistent structural constraints limit Lebanon's ability to respond effectively to funding contraction and to transition toward a more sustainable health system.

- **Governance challenges:** health sector decision-making remains highly influenced by political dynamics, with high-visibility hospital services often prioritized over strategic investments in primary care and prevention. This pattern reflects a continuation of existing practices rather than a shift toward more evidence-based and equity-oriented approaches.
- **Increasing reliance on highly-earmarked funders:** funding which is often directed toward short-term humanitarian priorities limits resource allocation flexibility and government ability to pursue system-wide planning. This shift toward emergency-oriented funding reinforces reactive decision-making, diverting attention from longer-term system strengthening.
- **Institutional instability:** frequent turnover in leadership, including prolonged gaps in key positions, e.g. Director General of the MoPH, disrupts continuity, weakens institutional memory, and limits the ability to sustain long-term reform agendas.
- **Financial governance:** donor concerns regarding transparency and accountability have increasingly led to the use of parallel financing mechanisms, with funds managed outside national systems. While intended to safeguard resources, these arrangements contribute to fragmentation of financing flows, weaken domestic ownership, and limit the MoPH's capacity to exercise effective stewardship. The absence of a centralized system to track donor and government health expenditure further constrains coordination and undermines evidence-based planning.
- **Structural rigidity within public financial management:** the existing line-item budgeting framework limits the MoPH's ability to reallocate resources in response to emerging needs, particularly in areas such as service delivery and human resources. Although discussions around programmatic budgeting are underway, such reforms remain complex, face significant political and institutional barriers, and are not guaranteed to resolve underlying inefficiencies.

These constraints intersect directly with donor exit dynamics, amplifying system vulnerability. As external partners reduce their support, the MoPH is expected to assume greater responsibility for programme implementation despite limited fiscal space, constrained human resources, and weak institutional capacity. This convergence of shrinking aid, fragmented financing, and rigid systems results in a form of **managed scarcity,** in which coordination may improve and short-term adjustments are implemented, but structural resilience remains fragile and transformative change remains limited.

Policy recommendations

Lebanon's experience underscores the need for a more deliberate and context-sensitive approach to its current funding reductions, donor withdrawal, and shifting aid modalities. The timing and mechanism of aid reduction are critical determinants of system stability.

In contexts where domestic capacity remains constrained, donor withdrawal should not proceed as a linear or time-bound process, but rather as a managed and sequenced transition, aligned with system readiness. This requires **closer coordination between donors and national authorities,** ensuring continuity of essential services, particularly for populations highly dependent on externally-financed care.

The protection and strengthening of primary healthcare are vital. While the PHC network has demonstrated its importance as a frontline access point for vulnerable populations, it remains heavily reliant on donor financing, particularly for medications and service subsidies. Sustaining PHC therefore requires increased domestic investment, particularly through greater allocation to health within the national budget and stronger prioritization of PHC by the MoPH, alongside a rebalancing of health financing away from hospital-centric models toward prevention and early intervention. Without such a shift, donor contraction risks disproportionately weakening the most equity-oriented components of the system.

Programme quality should be safeguarded during transition processes. In the case of HIV and tuberculosis, while commodity financing has been

partially maintained, critical elements, e.g. training, supervision, and community outreach, have been weakened. Transition should be explicitly integrated into discussions on exit strategies, with recent grant cycles increasingly prioritizing sustainability-oriented interventions led by the MoPH in collaboration with donors. Transition strategies must go beyond financial substitution and address the full ecosystem of programme delivery, including human resources, technical capacity, and engagement with civil society actors. Failure to do so risks preserving nominal service availability while eroding effectiveness and long-term outcomes.

Strengthening governance and institutional capacity is a priority. The current fragmentation of financing flows, combined with donor practices that bypass national systems, limits the MoPH's ability to exercise effective stewardship. Enhancing transparency in health financing, consolidating expenditure tracking, and progressively aligning external funding with national systems, under the MoPH leadership, are critical towards restoring government ownership. Also, improving institutional continuity and reducing political interference in decision-making are essential to enable sustained reform.

Financial protection must also be explicitly addressed. The progressive transfer of costs to households, particularly for high-cost services, is increasing inequities and undermining access to care. Expanding pooled financing mechanisms and reducing reliance on OOP payments are therefore essential components of any sustainable transition strategy. The proposed UHC reform offers an important opportunity, provided it is supported by clear implementation pathways and sustainable financing mechanisms.

Sustainable investments in health system strengthening are needed alongside humanitarian assistance. Donors are encouraged to reduce rigid earmarking and adopt more flexible funding approaches that preserve and reinforce critical system functions, e.g. surveillance, digital systems, and workforce capacity, which remain heavily reliant on external support yet are essential for long-term resilience. Allowing these functions to deteriorate as aid declines would undermine the system's ability to absorb future shocks. A more balanced approach that sustains investments in system strengthening while gradually transitioning service delivery financing is therefore essential to ensure the durability of health outcomes.

Conclusions

Lebanon's health system demonstrates **strong absorptive capacity,** maintaining essential services despite severe economic and funding shocks largely through donor support. It also shows **elements of adaptive capacity,** with incremental adjustments, e.g. partial domestic financing, improved coordination, and efficiency gains. However, **transformative capacity remains limited,** as deeper structural reforms are constrained by governance challenges, fragmented financing, and weak institutional capacity. At the same time, **several responses risk becoming maladaptive,** including increased household financial burden, reliance on donor-funded staff, and erosion of programme quality.

These dynamics suggest that the system is sustaining functionality in the short term while accumulating long-term vulnerabilities. Without a managed and context-sensitive transition, current adaptations may not be sufficient to prevent further system strain. Strengthening resilience will require aligning donor transition with system readiness and domestic reform, protecting primary healthcare, and reinforcing governance and financial protection mechanisms.

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This brief is one of a series on aid cuts produced by ReBUILD for Resilience. Find the others and further information on this study – Aid and health system resilience in fragile and shock-prone settings: reflections from ReBUILD for Resilience – on the ReBUILD website.

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