

## **Minutes of the Ad-hoc Health Working Group Meeting**

**15-12-2017**

**UNHCR S&K Bldg 9<sup>th</sup> floor**

The objective of the meeting is two-fold:

- UNHCR to present an overview on referral care as well as the challenges faced by refugees, UNHCR and partners
- UNHCR to consult on the way forward with the funding available

### **Main Points of the presentation:**

#### **a) Trends:**

- There is an increase in the delivery of services by UNHCR with an observed increase in the number of admissions per month from January 2015 till November 2017 with deliveries comprising slightly more than 50% of the total admissions. More complications are being observed among older people.
- There is high impact resulting from the high cost of hospitalization; detention and other protection concerns
- There are significant unmet needs for hospital care as UNHCR is only supporting “the tip of the iceberg”

#### **b) UNHCR's Objectives for 2018 and beyond:**

- Need to continue with available resources
- Need to provide a safety net
- Need to provide protection for catastrophic expenditures

#### **c) Main Proposed changes for UNHCR Referral Care Programme SOPs**

- Introduction of 100\$ threshold before UNHCR assistance kicks in
- Coverage remains as follows: Generally, UNHCR contributes 75% of the hospital bill with higher coverage for specific conditions i.e. 90% for psychiatric conditions and 100% for SGBV cases. Noting that severely vulnerable families will no longer be covered at 90%.
- Protective cap is included; out of pocket expenses will never exceed more than 800\$
- Unregistered refugees with life threatening emergencies will continue to be offered fast track status determination at admission- however, this option will not be available if

admission is expected (i.e. delivery). Pregnant women will therefore be requested to register in good time before delivery. - Safety net can be provided with emergency cash assistance for those unable to meet costs

- There will be a reduction in the hospital network from 48 (currently contracted) to 40 as 70% of all admissions are in 20 hospitals. The utilization rate of hospitals as well as issues of fraud where taken into consideration in the reduction of the network.

- General policy is aimed at being more equitable.

#### **d) Results of the UNHCR SHC Expenditure Survey**

→ Please refer to power point presentation

#### **e) Possible impact of the change in UNHCR Referral Care Programme SOPs**

- Increase in out of pocket expenditure
- Decrease in access to hospital care due to either unwillingness of refugees to seek more expensive care or hospitals demanding higher deposits
- Increase in home deliveries affecting birth registration
- Increase in Syrian refugees' return to Syria for hospital care
- Risk of hospitals inflating their rates to reach 800\$
- Increase of deliveries in MSF Clinics (however MSF has not planned for that)

#### **f) UNHCR Mitigation Measures include:**

- Communication with refugees well in advance of the implementation of the changes
- Putting a safety net in place for those persons who are unable to cover the costs
- Partners supporting in terms of increasing ANC uptake and reducing out of pocket expenditure related to ANC and assisting with the hospital patient share
- UNHCR will add details to contractual agreements with hospitals addressing excessive deposits and denying urgent care
- UNHCR's ongoing monitoring of hospitals will be strengthened
- Monitoring includes: UNHCR'S monitoring, partners and MoPH monitoring, complaints monitoring, hospital review and systematic review of the programme

#### **g) Implementation of the changes to UNHCR Referral Care Programme SOPs:**

- Proposed timeline: February 1<sup>st</sup>, 2018

#### **h) Next steps:**

- Discussions to be initiated at field level HWGs
- UNHCR will look further into the financial analysis

- UNHCR will hold bilateral discussions with donors and actors involved in supporting hospital care

### Q & A / Comments

1. Is the increase in deliveries attributed to an increased access to the services or to an increased birth rate? (Jamale Chedrawi-ECHO)
  - ➔ The proportion of deliveries compared to other conditions is constant over time which suggests that the reason is increased access. An increase in poverty implies increase in the seeking of support by refugees who previously paid for their own care. It is important to note that unregistered Syrian Refugees are also covered with a possibility of persons coming straight from Syria to access hospital care through UNHCR. However, there is no evidence to support that.
2. Is there any data on refugees going back to Syria to deliver? (Rouham Yamout- UNICEF)
  - ➔ There is anecdotal data on refugees going back to Syria for hospital care because health care is free and many conditions are not covered in Lebanon. There is anecdotal data on people moving both ways (Lebanon-Syria/Syria-Lebanon).
3. It is expected that the change in policy will increase deliveries in MSF clinics but will also increase MSF's payment to hospitals for delivery referrals (MSF)
4. How does the change in SOPs affect admissions to the Emergency Room? Will persons whose bill is less than 100\$ be excluded from support? (Jamale Chedrawi-ECHO)
  - ➔ UNHCR's support will kick in after 100\$. Currently most ER cost exceeds 100\$.
5. The issue is that we have decreasing funds and something needs to be done. However, what has been done in terms of cost-effectiveness? In Lebanon, many procedures are overpriced. Can we explore the possibility of decreasing the cost of acts? (Rouham Yamout- UNICEF)
  - ➔ UNHCR relies on the system in place and MoPH flat rates do constitute a limitation. However, UNHCR additionally receives additional discounts, take cost into account in the choice of hospital to include in the network, monitors costs through audits and control.
6. The problem is that care is being subsidized in the private sector and the private sector cares about making more money (Rouham Yamout- UNICEF)
  - ➔ There are public hospitals in the network but it seems there is no political will to improve the system
7. Is there room to discuss with MoPH rates for delivery? Deliveries within MSF clinics are less costly. However, MSF relies on a different model of care which is midwife led and so no real comparison can be made in terms of cost.
8. The challenge is to deliver the services with the available funds. The solution would be to provide the service while strengthening the system for more benefits. (Nada Najem- IOM)
  - ➔ The issue is that systems changes require time while it now that there is a shortage in funds and that a solution/ change must be implemented. UNHCR faced the risk of not being to cover at all for SHC in October, November and December of 2017.

9. Is UNHCR saving a lot of money for the proposed changes to be implemented? 100\$ threshold and 800\$ ceiling do not seem to be based on evidence. (Jamale Chedrawi-ECHO)
10. Risks need to be weighed; how will the changes be affecting people (Jamale Chedrawi-ECHO)
11. There might be a contractual issue between the EU and UNHCR; it is not sure whether changes can be implemented starting February 1<sup>st</sup>, 2018 (Sara Campinoti- EU Madad)
12. When should pregnant women be fast tracked?
  - ➔ As soon as possible; first ANC visit. Partners should support in the dissemination of this information.
13. Will changes to the hospital network be implemented in February? Can the new list of hospitals be shared? (MSF)
  - ➔ Yes- the new list of hospitals will be shared.
14. There is a concern that losing more hospitals in Jan/Feb would imply less access to SHC because of limited spots and seasonal admissions increase/peak during this time of the year. (MSF)
  - ➔ UNHCR has taken out hospitals with a lower number of admissions for the network. Moreover, should there be no spots available, UNHCR has a mechanism for non-contracted hospital admissions.
15. When will a final decision be made?
  - ➔ This is the proposal and further communication with donors is needed
16. What about the support of midwife-led model of care? Can we obtain the green light from MoPH? (Rouham Yamout- UNICEF)
  - ➔ UNHCR is engaging with RHUH as they have an interest in midwife led deliveries. There is a potential at least in public hospitals. It is difficult to get the doctors syndicate and the syndicate of hospitals on board especially since they have a strong lobby.
  - ➔ ICRC: The problem in Lebanon is that health care is driven by fee for service
17. If the challenges remain the same in the current system, the health sector needs to consider creating a parallel system, similar to what MSF is doing. (Rouham Yamout-UNICEF)
18. Structural change is needed

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