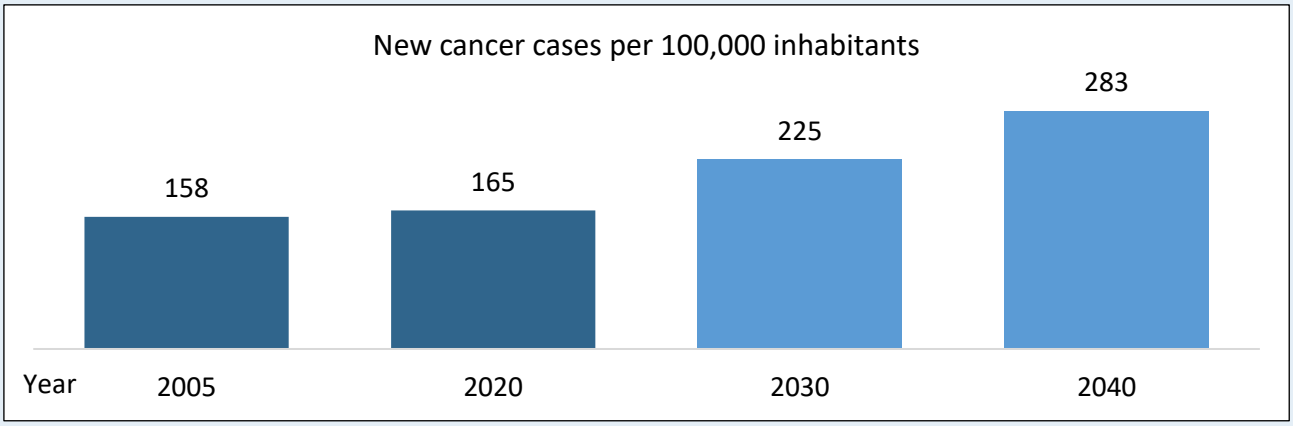
LEBANON

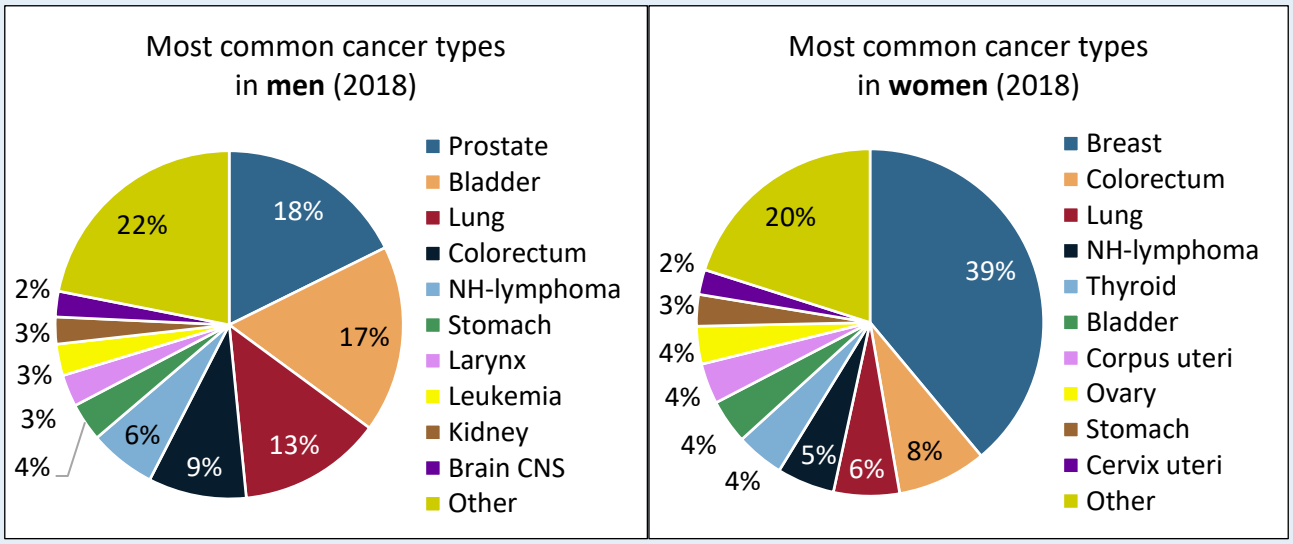
Population: 6.9 million
GDP per capita: USD 7,584
Life expectancy: 78.8 years
Total health expenditure: 8.4% of GDP (in 2018)

Cancer epidemiology

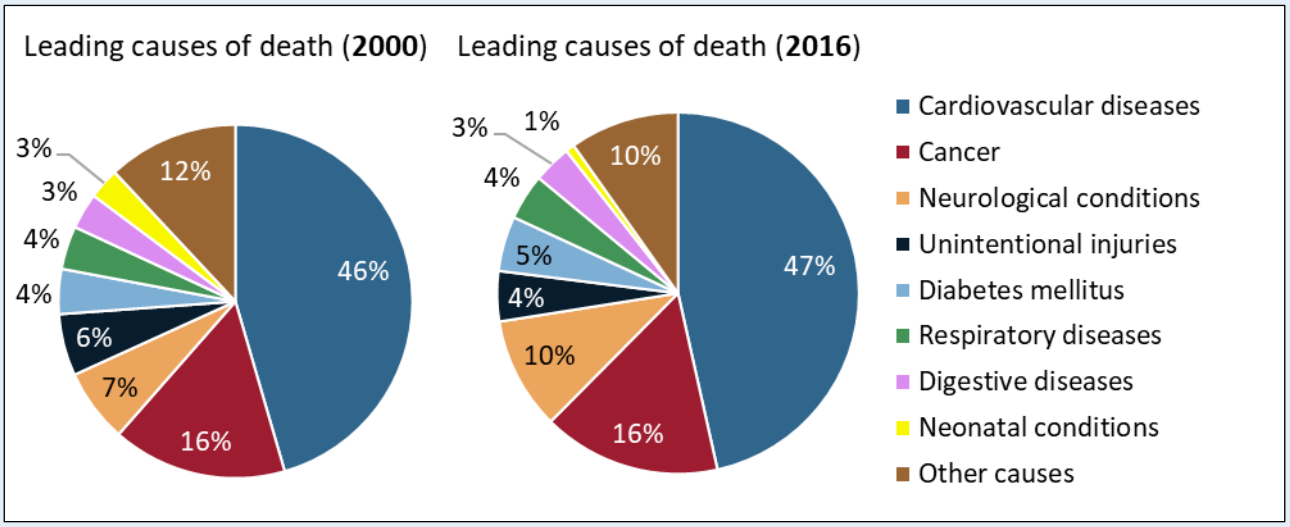
- The number of newly diagnosed cancer cases (incidence) has been increasing and is expected to increase further in the coming decades.



- There are many different cancer types diagnosed in men and women.



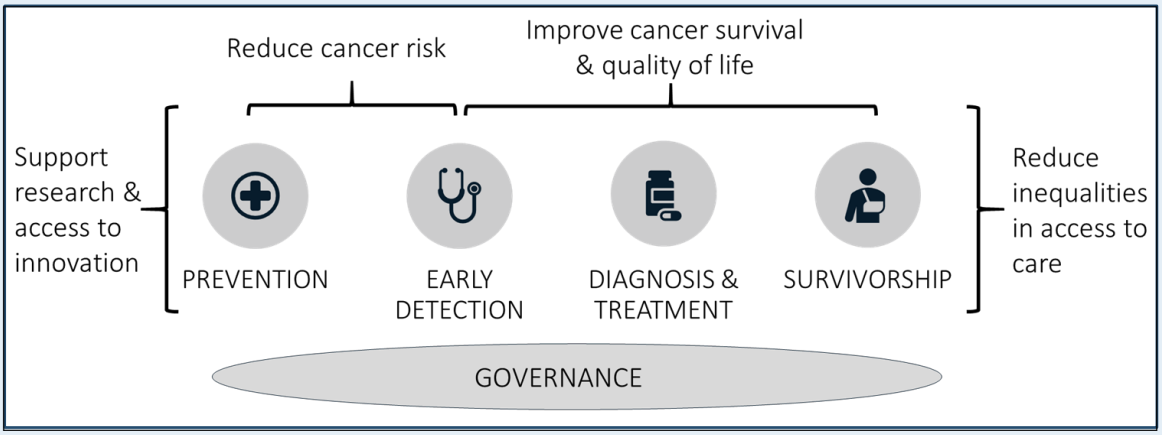
- Cancer is gradually becoming one of the leading causes of death.



Economic burden of cancer

- **Direct costs** within the health care system: USD 24 per capita in 2018 (≈3.5% of total health expenditure)
- **Indirect costs** of productivity losses (premature death, sick leave, early retirement): USD 18 per capita in 2018
- **Informal care costs**: not quantifiable

Areas of cancer control and overarching goals



Recommendations to improve cancer care

General steps to improve cancer care:

1. **Measure and understand** the magnitude and the development of the disease burden of cancer
2. **Plan, coordinate, and implement** – financial and non-financial – actions to address cancer
3. **Monitor and evaluate** actions on cancer control

Economic crisis

- The main challenge in cancer care is the ongoing economic crisis. The crisis affects every aspect of life, including the functioning of the health care system. Until the crisis is resolved, the following recommendations are only of secondary priority.

Governance of cancer care

- There is no current or recent national cancer plan that addresses all areas of cancer care. Cancer was only among the NCDs mentioned in the NCD plan for 2016–2020, which focused mainly on prevention and early detection. The National Plan for the Awareness and Early Detection of Colorectal Cancer from 2018 also focused on these areas of cancer control for colorectal cancer. Establishing a comprehensive national cancer plan needs to be a priority. The plan would need clear aims to reduce incidence and improve survival as well as include a funding plan for all planned actions. The actions would need to be monitored including using the national cancer registry to analyze treatment patterns and efficient use of resources.

Organization and financing of health care and cancer care

- Before the economic crisis, public spending on health care amounted to around 4% of GDP, which fell short of the informal WHO spending target of 5% of GDP. Additional spending to bring the country closer to the benchmark and as part of implementing UHC would be needed.
- Around 47% of local citizens are covered by social insurance schemes or private schemes. The remaining citizens lack coverage and the MOPH has to act as an “insurer of last resort”. Ways to either cover the uninsured citizens through existing schemes or to bring the limited health care package offered to them more in line with what insured citizens receive need to be explored.
- Access of UNHCR/UNRWA-registered refugees to health care services is continuing to rely on international support. Despite the support, most refugees cannot afford cancer treatment as a large share of treatment

services still needs to be covered out-of-pocket. A permanent solution that is both financially sustainable and allows good access needs to be found in collaboration with international stakeholders.

- Co-payments for cancer care services accessed by insured patients can be high as they are defined in relation to the total price of services. A switch to paying a fixed fee as a co-payment could be considered.
- The MOPH-provided cancer care services to the uninsured patients faced financing problems already before the economic crisis, in particular in relation to cancer drugs. A financially sustainable solution needs to be found.

Cancer registration

- Continuing to improve cancer registration is important. This includes foremost a better registration of cancer cases among the large refugee population. The long delays in the public publication of aggregated data also needs to be addressed.
- The national cancer registry does not publish data on cancer mortality, although some hospital-based registries are able to record this information. Improper cause of death registration is an obstacle and needs to be addressed to provide more reliable cancer mortality data.
- Experience in assessing survival in some leading hospitals could be shared with other hospitals to get a better picture of differences in the quality of care provided across the country.

Prevention

- The fight against tobacco consumption needs to be stepped up. Existing age limits for tobacco purchase need to be enforced. Existing smoking bans in public indoor places also need to be enforced. Cigarette smuggling needs to be put a stop to. Excise taxes on cigarettes could be increased much further, given the exceptionally low cigarette prices.
- Obesity needs to be addressed. Although awareness campaigns have been run by the MOPH, outreach is limited. A better partnership between the MOPH and NGOs could increase outreach, including by using more social media. Measures need to be taken to encourage changing dietary habits back from a Western diet with fast food to a Mediterranean diet. Excise taxes on sugary drinks could be introduced. Ways to increase physical activity also need to be encouraged.
- A strategy to roll out a vaccination program against HPV in children could be considered, as cervical cancer is the tenth most common cancer type in women.
- The hepatitis B immunization coverage in infants needs to be improved in line with the WHO target.

Early detection

- Health literacy in the general population on early symptoms of cancer needs to be improved. Awareness campaigns are being run for breast cancer, but they would need to cover common symptoms of other cancer types as well.
- Steps to turn the non-organized breast cancer screening program into an organized one could be taken to improve participation. Mammography could also be provided for free to encourage participation.
- Given the increasing obesity rates and following the National Plan for the Awareness and Early Detection of Colorectal Cancer from 2018, opportunistic colorectal cancer screening could be turned into an organized program and/or free screening services could be offered to improve participation.

Diagnosis and treatment

- There were no shortages of medical staff before the crisis. Since then, there has been a brain drain of young physicians who left the country for financial reasons. Depending on how many of those return, recruiting and training more medical staff will be necessary.
- The availability of modern cancer drugs (targeted therapies and immunotherapies) for cancer patients covered by public or private insurance used to be good and comparable to Western European standards before the crisis. Uninsured cancer patients only had access to older cancer drugs. Making up for lost ground both in terms of regulatory approval and reimbursement approval of newer drugs will be necessary after the crisis.

- Reimbursement decisions by the public social insurance schemes used to focus mainly on the price of drugs instead of also taking into account the value that they provide to patients. A shift towards a more value-based assessment could help in the prioritization of introducing modern cancer drugs.

Survivorship

- Formal psycho-oncology services could be established or public support to NGOs for providing these services could be increased.
- Informal caregivers with regular jobs could be better supported, such as through a right to flexible working arrangements and paid leave.
- The reintegration in the labor market of cancer survivors could be supported by flexible working arrangements.
- Cancer survivors could be protected from discrimination in the acquisition of certain services (e.g., health insurance, life insurance, loans, mortgages), by imposing time limits up to which a previous cancer diagnosis needs to be disclosed.