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Extending Social Health Protection in Lebanon

The role of the National Social Security Fund (NSSF) in achieving Universal Health Coverage

Regional Office for Arab States
Social Protection Department
International Labour Organization

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Acronyms

ACAL	Association des Compagnies d'Assurance au Liban
CAS	Central Administration of Statistics
CBHI	Community-Based Health Insurance
CGTL	General Confederation of Lebanese Workers
CHE	Current Health Expenditure
CSC	Civil Servants Cooperative
CT	Computed tomography
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
GDP	Gross domestic product
GSF	General Security Force
ILO	International Labour Organisation
ISF	Internal security forces
JKN	Jaminan Kesehatan Nasional
K2P	Knowledge to Policy
LFHLCS	Labour Force and Household Living Condition Survey
MOPH	Ministry of Public Health
MOSA	Ministry of Social Affairs
MRI	Magnetic Resonance Imaging
NGOs	Non-Governmental Organizations
NSSF	National Social Security Fund
OCED	Organization for Economic Co-operation and Development
OOP	Out-of-pocket
PHCC	Primary Health Care Centre
ROAS	Regional Office for the Arab States
RSSB	Rwandan Social Security Board
SDC	Social Development Centre
SHI	Social Health Insurance
SHP	Social Health Protection
SSF	Special Security Force
SWOT	Strengths, Weaknesses, Opportunities and Threats
THE	Total Health Expenditure
UCS	Universal Coverage Scheme
UHC	Universal Health Coverage
UNHCR	United Nations' High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
WHO	World Health Organization

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Acknowledgments

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Executive Summary

In 2019, the National Social Security Fund (NSSF) administration mandated the International Labour Organization (ILO) to conduct a study exploring possibilities of strengthening the health insurance model and extending social health protection to uncovered workers, including those in the informal economy. The situation assessment aims at analysing and understanding the health system and the health financing landscapes; identifying coverage gaps and needs, particularly for informal workers and assessing the feasibility of extending coverage of the social health insurance scheme.

The situation assessment is guided by ILO core standards on social protection (in particular conventions No. 102 and 130 as well as Recommendation No.202) and incorporates both the results of the field mission in Beirut that took place in July 2019 and background information on Lebanon health system and informal workers characteristics, based on the results of a desk review and recent information from the LFHLCS 2018/19.

While the primary focus of the situation analysis is to support strategic decision making by NSSF on the extension of coverage of its health insurance scheme, the report necessarily touches on two closely related issues: a) It discusses the relationship between NSSF and other financial health protection mechanisms in ensuring **Universal Health Coverage in Lebanon**; b) It identifies priorities for strengthening and improvement of the **health care scheme** of the NSSF, including for the currently insured.

Section 2 presents methods and the framework of analysis, section 3 provides an overview of the current health financing landscape in Lebanon, section 4 rapidly assesses the NSSF social health insurance scheme, section 5 recalls the characteristics of uncovered groups and coverage needs, and section 6 outlines key considerations for the design of a coverage extension. Section 7 concludes with recommendations and a proposed roadmap for reforms.

The main findings and policy recommendations that the study have been summarized in 4 policy papers:

- Extending Social Health Protection in Lebanon: Health Financing Landscape and the Role of the NSSF in Achieving Universal Health Coverage
- Extending Social Health Protection in Lebanon: Reforming the Health Insurance Scheme of the NSSF for Enhanced Effectiveness and Efficiency
- Extending Social Health Protection in Lebanon: Bridging the Coverage Gap
- Extending Social Health Protection in Lebanon: Enhancing Protection for the non-Lebanese Population

1. Background and scope

1.1. Context and Rationale

1.1.1. Epidemiological profile and health care needs in Lebanon

Key indicators of health outcomes have improved considerably and constantly over the past decades in Lebanon, however, as many middle-income countries, Lebanon now faces the challenge of responding to the health care needs of an ageing population and increased rates of chronic, non-communicable diseases, for which the current social health protection system is ill-equipped. Non-communicable diseases are the leading cause of death in Lebanon, accounting for 84% of all deaths. Among these, the leading cause of premature mortality in Lebanon is ischemic heart disease,a followed by stroke, road traffic injuries, and diabetes. The country also has a high prevalence of mental illness (a 2002 study found a prevalence of 17% for any mental disorder), neuropsychiatric disorders are the second-leading cause of disability-adjusted life years (DALYs), after cardiovascular disease and diabetes. The age-standardized proportion of males in Lebanon that have raised blood pressure (systolic blood pressure>=140 mmHg OR diastolic blood pressure >=90 mmHg) is 23.3%. The proportion that have raised fasting blood glucose ((>=7.0 mmol/L or on medication) is 14.5%, slightly higher than the regional average for this condition (13.4%) (WHO 2020).

The health profile of the country calls for additional investments in primary care and ensuring that people access services that allow them to prevent a number of health-related risks throughout their life cycle. The current structure of hospital centric curative care of relatively high quality on the one hand and primary care facilities largely unregulated and of relative poor quality on the other, is not supportive of such a shift and is fostered by current financing mechanisms.

The on-going humanitarian crisis has had consequences on the health sector as well, with one third of the population considered as refugee or migrant. The refugee crisis has been on-going for 10 years, with singular magnitude as Lebanon hosts the largest number of Syrian refugees per capita (UNHCR 2019). This inflow also has significant consequences on the health system, with increased need for health care services (Ibrahim and Daneshvar 2018) and pressure on some health providers.

Lebanon faces deep and structural social, political and economic challenges. The recent financial crisis and the Covid-19 pandemic have put the country at a greater disadvantage, as its socio-economic shocks has further exposed those vulnerabilities, put more pressure on livelihoods and endangered the economic security of thousands of citizens in Lebanon. In fact, rising unemployment and underemployment together with declining remittances are making it harder for many Lebanese to meet ends.

The COVID-19 outbreak has further shed light on inequities and challenges in the health sector. On 21 February 2020, Lebanon confirmed its first case of COVID-19 and on September 30th, there were 39,620 confirmed cases and 367 deaths.[1] A number of public and private hospitals were equipped to receive COVID patients. The outbreak also highlighted discrepancies and fragmentation in coverage. In addition, refugees' access to protection, basic assistance, or health services seems to have been hindered since the start of the pandemic (Danish Refugee Council 2020).

1.1.2. Access to health care and health financing landscape

The majority of the population does not access effective mechanisms for social health protection, and as a result a very sizable share of health costs comes out of households' pockets. According to LHFLCS data, a fourth of residents faces regular expenses related to their health. The majority of the population works in the informal economy - 55% of workers according to the Labor Force and Household Living Conditions Survey (LFHLCS 2018/19) - is not covered by any social health protection

1 Monitoring of COVID-19 Infection in Lebanon - 30/09/2020 at the Ministry of Public Health https://www.moph.gov.lb/userfiles/files/Prevention/nCoV-%202019/Monitoring%20of%20COVID-19%20Infection%20In%20Lebanon/30-9-2020.pdf last accessed 18 March 2021

(SHP) scheme. Lebanese without formal public health insurance can benefit from the Ministry of Public Health (MOPH) coverage for hospitalization and catastrophic drugs (El-Jardali et al. 2014), but the capacity of MOPH to provide quality health care acting as an insurer of last resort is limited. As a result, household out-of-pocket (OOP) expenditure in fees for services represented 33.1% of Current Health Expenditure (CHE) in 2017 (MoPH 2017a). This is well above the standard threshold of 15% of CHE suggested by the WHO as part of countries' efforts to attain Universal Health Coverage (UHC) and it is an indication of the social health protection coverage gaps (in terms of population covered and level of benefits).

The high fragmentation of public purchasers of health care services - while private provision dominates the health sector - poses a threat to the financial sustainability of social health protection in the country. Lebanon's health system was severely affected by the Civil War (1975 to 1990) which left the country with a fragile service delivery dominated by private facilities and weak regulation (Lerberghe, Mechbal, and Kronfol 2018). This context led to a rapid increase in health expenditure since the end of the nineties. Fragmentation challenges cost containment strategies, undermines the possibility to adopt strategic purchasing practices ensuring best value for money and hence poses a threat to the financial sustainability of social health protection in the country.

There are now six employment-based social insurance funds publicly managed in Lebanon and one tax-based programme acting as "last resort" managed by the Ministry of Public Health (MOPH). Public Social Health Insurance (SHI) funds encompass the National Social Security Fund as a mandatory insurance for some segments of the formal sector employees; the Civil Servants Cooperative; mutual funds; internal, state and general security forces schemes. MOPH plays a role of "insurer of last resort", providing ad hoc coverage for uninsured patients for secondary and tertiary services on a case-by-case basis upon the application from the patient. The UNHCR and the UNRWA also cover selected health expenses for refugees.

In 1963 the National Social Security Fund (NSSF) was launched with the aim of gradually ensuring SHP coverage for all. Yet the social health protection coverage of informal workers and their families in Lebanon remains largely unaddressed. As of today, the NSSF covers certain categories of private formal workers and public service contractors and their dependents. The NSSF not only administers a health care scheme, but also family allowances and an end of service indemnity scheme. Shortly after the end of the Civil War, the NSSF launched a voluntary scheme for health insurance. However the voluntary nature of enrolment and the lack of financial back up led the NSSF to stop expanding the scheme after 2005 (El-Jardali et al. 2014), except for the previously enrolled who are no longer eligible under the compulsory scheme. It is now estimated that about 2% of enrolees belong to the voluntary branch.

As part of a draft UHC bill – currently under examination by the relevant parliamentarian committees - it is proposed to address health financing gaps through a partially contributory system, whereby part of the population would contribute and the ones who cannot would be enrolled in the system on a subsidized basis. Detailed plans are not available at the time of drafting this document, in particular on the costing of the benefit package that would be included, the sources of financing to pay for this package, and the exact scope of population coverage, the contribution levels and the definition used to identify those who would have access to the subsidized or non-contributory mechanism.

A public opinion poll commissioned by the ILO in 2012 found that 43% of respondents find it 'very difficult' to access high-quality, affordable health care services, and 37% find it 'somewhat difficult' (ILO, 2012). Reporting difficulties in accessing health care was correlated with lack of social or private health insurance, geographically peripheral area of residence, low level of education, young adult or elderly (as opposed to middle-aged adults), self-employment or unemployment and low income. Importantly, 76% of the total sample of the poll declared that they would "Strongly support" the introduction of a healthcare scheme for everyone in Lebanon regardless of income. Only 21% preferred the following statement: "Access to healthcare should be provided to those who can afford it, and for those who cannot afford it, there should be minimum assistance". These results were consistent across gender, geographic region, work status, socio-economic and covered / uncovered groups. Among those who reported a preference for seeking services in the private sector, 64% declared that if the State improved the public provision of healthcare, they would agree to the restriction of coverage only to public providers. Finally, 59% of respondents supported the following statement: "The government should play an important role in encouraging a preventive approach to healthcare, and introduce enforceable procedures", and 41% agreed that "people should use a preventive approach to healthcare, and go for regular check-ups" (41%).

In order to face these challenges effectively, reform of the health care system is urgently needed, including having social health protection as a rights-based approach towards the achievement of UHC. It is now time to take a close look at the health care system in Lebanon and the opportunities for reform that will improve coverage, financial protection, efficiency and equity of health care for all, and bring the country a step closer to its goal of UHC.

1.2. Background and scope of this situation assessment

In 2019, the NSSF administration mandated the ILO to conduct a study exploring possibilities of strengthening the health insurance model and extending SHP to uncovered workers, including those in the informal economy. The situation assessment aims at analysing and understanding the health system and the health financing landscape; identifying coverage gaps and needs, particularly for informal workers and assessing the feasibility of extending coverage social health insurance scheme.

The situation assessment is guided by ILO core standards on social protection (in particular conventions No. 102 and 130 as well as Recommendation No.202). To that end the health system is considered as a whole, following the principles of availability, accessibility (including affordability) and - to a lesser extent due to the scope of our mission, acceptability and quality[2]. The issue of fragmentation in health care financing is taken into account (McIntyre 2008).

The assessment incorporates both the results of the field mission in Beirut that took place in July 2019 and background information on Lebanon health system and informal workers characteristics, based on the results of a desk review and recent information from the LFHLCS 2018/19.

While the primary focus of the situation analysis is to support strategic decision making by NSSF on the extension of coverage of its health insurance scheme, the report necessarily touches on two closely related issues:

- It discusses the relationship between NSSF and other financial health protection mechanisms in ensuring UHC in Lebanon;
- It identifies priorities for strengthening and improvement of the health insurance model run by the NSSF, including for the currently insured.

The report is structured as follows. Section 2 presents methods and the framework of analysis, section 3 provides an overview of the current health financing landscape in Lebanon, section 4 rapidly assesses the NSSF social health insurance scheme, section 5 recalls the characteristics of uncovered groups and coverage needs, and section 6 outlines key considerations for the design of a coverage extension. Section 7 concludes with recommendations and a proposed roadmap for reforms.

2 General Comment No. 14 of the Committee on Economic, Social and Cultural Rights and ILO Recommendation No. 202.

2. Methodology for the Assessment

To conduct this assessment qualitative methods were used, using both primary and secondary data. We followed a threefold approach:

- **Desk review and health financing system analysis** to identify social health protection gaps in Lebanon specifically for informal workers and keeping in mind the SDG targets on universal health coverage and universal social protection;
- **Interviews with key stakeholders** and collection of available qualitative and quantitative data from NSSF (reports, unpublished documents and data collected through NSSF information system) to fill potential gaps of the desk review, as well as to investigate current NSSF objectives, organization and capacity;
- **Focus group discussions** to identify current social health protection needs of informal workers.

Desk review: Social Health Protection Gaps in Lebanon

The desk review identified relevant documents on i) Lebanon social health protection and private health insurance context as well as informal economy in Lebanon; and ii) international examples and best practices for extension of social protection to informal economy. Results of the review helped prepare the fieldwork and are integrated in the final report.

The literature review was not meant as a systematic review but as a scoping review identifying key information gaps. It integrated academic and grey literature, obtained through direct contacts with the ILO and the NSSF. The review also identified relevant documentation in public access. Sources included online resource centres and journals (PubMed, Medline, Lancet) as well as general search engines. Other useful websites (public institutions, academia in Lebanon) were carefully scrutinized to identify relevant resources.

The scoping review of international examples was based on the team's previous knowledge of successful cases as well as the ILO Guide for the Extension of Social Security to the Informal Economy (ILO 2019), and extended through a scoping review of available literature.

Interviews with key stakeholders: NSSF challenges and opportunities for extension

In a second phase, the mission helped in collecting data directly i) from key informants at policy level (NSSF, Ministries, development partners); ii) from beneficiaries and iii) from healthcare providers. Interviews using an open-ended questionnaire helped in filling knowledge gaps and provided more insights on the NSSF challenges and opportunities for extension. The ILO assessment team helped in identifying interviewees prior to the mission. The list of stakeholders is in annex.

Focus Group Discussions: Social Health Protection needs and preferences of informal workers

Focus group discussions (FGDs) helped gather data on the needs and expectations of target beneficiaries. The proposed research question leading the FGD was "What are healthcare coverage needs and preferences of informal economy workers?". These focus groups were not meant to propose a detailed design for an adapted social health insurance scheme. In particular willingness to pay could be assessed during a follow-up survey depending on the next steps NSSF is ready to take. The goal was mainly to point at needs and gaps that should be addressed by a potential SHP mechanism.

Focus group discussions with informal economy workers were organized by two Labour Unions, the General Confederation of Lebanese Workers (CGTL) and FENASOL. Workers from these different sectors were met: Agriculture; Construction and Domestic work. A meeting with the head of the Lebanese Hotels' Association was also organized.

A discussion guideline was established beforehand. It included both closed-ended and open-ended questions and can be found in annex. Each focus group included moderators and note-takers and lasted about 90 minutes. The number of participants depended on arrangements made with counterparts.

The following charts summarizes key methodological steps for this assignment:

Step 1: Desk review and health financing analysis	
State of knowledge and information gaps on: Lebanon social health protection and private health insurance context as well as informal economy in Lebanon	International examples and best practices for extension of social protection to informal economy

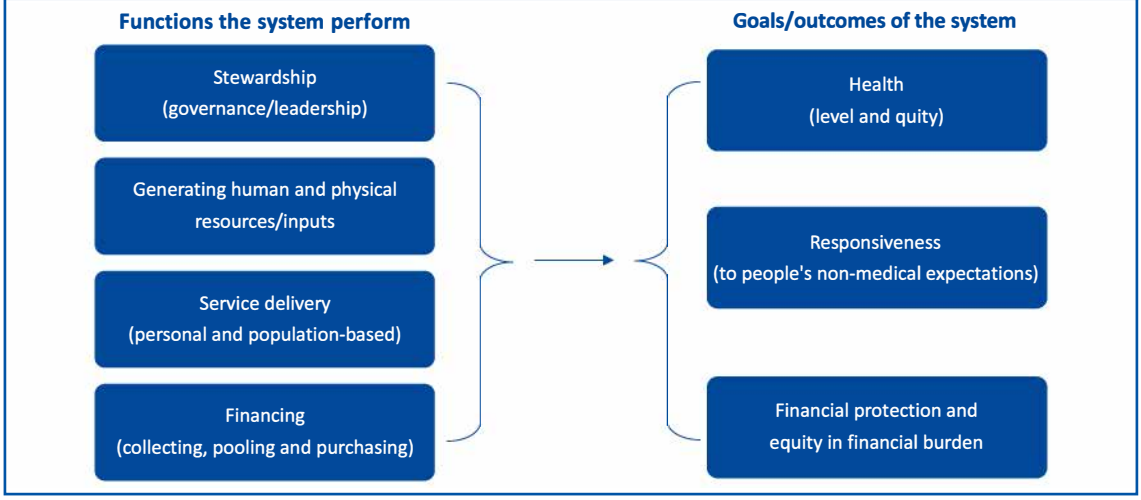
Step 2: Interviews with key stakeholders and collection of secondary data	
Key informants at policy level	Beneficiaries and healthcare providers

Step 3: Focus group discussions	
Labour Unions and representatives from agriculture workers, construction workers, domestic workers	Employers' representatives

Framework of analysis

The framework used for the health system assessment is the following. It entails four main functions (stewardship, generating human and physical resources/inputs, service delivery and financing) leading to three goals (health, responsiveness and financial protection and equity in financial burden) in the framework of UHC.

Figure 1: Health system's functions and goals



Source: Kutzin 2013

3. Overview of health financing in Lebanon

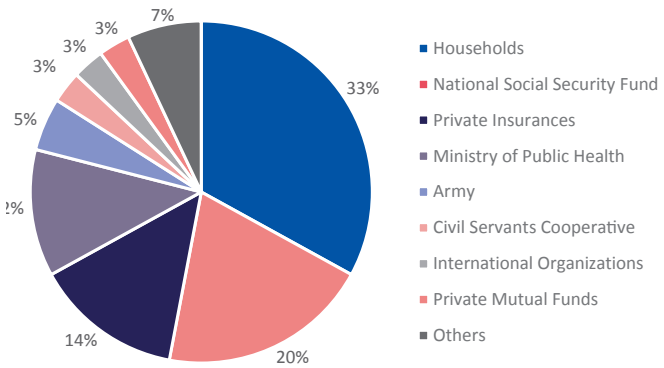
3.1. Stewardship

Stewardship in Lebanon is divided between numerous stakeholders and practice differs from the legally intended setup. Legal mandates specify that the MOPH is responsible for regulating health care supply (according to Decree No. 8377 issued on December 30th, 1961). NSSF is in charge of managing the social security system, including health care benefits (article 1 of Social Security Law enacted by Decree No. 13955, September 1963). In practice stewardship is much more fragmented and there seems to be little to no cooperation between institutional stakeholders on health delivery and social health protection.

This fragmentation is further reflected in terms of financial shares, as no main purchaser of health care seems to emerge (see graph below). Main institutions responsible for stewardship on health care schemes include (by decreasing share of total health expenditure (THE), see graph below for values):

- The **Ministry of Labour**, with the legal mandate over the NSSF as per Decree No. 13955 of 26/09/1963 (the NSSF represents 20% of THE in 2017);
- The **Ministry of Trade**; regulating private insurances (with 13.6% of THE in 2017, private insurances are the second most important purchaser of health care in terms of spending volume, but not in terms of population coverage);
- The **Ministry of Public Health**; regulating both health care providers (public and private) and its own purchasing schemes (12.3% of THE in 2017) under decree no. 16662 of 18/06/1964;
- The **Ministry of Defence**, supervising the Military Medical Services for the Army (4.8% of THE in 2017) in accordance with the National Defence law article no. 68 of 06/05/1987;
- The **Office of the Prime Minister**, administering the Civil Servants' Cooperative under article decree no. 960 of 30/06/1973, and covering the staff of the Public Security, Customs' employees, and those of the State Security forces (3.8% of THE in 2017);
- **International organizations**, including the UNHCR (representing 3% of THE in 2017);
- The **Ministry of Interior** regulating the Internal security forces (ISF), General Security Force (GSF) and Special Security Force (SSF) schemes3 (3.8% of THE in 2017);
- **Professional associations** are stewards of mutual funds. In addition the Ministry of Agriculture is regulating mutual funds;
- The **Ministry of Social Affairs**, through its network of primary healthcare centres, dispensaries and Social Development Centres (SDCs).

Figure 2: Financing Agents as a share of Total Health Expenditure (THE), 2017



Source: Authors, according to National Health Accounts 2017 (MoPH 2017). Others include: Internal Security Forces, Mutual Funds Public, General Security Forces, Customs, State Security Forces

3 According to the regulation of the General Directorate of General Security Rule 47 Date of 16/09/1983, regulation of the Internal Security Forces, Chapter Three, Chapter Seven, Health Affairs, Articles 146-147-148

The National Social Security Fund (NSSF) is the first funder of health expenditure with 20% of Total Health Expenditure (THE) in 2017. The second most important funders of health expenditure are private insurance companies (13.6% of THE), arguably because they finance a scope of expensive interventions without much cost containment measures,[4] before the Ministry of Public Health (MOPH), (12.3% of expenditure). The army funds 4.8% of THE. With 8 financing agents representing less than 16% of THE, the health financing landscape reflects the fragmentation in stewardship (MoPH, 2017). The Civil Servants Cooperative; mutual funds; internal, state and general security forces; customs and international organizations all operate as financing agents. Hence, it shows that facilities receive payments from a wealth of sources, undermining the bargaining power of purchasers (NSSF, in the first instance).

3.2. Revenue raising

Total health expenditure is relatively high, hence an overall lack of financing for health is not the main issue at hand. Rather, very limited revenue raising via broad public risk pooling mechanisms results in much of the costs being borne by households, which reinforces inequity and limits opportunities to implement cost containment measures with service providers. Over-utilization of expensive diagnostics is one of the key drivers of high health expenditure. Current Health Expenditure (CHE) as a share of Gross domestic product (GDP) in Lebanon (8,2%) is slightly higher than other middle-income countries. CHE amounts to 719 USD per capita and Domestic General Health Expenditure to 360 USD per capita in 2017 (WHO 2020).

Private expenditure constitutes the bulk of health funding in Lebanon. More than half (53.4%) of the total health expenditure (THE) was financed by households, including through OOP and private health insurance premiums, in 2017.[5] Public funding, at 46.6% of THE, includes Treasury and social contributions to social security as well as public mutual funds and external donors' contributions (MoPHs, 2017).

Out-of-pocket payments are high and represent the first single source of funding as a share of THE. Households have to bear 1/3rd of health expenditure through direct (out-of-pocket) payments. This high share puts people at risk of impoverishment when using health services. Direct payments act as a deterrent of health care access. OOP represents over a third of the country's health expenditure, this is significantly higher than the level observed in countries with comparable GDP per capita such as Turkey (17%) or Thailand (12%). Annual OOP per capita amounted to 239 USD in 2017, which is very high for a middle-income country and in comparison to neighbouring countries (i.e. 104 USD in Jordan, 77 USD in Turkey, 64 USD in Egypt).

Premiums to private health insurance schemes are also an important source of funding. Altogether employers' and households' premiums represent 13.6% of total health expenditure. Private health premiums are relatively large compared to premiums in other middle-income countries.

From a general interest point of view, the private health insurance market provides low efficiency. The "*Association des Compagnies d'Assurance au Liban*" (ACAL) publishes yearly aggregated results of its members. In 2016, medical insurance premiums amounted to 456 million USD, compared to 343 million USD disbursed as claims the same year, representing 75% of the premiums (Association des Compagnies d'Assurances au Liban 2016).

Social contributions represent the third source of funding. Employers and workers contributions represent 19.2% of health spending. NSSF contributions[6] corresponds to 11% of the gross salary (employers pay 8% and employees 3%) with a maximum of 2.5 million LBP. To be noted, the Government is legally bound to provide a contribution to NSSF representing 25% of the health care scheme benefit expenditure.

4 As private health insurers usually apply risk rated premium (i.e. contributions based on personal health profile rather than ability to contribute), there is less incentive for cost containment than in solidarity-based schemes with broad risk pools.

5 Our figures differ from the MOPH official figures, as we do not consider social contributions to be private funding (according to System of Health Accounts 2011).

6 Includes preventive and curative medical care; delivery, pre- and postnatal care; sickness and maternity allowance; and funeral expenses.

The Government subsidizes the health sector out of general revenue. Domestic General Government Health Expenditure (including social contributions) represent 4 % of GDP. In Lebanon the Constitution does not allow for earmarking taxes, according to the principle of "unity" of the budget mentioned in article 83. Therefore this has been until now politically difficult to specifically earmark a tax towards the health budget.

Table 1: Sources of funding as share of Total Health Expenditure, 2017

Source of funding	Share as % of THE
Private funding	51.1
Out-of-pocket expenditure	33.1
Premiums to a private prepayment scheme (private mutual funds, private insurance)	18
Including	
- Premiums from households	11.2
- Premiums from employers	6.8
Public funding	46.4
Treasury	29.1
Social contributions to a public prepayment scheme (social security, cooperatives and public mutual funds)	17.3
Including	
- Contributions from workers	4.9
- Contributions from employers	12.4
Extra budgetary (international organizations)	2.5
GRAND TOTAL	100

Source: Calculations based on MoPH 2017a

3.3. Pooling

The health financing landscape in Lebanon presents numerous funds with very limited pooling. Numerous public schemes with separate funds coexist in Lebanon (see Annex 3 for summary table of main schemes).

The main public coverage mechanisms include the following:

- The **NSSF** has a social health insurance scheme initially intended to cover all workers and their families and currently covers on a mandatory basis permanent workers employed in the private sector and public sector employees that do not benefit from the Civil Service Cooperative scheme, teachers of private schools, Lebanese students and foreign students and foreign workers under certain conditions and self-employed of certain economic sectors (see Chapter 4 for more detail).7 In practice coverage reaches about 1,546,000 beneficiaries (among which 610,000 are active contributors), or 23% of the Lebanese population (NSSF 2019). This population group is affiliated to the social health insurance scheme (covering namely ambulatory and hospital care and drugs).
- There is a separate mandatory social health insurance scheme for the military, which covers around 6% of the population (about 340,000 beneficiaries including contributors and dependents) (WHO 2003) The scheme covers ambulatory and hospital care (100% for members, 75% for spouse and children, 50% for dependent parents).

7 The Social Security Law (1963-20890) mentions that all foreign workers working in Lebanon are subject to all Social Security obligations. However the Law also specifies that they can only receive social security benefits if 1/ they have a work permit; and 2/ there is a reciprocity agreement with their country of origin. See below for a discussion of coverage of migrant workers.

- **ISF, SSF and GSF** social health insurance schemes managed by Ministry of Interior also cover on a mandatory basis 'other uniformed staff' for the same benefits as the military, for almost 100,000 beneficiaries.
- The **Civil Servants Cooperative** covers about 295,000 people, including 79,000 active contributors on a mandatory basis (Central Administration of Statistics (CAS), 2010).
- The **MOPH** has a programme by which nationals who are not otherwise covered can apply to get the cost of needed hospital care covered. This mechanism is not a scheme by which people are affiliated and provided an entitlement, it is meant to be a last resort for the uncovered nationals who cannot afford to pay for hospital care (World Bank 2017a). This mechanism had to be put in place in view of the large share of the population not covered by any SHP scheme. The benefit is granted on a case-by-case basis.
- The MOPH recently launched a pilot project funded with support from the World Bank to deliver an **Essential Package of Health Services** through a network of 75 Primary Health Care Centers (PHCCs) at a subsidized rate. Based on the Emergency Primary Healthcare Restoration Project (EPHRP, started in 2015), this new project targets 340,000 poor and vulnerable Lebanese (World Bank 2017a).
- The **UNHCR** guarantees coverage of specific primary care and hospital care interventions for the refugees and other persons of concern under its legal protection, representing 969,641 people in 2018. This is done through subsidized primary care centers on the one hand and approvals for hospital-based procedures and payment managed with the assistance of a third party administrator (TPA). The risk is borne directly by UNHCR.

Numerous mutual funds fill NSSF coverage gaps. There are 46 mutual funds covering 9% of the population (about 350,000 beneficiaries) with varied pool sizes and benefit packages (Union Technique des Mutuelles Santé du Liban, 2019). Most of them are playing a complementary role, meaning they cover the difference between the price of the service and the price reimbursed by the NSSF (co-payment). They can provide family coverage, with for example discounted (half) contributions for households' members. In exchange for these contributions, beneficiaries can receive up to 1,000 USD of benefits. The benefit package can also be broader than NSSF, with mutual funds acting as a supplementary insurance, which can, in some cases, include comprehensive health coverage plans in cities i.e. external laboratories. However, they do not cover pre-existing conditions. While we could not obtain data on the overlap between NSSF and mutual funds, it seems that NSSF remains the primary coverage for some mutual funds enrolees.

The private insurance market is well developed in Lebanon. In fact, few Middle Income countries rely so heavily on private insurance to finance healthcare. Private Health Insurances request high premiums (officially because they have to pay taxes) - reportedly about 30% higher than other medical schemes. Yet available data on private insurance financing is limited. Clients do not necessarily pay the whole of the premium themselves. Last available data (LFHLCS 2018/19) showed that 10.5% of residents hold a private health insurance policy up from 6.5% in 2005 (NSHLC, 2004/5). Moreover, around half of them (about 45%) did not subscribe to a plan directly but were enrolled through their employer mutual fund through an institution or a union. Private insurance can play the role of complementary insurance to NSSF. A 2009 study estimated that about one third of those covered by a private insurance were also NSSF beneficiaries and in that case private insurance covered hospital services only (Ammar 2009a). When private insurance beneficiaries are not insured with NSSF, their insurance packages usually contain both hospital and additional ambulatory care services (90% of those with private insurance).

3.4. Purchasing

The presence of multiple purchasers lead to limited bargaining power and purchasing strategies for cost containment. Fragmentation of SHP schemes and high reliance on private health insurance implies that different tariffs and payment mechanisms are applied, not only between private and public schemes, but also between the NSSF and the MOPH. Facilities reported that NSSF tariffs were more advantageous for them. This has a detrimental effect on the bargaining power of public purchasers. Private hospitals complain that reimbursement charges for services have not changed since 1998. As a result, it is evident that private hospitals are adopting balanced billing practices in charging patients additional fees that is fuelling the rise in OOPs (ILO, 2016).

NSSF and the military scheme use 'passive payment methods', namely fee-for-service, which wrongly incentivizes providers to bill more services (supplier induced demand) but does not consider value-for-money. Patients' outcomes and the quality of services are overlooked. Poor financial management led the NSSF to carry out ad hoc advances to hospitals (see next section) while reimbursements (for the first level of care) are made ex-post to NSSF beneficiaries, creating an incentive to bypass the primary care level in absence of a referral system.

The UNHCR is de facto an important purchaser of health services in Lebanon. Due to its volume of benefits and its payment mechanism, it has built experience in contracting providers and it is one of the few institutions that has successfully implemented some measures of cost containment. Since January 2017 the UNHCR contracts a third party administrator - a private for profit company – acting as a Health Management Organisation responsible for buying secondary / tertiary care to the refugees, while ensuring an appropriate level and quality of care was provided. This includes a direct, computerized link with hospitals, together with the medical file of the patient. This example is unique at the UNHCR (Spiegel et al. 2017) and could be interesting to learn from for public purchasers in Lebanon.[8]

In recent years the MoPH started to work on new purchasing practices to manage its programme of hospital care coverage for the uncovered patients who apply. The MOPH is contracting public and private hospitals for surgical (payment through pre-set rates, rates which are lower than the NSSF ones) and non-surgical (payment through Fee-For-Service) care. To incentivize the use of public hospitals, patients' co-payments are only 5%, against 15% in the private facilities (Lerberghe, Mechbal, and Kronfol 2018). With World Bank support, the MOPH is piloting special capitation payments with participating public hospitals (World Bank 2017a). Affiliating the population it intends to cover and providing an entitlement could give a greater bargaining power with providers to this programme. Similarly, the MOPH is piloting the delivery of an Essential Package of Health Services through a network of 237 PHCCs at a subsidized rate. Together with the UNICEF, the MoPH pays by item (in-kind support, including generic drugs, vaccines, medication for acute and chronic conditions, staff support, running costs, laboratory and medical supplies, training, and IT support).

3.5. Service delivery

Service delivery is characterized by a well-established private sector at a more advanced stage of development than in most middle-income countries. In Lebanon 80% of hospitals and 67% of the MOPH PHCC network are private (El-Jardali, Fadlallah, and Matarb 2017), adding up to almost 90% when including those run by non-governmental organisations (NGOs). In addition, health care provision is highly concentrated on hospital and curative care, with virtually no reference system acting as gate keeper. The public health care system has been greatly weakened by the civil war (N. M. Kronfol 2006). Since then health service delivery has predominantly been operated through private actors, mainly private individuals or groups of doctors and, to a lesser extent, NGOs. Furthermore, the fragmentation of funding sources and the lack of active payment methods (but rather the use of passive payment such as fee-for-service) acts as an incentive for private care provision. It is estimated that 82% of hospitals are privately owned (IGSPS, 2012). The hospital sector is divided into 28 public hospitals and 135 private hospitals.

The distribution of health services and their frequentation are highlighting an unequal health system. Visits to dispensaries, primary care centres, and hospitals revealed the existence of a two-tier system, whereby the more vulnerable Lebanese access dispensaries (that apply low-cost fees) and low-quality primary care centres and the well-off access primarily high-tech hospitals with high fees and covered by private insurance and NSSF.

There is an oversupply of doctors, equipment and non-necessary health services, particularly of complex medical care and longer hospital stays. The rate of C-sections is still very high at almost half of the country's births (49.4% in 2018, Ministry of Public Health 2018)[9], pointing at a high provision of non-necessary services. Indeed the WHO has estimated that C-section rates over 10% are not associated

8 The Global Concessional Financing Facility is also providing financial support to Lebanon, hoping that the injection of money will facilitate the integration of refugees into the national health system (Spiegel et al. 2017)

9 Out of 115,486 deliveries, 57,079 C-sections were performed.

with reductions in maternal and new-born mortalities (WHO 2015). Similarly, the use of fee-for-service as provider payment mechanism for all social health protection schemes tends to induce the overuse of services reflected in a high number of admissions, even for minor cases (N. Kronfol et al. 2014).

Spending is concentrated in high cost technological interventions used by small number of patients. Higher spending has not led to better quality care for the majority of the population. The current purchasing practices of public purchasers and their division plays an important role in this situation, which precludes moving towards a more equitable system.

3.5.1. Primary care

At primary care level, the MOPH has provided significant efforts to strengthen public providers, however budgetary allocations are still limited. There are 237 primary healthcare centres in Lebanon that are within the PHCC network (monitored by the MOPH). At least, there are an estimated 800 public and private / for profit dispensaries across the country (World Bank 2017a).

The public sector also counts 220SDCs. SDCs include a health care component and provide highly subsidized care (LBP 7,000 for a consultation including drugs) but often with a limited range of services. They can provide curative and preventive health care services, vaccinations, primary health care, reproductive health services for mothers and children, advice on reproductive health and other primary health care services, such as screening and deliver disability cards. They are managed by the Ministry of Social Affairs (MoSA). MOSA also assists centres ran by not-for-profit and non-governmental organizations as well as geriatric homes for the elderly.

Patients' confidence in public healthcare sector is low . The lack of confidence in the public healthcare sector in Lebanon is high when compared to developed countries, especially when it comes to hospitals care. (Antonios 2018). Patients who can afford private services prefer to use them. Overall the choice of provider and patient pathway seems determined by socio-economic categories (Blanchet, Fouad, and Pherali 2016).

Private sector facilities are divided by sectarian categories: 28% of medical centres and dispensaries are run by Christian and Muslim charities, while 15% of basic health care originate from political parties (Blanchet, Fouad, and Pherali 2016).

Accreditation was introduced at primary care level. In 2009, the MOPH in Lebanon collaborated with Accreditation Canada International, through a contractual agreement, to develop a National Accreditation Program for PHCCs and accordingly a national expert committee was formed. The first official survey was conducted in 2015.

Only a small share of Primary Health Care Centres in Lebanon has been accredited. Only 237 PHCCs are part of the PHCC network of MoPH, and only 52 of them have been formally accredited (World Bank 2017a). This is due to a large quality gap for facilities to obtain accreditation and a lack of funding at MOPH level allowing only a small number of facilities to obtain accreditation.

Dispensaries remain out of the control of MOPH. There are about 768 dispensaries in Lebanon, including public and private/for profit. A license, delivered by the MOPH under specific criteria, suffices to open a dispensary. However, it is a one-time process and there is no re-assessment of health centres after the initial licensing. Hence there is almost no control on their quality and the services they provide.

Both public and private facilities reported an increase in utilisation of services since the Syrian crisis. The proportion of visits to facilities has increased from 14% (2012) to 35% (2014) for Syrian refugees (World Bank 2015). Moreover, certain services are particularly strained such as obstetrics and neonatal wards in hospitals, and PHCs in areas of high concentration of refugees (WHO 2018).

3.5.2. Secondary and tertiary care

Health care in Lebanon is mainly hospital-based. In total there are 144 hospitals (2018 data). Hospital capacity is high compared to Lebanon's neighbours and higher or comparable to a number

of Organisation for Economic Co-operation and Development (OECD) countries (i.e. Canada, Denmark, New Zealand, Sweden, Turkey), with 27,3 beds per 10,000 population in 2016 (MoPH 2017b). Similarly hospitals' and health centres' densities are respectively well above and below averages for middle-income countries (and some high-income countries), denoting an imbalance towards hospital care.

The MOPH introduced the accreditation system using a phased approach to ensure a smooth transition for hospitals in 2000 (Haj-Ali et al, 2014). The development and the implementation of the accreditation policy in Lebanon was made possible because of the legislation that was passed in June 22nd 1962 and amended by the legislate decree #139 of September 16, 1983 (El-Jardali, 2007).

The oversupply of hospitals and medical equipment relates to a "medical bubble". In 2018 there were 4.23 hospitals (public and private) per 10,000 resident (including non nationals). Computed Tomography (CT) scanner density for Lebanon, for example, is the highest of the Eastern Mediterranean region and is higher than in most high-income countries, with 25.09 per million population (WHO data 2014). Similarly, Magnetic Resonance Imaging (MRI) unit density is also the highest of the Eastern Mediterranean region and in line with several high-income countries, with 8.3 per million population (WHO data 2014). High-tech equipment is particularly widespread as investments on private health care for a solvable demand are high. Yet it does not respond to an actual demand for such medical equipment, and visits revealed that some of this brand-new equipment was not used because of a lack of patients. One of the reasons is that the classification system used prior to accreditation was providing a financial incentive for hospitals to invest in equipment without rational planning (Ammar, Wakim, and Hajj 2007).

3.5.3. Health workforce

There is also an imbalance between doctors and nurses. Oversupply of doctors, especially specialists, has been highlighted (El-Jardali, Fadlallah, and Matarb 2017), while the MOPH does not own sufficient leverage to limit their number (their education is under the Ministry of Education and Higher Education, while the licensing is MOPH matter). Shortage of nurses on the contrary is recurrent (with 2.72 per 1,000 population in 2015), and despite a recent increase in the workforce as noted between 2009 and 2014 (Alameddine et al. 2017), many nurses seek employment abroad, while similar migration schemes are not in place in Lebanon. With the bulk of the workforce is composed of women due to several reasons, which are namely low salary, ill-adapted social benefits and taxation (IWSAW 2016). To be noted, doctors' income can be much higher as they can practice part-time in multiple facilities. Nurses on the contrary are usually employed full-time by one facility.

4. Rapid assessment of NSSF social health insurance scheme

4.1. Framework of operation

As originally intended by the legislator, the National Social Security Fund (NSSF) was meant to be the tool enabling full population coverage. The NSSF was established in 1963 under the umbrella of the Ministry of Labour.

The NSSF is a mandatory scheme for certain categories of employees: permanent employees of the private formal sector, employees in government-owned corporations and contractual and wage earners of the public administration that do not benefit from the Civil Service Cooperative scheme, teachers of public and private schools. Other categories of workers in specific sectors are also mandatorily covered. Workers who were previously enrolled in the NSSF can enroll on voluntary basis within 3 months after they lost eligibility to the compulsory scheme (see below and Annex 4 for full detail on scope of NSSF coverage).

The NSSF covers different contingencies under three branches: maternity and sickness, family allowance and end-of-service compensation. Family allowances can be provided to NSSF beneficiaries with a non-working wife or with children. The maximum monthly allowance has become a lump sum with maximum of 225 000 LP per family since 2001[10]. Each family can receive 33 000 LP per child up to 5 children and 60 000 for the non-working spouse. The end-of-service compensation covers old-age, disability and survivors with lump-sum benefits.

The NSSF refers to 'maternity and sickness fund' but the scheme mainly entails medical benefits (and funeral grants). Maternity and sickness benefits usually refer to a cash payment to the beneficiary to protect them against wage losses due to ill health or pregnancy and maternity. The cash sickness benefits, while foreseen at the creation of the NSSF, were never implemented. Instead paid sick and maternity leave are provided as an employer liability according to the Labour Law.

The health care scheme covers any disease that is not a result of work-related injury. In addition, the scheme covers maternity care expenses including antenatal, postnatal, and delivery care. The material scope of legal coverage includes general practitioner care, specialist care, pharmaceutical supplies, hospitalization, antenatal, postnatal, and delivery care. In addition to ancillary services like laboratory services and imaging services. The scheme also provides funeral grants (150% of the minimum wage) in case of death not caused by a work accident. Since the emergency work and occupational diseases branch of the NSSF is not yet implemented and given the applicable law related to work injury does not cover occupational diseases, occupational diseases are covered by the NSSF under the health care scheme.

4.2. Design of the NSSF health care scheme

4.2.1. Scope of population coverage

The NSSF is the main source of health care coverage in Lebanon, covering primarily the population employed in the private sector, public sector employees that do not benefit from the Civil Service Cooperative scheme and teachers. The NSSF scheme is compulsory for permanent private formal workers. Temporary and seasonal employees, as well as municipality contractual workers, should be covered by law, but the operational decrees for implementation of coverage have not been issued. Coverage of part-time employees is also limited in practice. Foreign workers are generally required to contribute to the NSSF but do not benefit from the schemes except in the presence of a reciprocity agreement (see more details on coverage of non-national workers in Section 5.7.1 below). Domestic employees are not covered as they fall outside the scope of the Lebanese labour law. Mandatory registration happens through the employer, and has to be completed within 10 days from the start of operations.

10 The allowance used to be 75% of the minimum wage before 2001.

The law also provides for the NSSF to cover on a mandatory basis certain categories of other workers even in the absence of a specific employer (newspaper vendors, dock workers, taxi drivers, doctors, mayors) as well as university students. Such workers are covered with a different contribution rate under the three branches or only health depending on the sector (details in Annex 4).

Voluntary coverage for the health care branch is available for the self-employed and for workers previously covered by the mandatory system but without coverage in their present employment.

Box 1: Summary of NSSF scope of population coverage under the law

The NSSF law and regulations covers the following workers for all benefits, including medical care on mandatory basis:

- Lebanese citizens who are:

  Employees
  - employees in the private sector (however there are no regulations for coverage of temporary and seasonal workers and coverage of part-time workers is limited);
  - permanent employees working for agriculture institutions;
  - employees of public institutions and independent offices who are not subject to civil service;
  - wage earners employees in Lebanon working abroad (in case they do not benefit from allowances of a foreign country);

  Other workers
  - wage earners not depending on one employer and working in marine sector and seaport only (dock employees);
  - taxi drivers (owners and wage workers);
  - independent newspaper vendors;
  - mayors;
  - bakers;
  - trainees.
- Foreign wage-earners who are nationals of countries with bilateral social security agreements with Lebanon (currently France, UK, Belgium, Italy).

The NSSF covers the following workers for **medical care** only on mandatory basis:

- Teachers in private schools;
- Lebanese University students ;
- Foreign students living in Lebanon from countries with bilateral social-security agreements with Lebanon;
- Doctors.

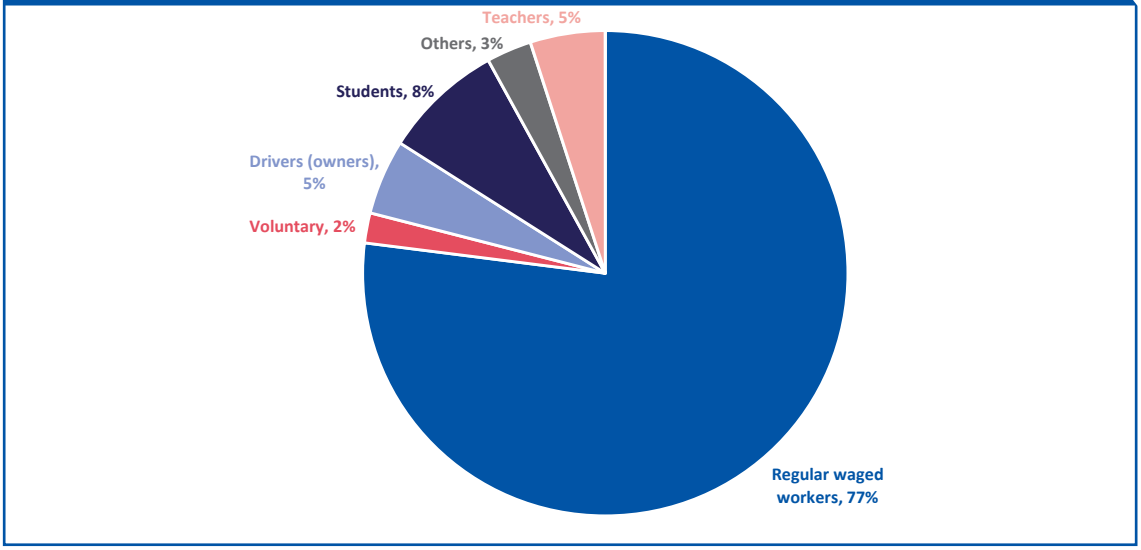
The NSSF covers, on voluntary basis, medical care for workers who were previously enrolled yet are no longer eligible under the compulsory scheme.

See Annex 4 and 5 for full details on the terms of coverage for each category

Since 2002 there has been a 'voluntary' section in the sickness and maternity branch for former adherents who lost their eligibility after retirement, employers and their relatives employees excluded from the mandatory scheme, liberal professions and self-employed persons. The voluntary contributions sit in a separate fund. Due to the lack of cross-subsidization and adverse selection, the financial situation of this section has been dramatic ,leading to hospitals left unpaid by NSSF for patients voluntary enrolled in the scheme, in turn resulting in discrimination between patients by service providers. The NSSF has suspended enrollment of categories eligible for the voluntary scheme except for workers who were previously enrolled and are no longer eligible under the compulsory scheme, within 3 months of losing eligibility.

The NSSF coverage for health care has expanded to the retired since 2017 (Law No. 27/2017). In order to be eligible to medical care retired workers should have 20 years of contribution and reached the retirement age. Coverage only applies to formal permanent private sector employees, government employees and teachers.

Figure 3: NSSF enrolees, by occupation (2019)

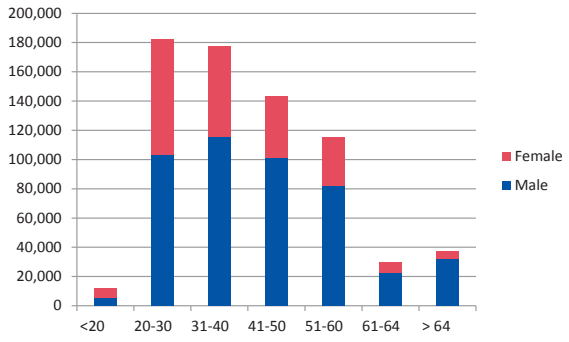


Source: NSSF data (2019) Note: Others include newspaper sellers, sea sector workers, doctors, drivers (wage workers)), bakers, mayors of municipalities and retired workers.

According to NSSF administrative records, in 2018 there were 696,992 enrolees in the health care scheme covering for 848,761 additional dependent family members. Beneficiaries comprise members' dependants, including the spouse (if the beneficiary is a male or the beneficiary's husband is disabled and unable to work), children up to 25 years if single and still in formal education, and parents over 60 years living in the same household.

The majority of enrolees are regular waged earners. Three out of four enrolees are private and public sector regular wage earners (77%). In addition 8% of them are students, 5% are teachers, 5% are independent drivers and 3% fall in the residual category (bakers, newspaper sellers, sea sector workers, doctors, drivers (employees), mayors of municipalities and retired workers). Importantly only 2% of enrolees are voluntarily registered.

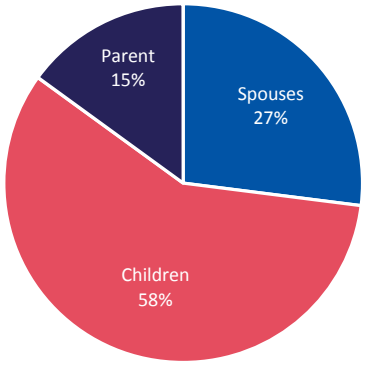
Figure 4. Age composition of contributors, by gender (female, male)



Source: NSSF data (2019)

The share of female active contributors reflects the low labour force participation of women in Lebanon. Only 29.3% women aged 15+ participate in the Labour markets. Yet, this pattern is slightly changing for younger generations. Looking at age range 25 to 34, the labour force participation rate for women is 49.7%, more in line with other countries in the region and of similar level of income (LFHLCS 2018/19).

Figure 5. Composition of family dependents by relationship with the main contributor



Source: NSSF data (2019)

Dependent family members are few (1.2 per contributor) relative to the average household size in Lebanon (four persons as per the LFHLCS 2018/19). When looking at the composition family beneficiaries, most of them are children (58%) and 15% are enrolees' parents.

4.2.2. Benefits covered

Benefit package

The benefit package of the NSSF medical branch is wide. It includes coverage of the following conditions requiring health care:

1. All illness, except those caused by work accident;
2. Maternity: pregnancy, delivery and their following;

In addition the scheme provides for a Funeral Grant, for death not caused by a work accident (150% of the minimum wage) but eligibility to the Funeral Grant is limited to a sub-set of categories of workers (permanent employees, taxi drivers, newspaper sellers and mayors).

There is no referral mechanism in place that would play a gate-keeping role and prevent inappropriate or overutilization of services. Patients can directly access specialist practitioners at an outpatient department in a hospital. This incentivizes inappropriate or overutilization of services. The structure of NSSF costs described below reflects this trend.

None of the drugs included in the benefit package are generics. Generics are indeed commonly considered as lower quality drugs in Lebanon. A combination of factors contributes to the prevalent use of brand drugs: the need for strengthening stewardship of MOPH, raising awareness about generics, and incentivizing key stakeholders (El-Jardali et al. 2017). Furthermore, due to important delays in reimbursements and high cost of branded medicines, NSSF patients with chronic diseases have to rely on NGOs to obtain free drugs. This is a significant source of inefficiency.

Employer organizations do not feel they are getting good value for money out of the NSSF health insurance programme and are concerned about high health care costs especially for hospital services. Many employers take out supplementary private insurance for their senior levels of management and have to take out private insurance for themselves as NSSF does not cover business owners.

There is no recent publicly available information on the expenditure per beneficiaries. For the year 2011 the average health expenditure per beneficiary was US$ 630 without co-payment and US$ 567 in presence of a co-payer, equivalent to 953 000 and 850 500 LBP at the exchange rate of the time (ILO, 2012).

Level of financial protection

The NSSF covers for 90% of hospitalization costs and up to 80% of medical consultations and medication, excluding dental care. Workplace injuries are not covered by NSSF under the health care scheme, but under a employer-liability system through private insurance.[11]

The NSSF health care benefit package mainly entails curative services and excludes preventative services. Coverage includes:

- 100% of inpatient hemodialysis and deliveries;
- 80% everything related to outpatient service cost including doctor fees (except for the cancer and terminal illness medications);
- 90% of hospitalization costs;
- 95% of cancer and terminal illness medications costs (in and out of a hospital);
- 80% of costs of hemodialysis out of a hospital;
- 90% of the costs of "open heart" medical care;
- 80% for diagnosis and treatment (X-ray of cancer).

The remaining costs are official co-payment rates to be bore by the patient. Visits (entry fee) to an emergency department are not covered, only relative laboratory tests as applicable. Co-payments of 10% for inpatient services and 20% for outpatient services (including medicines) still represent a sizeable financial barrier to NSSF members.

4.2.3. Revenue collection

Most of the revenues of the health care scheme are designed to come from NSSF social contributions, with partial government contribution. Employers and workers contributions add up to 75% of the health care scheme expenses, while 25% are meant to come from Government contribution. Social contributions are calculated as a percentage of monthly salaries (including overtime, bonuses and fringe benefits). The contribution rates are as follows:

Table 2: Contributions rates for NSSF

Contribution type	Employee's contribution	Employer's contribution
Sickness and maternity fund	3%	8%
Family allowance fund	-	6%
End of service allowance fund	-	8.5%

In order to finance medical care for the retirees the contribution rate for the medical care scheme was increased in 2017 by 1% for workers and 1% for employers (already factored in the figures reported above) plus an additional 1% contribution from government. In order to remain enrolled under NSSF's health care coverage, retirees have to contribute 9% of the minimum wage monthly.

Legally, non-resident employees are exempted from contributions if they work in Lebanon and if their employer produces evidence that they are entitled to benefits in their country of residence at least equivalent to those offered in Lebanon.

11 Since the emergency work and occupational diseases branch of the NSSF is not yet implemented and given the applicable law related to work injury does not cover occupational diseases, occupational diseases are covered by the NSSF under the health care scheme. At the moment there is no predetermined list of occupational diseases covered under the NSSF scheme.

4.3. Management and operations of the NSSF

4.3.1. Governance

A tripartite Administration Board governs the NSSF and executive management is entrusted to a Director General. The Board is composed of 10 directors representing the employers, 10 directors representing the employees and 6 directors appointed by the Government (26 in total). Strategic decisions for the NSSF have to be voted by the Board with absolute majority.

Internal decision-making in the NSSF is hampered by a number of governance related challenges. The large size of the Board and lack of explicit requirement for qualifications and expertise of members of the board has led to slow and ineffective decision making. The Administration Board must approve strategies of the NSSF, but its decision-power is hindered by vested interests, lack of commitment and need for renewal. The lack of renewal at the head of the Administration Board leads to decisional inertia, which is highly detrimental to reforms process. Due to absenteeism and a number of vacant positions absolute majority is seldom reached in the board and decisions on strategic matters postponed.

The structural lack of data analysis negatively affects strategic decision-making. The NSSF disposes of a wealth of data, and namely of the greatest database for OPD in Lebanon. This information however does not seem to be used. This is partly due to the lack of a dedicated department for statistical analysis, monitoring and actuarial analysis. Yet it could be analyzed for cost-efficiency purposes, to monitor the use of antibiotics for example, it would also constitute an input to conduct regular actuarial work informing the Board on the financial sustainability of the scheme.

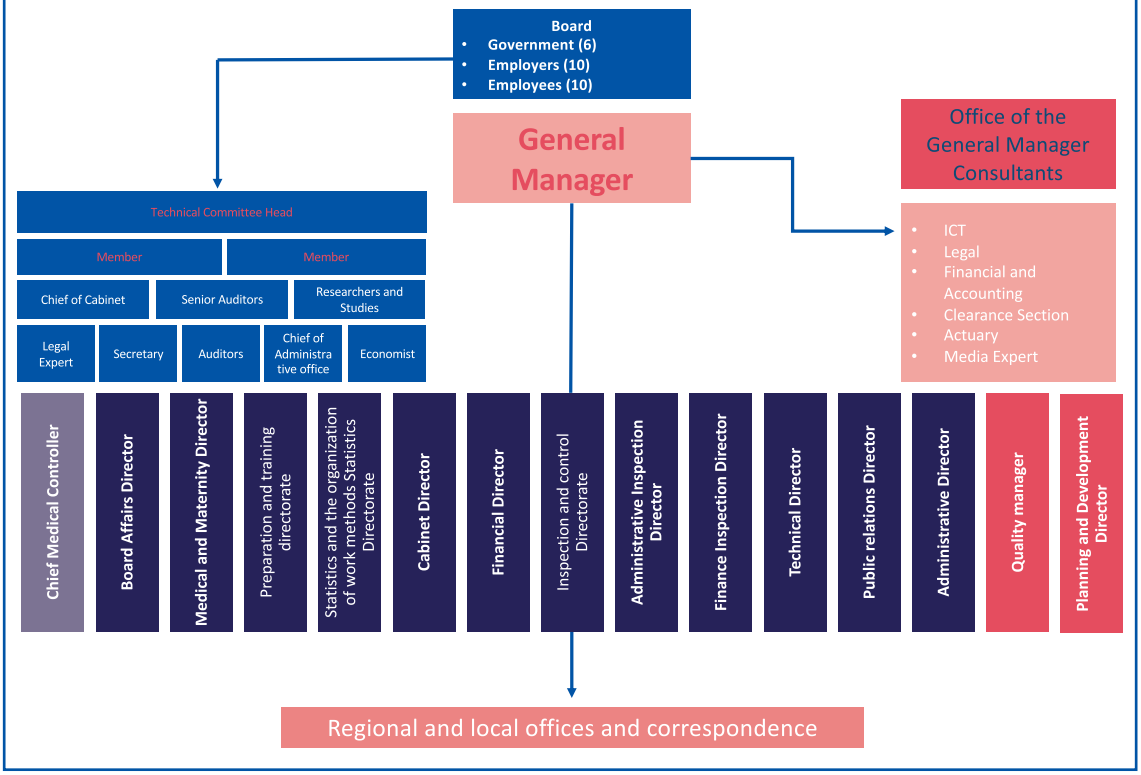
4.3.2. Organizational structure

NSSF Main Office is composed of the following 14 Directorates (EU-OMSAR, 2018):

- Financial Directorate;
- Administrative Directorate;
- Statistics and Organization of Work Methods Directorate (IT data processing services are part of the Directorate);
- Financial Inspection Directorate;
- Administrative Inspection Directorate;
- Inspection and Control Directorate;
- Sickness and Maternity Directorate;
- Public Relations Directorate;
- Technical Directorate;
- Cabinet of the Director General;
- Board Affairs Directorate;
- Preparation and Training Directorate;
- Quality Directorate;
- Planning and Development Directorate.

In addition, there is a Medical Control administrative unit acting as a Directorate. The Quality Directorate and Planning and Development Directorate have not become functional administrative units.

Figure 6: Organizational structure diagram



Source: EU-OMSAR project, Health Administration Review Mission Report, 2017

The NSSF's central administration capacity is limited and there is a shortage in staff. Many existing positions are vacant and do not get filled at both central and decentralized offices. In 2002 the total number of employees amounted to 2,500 while in 2019 it accounted of only, 1,500. Moreover, more than half of the positions were vacant (53%) in the first quarter of 2020. Stakeholders reported it was difficult for the NSSF to hire new staff. Numerous positions were opened but filling them is not the prerogative of the NSSF but rather of the the Civil Service Council through a of the Council of Ministers.

The capacity of subnational branches was equally overstretched and lack of basic equipment is common. The local administrations are overloaded with very burdensome processes (see below) to claim reimbursements, marked by repeated manual and duplicative fraud controls. Managers have to deal with a great number of tasks and feel they need more staff. In addition to the shortage of human resources at Branch level, basic equipment is also often lacking.

In addition, some important analytic skills are lacking, especially knowledge of health insurance, health financing and health economics. An aggravating factor is that the Preparation and Training Directorate has not been able to adequately provide training for the skills required by employees. Linking training and human resources, as suggested in the EU project report, will surely allow to develop the needed skills (EU-OMSAR, 2018).It should be noted that a full organizational assessment and proposals for restructuring and redefining internal functions have been made under the EU-OMSAR project on reinforcement of the National Social Security Fund (NSSF) in Lebanon , pending approval by the Board.

4.3.3. Registration and contribution collection

Registration and contribution payment are paper-based. For registration through firms, employees should be registered in the 10 days following hire. Payments are collected at the branch level directly from the employees' delegates. Individual registrations and payments happen directly at local branches. One third (35%) of all NSSF beneficiaries are in Beirut as big companies are registered there. This means that Beirut local branches have to deal with greater volume of claims.

A new administrative structure in local branches is soon to be implemented. Pilots are being tested in three branches, among which Jounieh, Nabatieh and Bourj Hamoud. ISO is being implemented in 7 branches (Burj Hamoud was the first one).

A pilot was implemented in the NSSF center of Burj Hammoud that passed the ISO certificate. As a result of the ISO certification, the center implemented a 1-day policy of paying to the beneficiaries their receivables in the same day of the submission except for requests from companies, which takes more time to process. In collaboration and close coordination with the EU-OMSAR project at the NSSF, the center of Burj Hammoud revisited the service processes and decreased the steps to intake and finalize the transactions or approvals at the center. Furthermore, to safeguard that the services are provided adequately to the beneficiaries and by a decision from the NSSF director-general, the membership to Burj Hamoud center was blocked given that the current resources at the center cannot cater more beneficiaries. There was a concern that this might have led to increase in utilization of other centers by Burj Hamoud catchment area's potential members requesting to register. It might also have prevented some to register, thereby acting as an obstacle towards enrolment.

4.3.4. Provision & claim

There is a duplication of tasks for the coverage of inpatient services. In visited facilities, NSSF patients had to first register for admission at the hospital general reception. After their admission they had to submit their paper-based application for coverage at the NSSF administrative desk, in the hospital (with on-site NSSF staff, including a medical controller and a claims' controller). Therefore the need to digitalize the claims process at the hospital level was also raised, for hospitals already equipped with computers and skilled staff (this might not be the case in all hospitals in Lebanon). Some visited facilities are already using digital files for patients' admission, it would be easy to link both. By comparison, the MOPH process is also burdensome. It involves applying for the MOPH scheme before getting admitted in the hospital. It also does not cover specific procedures. It can take up to 18 months for hospitals to get paid afterwards.

There are heavy procedures of pre-approval and duplication of administrative capacities across public schemes at hospital level. Indeed, at hospital level, administrators are posted from NSSF, MOPH and other programmes, which constitutes a duplication of personnel and a financial burden for the public purchaser. If synergies and coordination were in place, costs could be saved on this end.

As a result, it can be very lengthy for beneficiaries to claim and obtain reimbursement. Because of overcrowded services and long waiting lines, beneficiaries have to take days off work to come to the local branch and make their claim. In some branches, they have to wait up to 6 months, which is highly challenging for chronic diseases such as diabetes for example. Some patients who have chronic diseases reported having to borrow money to buy the required medicines. The local branch of Bourj Hammoud has been applying a same-day reimbursement policy as part of its the quality program (Qualeb), in cooperation with the Ministry of Economy and Trade.

Overstretched capacity and burdensome processes are leading to important delays in the processing of reimbursements. According to NSSF officials, more than 5,800,000 health insurance claim forms (out-patient services) and 700,00 hospitalization claims unprocessed were accumulated and left unpaid by 2018. Certain claims date back from 2010. The time taken to reimburse patients is typically 14-16 months. Various stakeholders acknowledged that there is a risk of widespread fraud by both patients and providers to augment NSSF claims.

The NSSF is already aware of the necessity of automation of medical claims and more broadly all NSSF services. In 2016, 93% of the total number of submitted requests to NSSF were health care and maternity care benefits claims, while only 1% were applications for end-of-service indemnity and 6% were family allowance applications (EU-OMSAR, 2018). Therefore it represents the vast majority of submitted claims and automation of this branch would greatly reduce claims processing burden.

Control processes are very burdensome and inefficient. Processes are based on fraud control (on both patients and providers), which requires human and financial resources. In order to achieve efficiency the NSSF should consider moving towards output control (including quality of care) automation of some processes and warning systems. This should be achieved through the collaboration with the MOPH, in link with its accreditation efforts.

Reimbursement process is skewed towards inpatient services and incentivizes the use of hospital over primary care services. Approximately 55% of NSSF expenditure is on inpatient care as with 45% on outpatient care (ILO, 2016). While GP services are being reimbursed ex-post, third-party payment is applied for higher levels of care (hospital IPD). It is easier for patients to go to the hospital directly, especially when they have connections there, than to have to claim reimbursement ex-post. Each year 300,000 cases are admitted in hospitals. More than half of them are admissions resulting from emergency visits (while the entry fee to the ED is not covered). However this number could be greatly reduced if lab tests were done in OPD, for example if the NSSF was contracting PHC affiliated to hospitals. This would imply strategizing providers' contracting.

4.3.5. Purchasing function and cost containment

There is no strategic management of the providers' network. The network of providers includes both public and private facilities. However dispensaries are not allowed to enter into contractual arrangements with the NSSF and need to start undergoing the MOPH accreditation process to be certified as health centers to enter the network. Pharmacies are excluded, which leads to burdensome processes for beneficiaries to obtain reimbursement of the medication they buy, including control processes whereby patients have to bring empty medication boxes to their NSSF branch.

There isn't any harmonized procurement of medicines. Pharmaceuticals represent an important share of the Lebanese market. Some of MOPH-covered medicines (including some cancer drugs) are procured through the Central Warehouse (representing a small share of all procured drugs in Lebanon) and its Drug Dispensary Center. Vaccines and essential medicines for its PHC network are procured through UNICEF and YMCA. The MOPH, through its Pharmaceutical Inspection department, sets drug prices for patients in the private sector and the mark-ups of importers and pharmacies (for imported medicines only).

The NSSF health benefits expenditure pattern reveals an imbalance towards medicines, medical tests and specialist care. Medicines are by far the most significant cost item (57% excluding chemo medicines - and 66% including chemo medicines - of NSSF benefits expenditure), followed by visits to specialists (12% of NSSF health benefits expenditure) and diagnostic tests (10% of NSSF health benefits expenditure, and 14% including X rays, MRI, CT scan). Importantly, GP visits represent only 3% of spending. This further reflects the imbalance towards curative hospital-based care mentioned above. The figure below highlights the main services driving NSSF expenditure increase. Diagnosis services seem to represent the greatest increase.

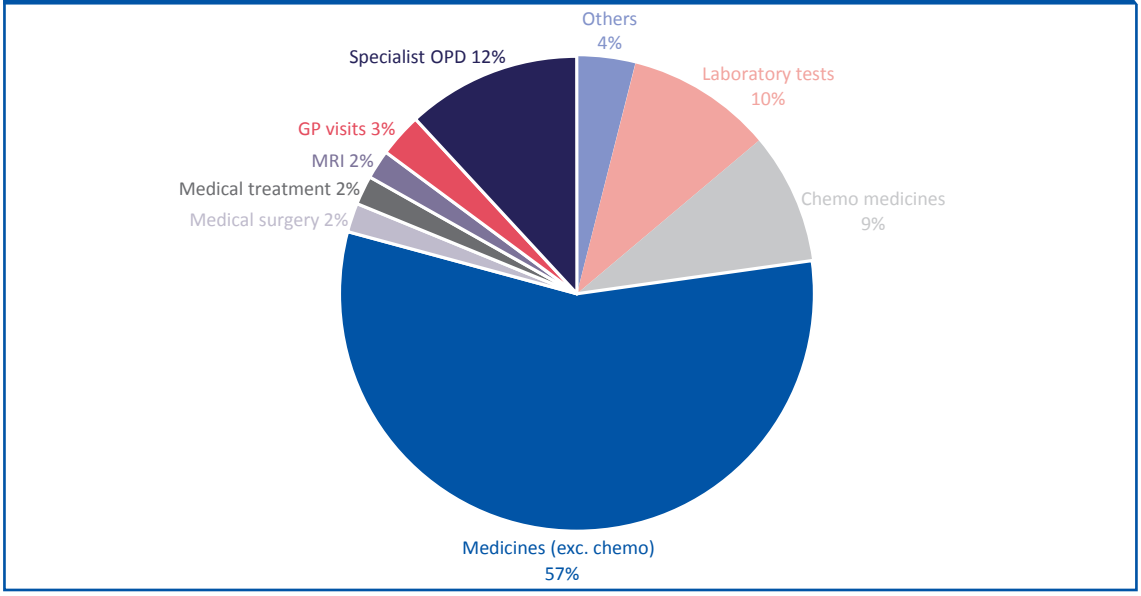
Payment mechanisms are highly inefficient and should be further improved. Primary care is paid on a fee-for-service basis by MOPH and reimbursed ex-post for NSSF beneficiaries. Hospitals are paid by fee-for-service, on the basis of a list of pre-agreed prices per service. In practice the NSSF provides regular advance payments to hospitals and uses fee-for-service for the final settlement of claims. Payment of outpatient services is based on fee-for-service as well, and patients are reimbursed according to NSSF tariffs. On the long term NSSF is working on getting an average cost to refine its payment mechanism.

Tariffs and methods differ from one purchaser to another. At hospital level for example private health insurance pay upfront, fee-for-service at a high price. MOPH applies lower tariffs than NSSF.

This is a source of inefficiency as the hospital applies different prices for the same service. This can also lead to the hospital delivering low quality services to MOPH or NSSF patients in comparison to privately insured patients.

The NSSF has experienced severe financial challenges to reimburse hospitals. Hospitals are being paid annual advances since 2015 for them to accept NSSF patients. This point is of concern in terms of financial management and sustainability of the scheme. As hospitals are paid fee-for-service, advances do not offer incentives to rationalize their spending.

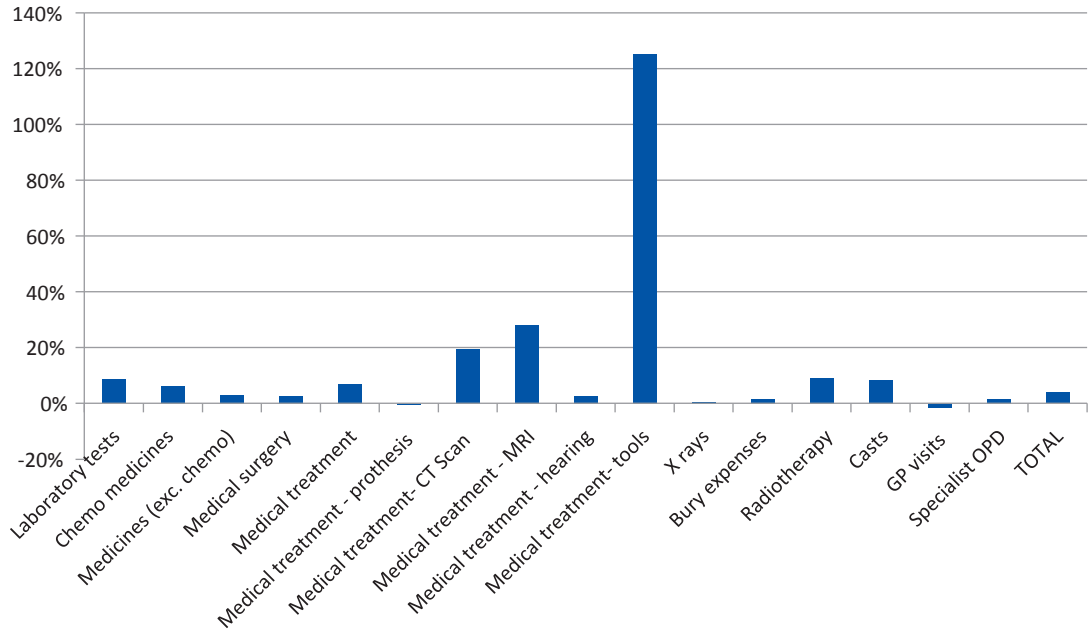
Figure 7. NSSF expenditure pattern by type of service, 2018



Source: NSSF data, 2019. Note: Others include radiotherapy, X rays, bury expenses, CT scan, casts, medical treatment tools, medical treatment – hearing, prosthesis..

Medical professionals are not subject to prescription accountability. Therefore they are directly targeted by the pharmaceutical industry that very commonly pays for research and conferences for professionals to attend. This influence has a detrimental impact on medicines consumption, limiting cost-containment possibilities (Ammar 2003b). Together with progresses in technology, this explains the sharp increase in medicines expenditure below. In this sense, the introduction of the unified medical prescription benefits helped alleviate the burden of pharmaceutical costs and improve access to medicine, yet implementation has to be improved as well as further linked to pharmacies and hospitals.

Figure 8: NSSF expenditure increase rate by type of service, 2014-2018



Source: NSSF data, 2019

Significant cost-saving measures could be adopted, such as favoring the use of generic medicines and primary care physicians. To reduce the cost of medicines, NSSF should consider covering generic medicines. On the long term it would also be advantageous to let the MOPH procure medicines and avoid fragmentation. The high cost of specialist care should be counterbalanced with a gate-keeping mechanism at primary care level. The very small share represented by GP visits is also pointing in that direction.

With most of the resources and efforts concentrated on claims control, beneficiaries' experience tends to come second. There does not seem to be regular beneficiary and providers satisfaction surveys, leaving little indicators to monitor quality of services and levels of co-payments for example. In addition, complains mechanisms for NSSF patients are not necessarily user friendly (for example there is no hotline). They have to call the NSSF local branch number or bring their complaint to a box in the local branch. Litigation is often not formalized, thereby encouraging clientelism.

4.3.6. Financial management and sustainability of the scheme

The financial status of the scheme seems unfavourable. Despite a lack of up to date and detailed data on NSSF financial status, spending on health care seems to have increased drastically and reports state that the institution has been in deficit for years (Antonios 2018). This should be further researched but at the time this report is drafted not enough information has been gathered to do so, particularly on the accounting system, the financial situation and income statements, cash flows, liquidity and financial ratios as well as analysis of the reserves.

Several cost drivers can be identified, even with the limited information gathered so far. Among other causes, provider payment mechanisms seem unfitted. Patients are also more likely to use inpatients than outpatient services and the funding is skewed towards hospital rather than primary care (Antonios 2018). Financial management processes seem weak. There is no annual budget planning process, at overall institutional level or at the level of departments or regional branches. Together with weak purchasing mechanisms, cost control is very limited. Compliance issues were also mentioned when it came to receiving contributions from employers (delays and amounts).

The Lebanese government has accumulated large payment arrears with the NSSF. For example, at the time of the mission, the NSSF still had not received the allocation from the Ministry of Finance corresponding to the end-of-service indemnity of 2017. The co-contribution of Government to the health care scheme has also not been received by NSSF since the year 2017. According to Lebanese media, in 2018 the Government owed USD 1.5bn to the NSSF in arrears (Business News, 2018). This is particularly problematic in the context of our assessment, as if NSSF is looking to extend coverage further than the informal workers who can fully contribute, the NSSF might require greater subsidization from the State and might increase its dependency towards the GoL's financial management.

Several stakeholders consulted during the preparation of the report lamented the lack of transparency in the NSSF financial management. The health insurance fund of the NSSF runs in structural deficit (estimated at USD 1.3 billion in 2017), which give rise to large liabilities for the government, which has a legal obligation to cover some of the costs of NSSF (Business News, 2018). Inadequate contribution rates, excessive and unchecked benefit payments, and other possible leakages may be at the origin of these losses. In the absence of a clear financial picture, reforms have been delayed and the government has been reluctant to meet all of the financial requests of NSSF. This has required, injection of liquidity from End-of-Service Indemnity, which has been running surpluses, despite the Social Security Law establishes ring-fences of funds for different branches (IMF 2007). There is no recent financial data available to assess the implication of such practices on the overall financial sustainability of the NSSF, which is likely to have sharply deteriorated due to the current economic and financial environment in Lebanon.

The EU-OMSAR project on Reinforcement of the National Social Security Fund (NSSF) carried out a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of the health care scheme of the NSSF. Findings are presented in Annex 5.

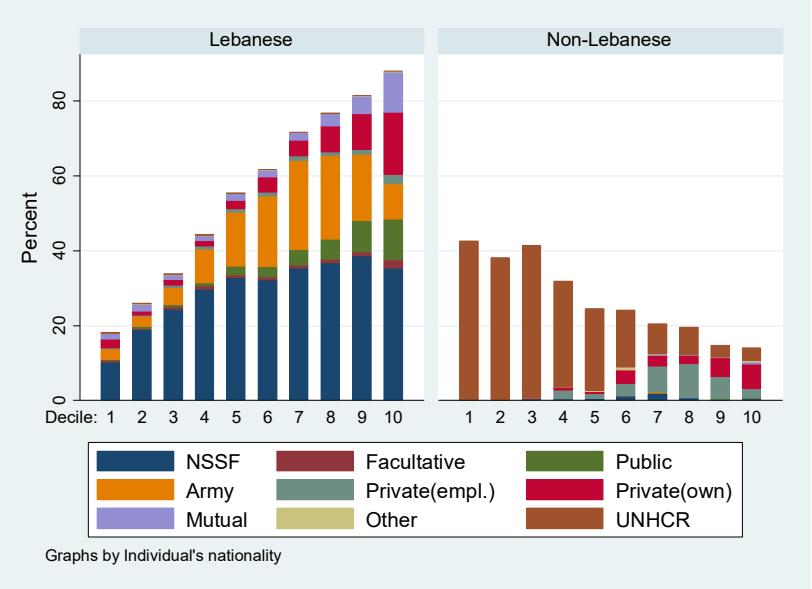
5. Characteristics of uncovered groups and coverage needs[12]

5.1. Overview of the health insurance affiliation landscape in Lebanon

According to a recent assessment of social protection coverage gaps based on the LFSHLC 2018/19 survey data (ILO, 2020) 42.1% of the Lebanese population are not directly covered by any type of health insurance policy, and 27.5% live in households where no-one has access to an health insurance policy.

Health insurance coverage is significantly lower for poorer households, however there are large coverage gaps also for middle-class and better off households, who would have the capacity to afford health insurance contributions but are not affiliated. Several lifecycle and socioeconomic vulnerability factors (e.g. large households size, lower education background, disability) are associated with lower health insurance coverage. Affiliation rate are also significantly lower for women (52.4% uncovered) and for the unemployed (65% uncovered).

Figure 9: Health insurance coverage (household members on policy), by income decile



Source: ILO & CAS (2020)

Informal employment represents 55% of total employment in Lebanon, according to the LFHLCS 2018/19. Informal employment relationships can be found in both formal and informal enterprises and public establishment.[13] A large share of informal workers is self-employed (29%). This has important implications. Self-employed workers include employers, independent professionals and own-account workers; as well as subsistence own-account workers. The LFHLCS shows a slow but steady change in the structure of employment, away from agriculture (about 4%) and industry (about 21%), and towards services (about 76%). The continuous drop in economic growth, the financial crisis and the COVID pandemic will continue to have an impact on the size of precarious and informal employment.

12 This section summarizes findings from both literature and focus groups discussions with workers. When references are not expressly made, information arises from the focus groups discussions.

13 Lebanon has adopted a legal statistical definition of informal employment, which defines as informal all employment relationships which lack social security affiliation provided by employer, and if that is unclear paid sick leave and paid annual leave are examined to determine the employment relationship.

Informal workers and workers in non-standard forms of employment are significantly less likely to have access to health insurance (Table 3). The lowest health insurance affiliation rates are found in households where no one is employed in the formal sector (72.1% uncovered) as well as for individuals who are informal employees or self-employed (respectively 71% and 66% uncovered) and for workers in the agriculture and construction sector (respectively 73% and 64% uncovered). Part time workers also have lower rates of health insurance affiliation (61% uncovered, compared to 34% of full time workers).

Table 3: Individual health insurance coverage status (Lebanese Citizens)

Employment status	% with access to Social Health Insurance		% with access to Mutual Health Insurance	% with accessto Private Health Insurance	% Uncovered (not on a policy)
	Policy Holder	On Policy	On Policy	On Policy	
Whole pop.	19.2	49.6	3.2	6.5	40.6
Formal employed (public)	94.6	96.4	2.7	0.9	0.0
Formal employed (private)	68.5	73.4	4.8	11.1	10.6
Informal (employed)	5.4	19.3	3.6	6.1	70.9
Informal (self-employed)	6.1	23.6	3.3	6.7	66.4
Inactive	10.9	49.3	2.8	6.6	41.2
Unemployed	7.7	26.1	2.3	5.7	65.8

Source: ILO 2020, based on LFHLC 2018/19

The majority of informal and vulnerable workers are not direct holders of health insurance policies, but are affiliated on the policy of other household members. For example, while only 6% of the self-employed workers are the direct holders of a social health insurance policy, 24% are affiliated for health through their family members. Direct affiliation rates are as low as 12% and 23% for workers in the agriculture and construction sector respectively.

Not all uncovered workers are poor or unskilled. According to information from the LFHLCS 2018/19 (Table 4) almost 40% of uncovered workers had earnings above 900,000 pounds per month in 2018. The average earnings for uncovered workers are significantly higher from formal employees (36% earned on average 1.5 million pound a month) compared to uncovered informally employed workers and self-employed workers. While informality is high among poor workers[14], not all informal workers are poor and across all categories of workers – including own account and self-employed workers - there appears to be a sizable share for whom affordability should not represent a major obstacle to joining the social health insurance system. Similarly, not all informal workers are unskilled. Almost one fifth (18%) hold a university degree.

14 For example Gatti et al. (2014) estimate that 82.5% of the poorest 20% workers are informal.

Table 4: Income levels of uncovered workers (Lebanese Citizens)

	Wage Quintile					All
	1st - lowest	2nd	3rd	4th	5th - highest	
Average monthly wage of workers uncovered for health (not policy holders) (2018) - all	431,797	605,432	726,467	920,941	1,511,406	
Share of workers uncovered for health (not policy holders) by income quintile (2018) – all	15.1%	22.6%	23.2%	21.8%	17.2%	100%
- formal employees	5.9%	13.2%	18.9%	25.9%	36.1%	100%
– informal employees	13.9%	22.0	24.7%	23.2%	16.2%	100%
– own account/self employed	19.2%	26.8%	23.5%	19.3%	11.1%	100%

Source: ILO 2020, based on LFHLC 2018/19

The health insurance coverage gaps highlighted from the survey data analysis overlay with the legal coverage gaps present in the social security system in Lebanon. The main categories of workers excluded from the scope of coverage of the NSSF are summarized in Box 2. The rest of this section provides insights on specific categories of workers to be targeted for the extension of NSSF coverage with a view at closing existing coverage gaps.

Box 2: Overview of key coverage gaps of NSSF system

The following categories of workers are currently excluded from the scope of coverage of the NSSF:

- Private sector workers that are not on permanent contracts such as temporary contracts and seasonal work, including agriculture workers who are not permanently employed by an agricultural institution and non-permanent construction workers.
- Coverage of part time workers is provided by law but limited in practice.
- Municipality contractual workers
- Contractual public sector teachers*
- Independent own-account workers and employers are not mandatorily covered (except taxi drivers, newspaper vendors, dock workers, mayors, doctors and those who have joined the voluntary scheme before its suspension for these categories). (see previous sections).
- Domestic workers.
- Foreign workers from countries with no bilateral social security agreement (for further discussion see Section 5.7.1 below).

See Annex 4 and 5 for more details

* A joint committee formed by the Ministry of Education and the NSSF was established to determine whether these should be covered under NSSF or Civil Service Cooperative Scheme. For the time being no decision has been made and the matter is under discussion.

5.2. Informal workers in the formal sector

A large share of informal work in Lebanon takes place in formalized establishments. It is composed of workers in an informal employment relationship because of either their ineligibility for affiliation to NSSF (i.e. for example the temporary nature of their contract) or failure to affiliate them from their employer (because of poor compliance and poor enforcement of the law). Informal employment in the formal sector should be progressively eliminated, as those establishments are already registered and

should be relatively easy to get to comply with social security enrolment. The LFHLCS 2018/19 indicates that almost 20% of informal employment is currently within the formal sector. This would represent a potential of more than 300,000 workers and their beneficiaries (up to threefold depending on the size of households) to be covered on a contributory basis through salaried employment.

Not covering temporary employees in the formal sector creates an incentive for employers to keep workers in such types of contract to save on social security contributions. By law, private sector temporary workers should be covered by the three branches, with same contribution rates as a permanent employees in private sector. In practice, the implementation decrees have not been developed. Given that the NSSF does not cover private sector temporary workers, the incentives for employers to save in social security contributions by overusing temporary contacts and keeping workers under them are sizable, especially in difficult economic times and for small businesses with limited profit margins.

In addition seasonal workers are excluded and coverage of part-time workers is limited. Same as temporary workers, seasonal workers should be covered but the implementation decrees have not been developed. As per regulations, employers should register workers within the first 10 days of work. According to stakeholders, due to the short period seasonal workers are hired for, employers are discouraged to do so.

It is not uncommon for firms to under-declare salaries, so to minimize the cost of social security contribution, with potentially very detrimental effects on the financial sustainability of the health care branch of the NSSF in particular. As mentioned above the compliance monitoring systems and inspection capacity of the NSSF are limited, and there is insufficient coordination and data sharing with other key actors such as the Ministries of Labour and Finance.

5.3. Employers and self-employed

A voluntary scheme that provides medical care coverage, in the event of sickness and maternity, was set up in 2003 for family workers, employers and self-employed workers who are not eligible for the compulsory scheme, provided that they are nationals and residents in Lebanon for at least 3 months. This scheme has encountered financial substitutability issues due to its voluntary aspect that leads to adverse selection. Therefore the NSSF has suspended the enrollment of all categories eligible for the scheme, expect for those that were previously enrolled and are no longer eligible under the compulsory scheme. Several categories of self-employed workers and employers are covered under professional mutual schemes which are in some cases mandatory. According to an informant, however, certain categories such as pharmacists, engineers or architects are advocating for NSSF coverage due to the more comprehensive benefit package.

5.4. Agriculture workers

Almost two thirds of agricultural lands in Lebanon are located in North Lebanon (Akkar) and the Bekaa Valley (59% of the total arable land in Lebanon). Since the economic crisis, agriculture commodity prices have dropped. Although 90% of the land is already under cultivation, land management skills are still lacking for farmers to more efficiently use their land and increase agriculture productivity in the country (Food and Agriculture Organization (FAO), 2018).

While 4% workers are employed in the agriculture sector (LFHLCS 2018/19), it is not clear how many people live off agriculture. Some estimates advance that around 20% of the population lives off agriculture (FAO 2019), and that 80% of agricultural workers are Syrian. According to the interviews and focus group conducted, this situation precedes the crisis in Syria and the agricultural sector has been relying on a seasonal workforce from neighbouring Syria prior to the crisis. That being said, the crisis changed the structure of such flows and Syrian workers and their families who were for instance accessing care in Syria in the past are not necessarily in a position to do so any longer.

The NSSF regulatory framework excludes most agriculture workers from legal coverage. The Lebanese Labour Law is applicable to all workers and employers except, agricultural workers, enterprises limited to family members, domestic workers and public servants. According to social security law of

1963, agriculture workers should be covered under the scope of the NSSF health care insurance scheme. Law No.74/8 of 1974 and Decree No.7757 issued on 7/5/1974 stipulates the coverage of "all Lebanese permanent workers, who are employed in an agricultural institution within the Lebanese territory by all sub-branches of the Social Security System." However Lebanese Law does not include any definition of an "agricultural institution" (FAO, 2016) and in practice NSSF coverage is only limited to agricultural enterprises that are also operating in other sectors (e.g. food processing, medical).

Agriculture workers' health insurance coverage is very low and patchy. Only 5% of farmers are covered through an employer. In addition, few mutual funds have been set up for agricultural workers, covering now 25,000 beneficiaries. The enrolment is family-based, against a monthly contribution of 30,000 LBP per household (about USD 20). Certain sectors, such tobacco farmers, are better organized than others, due to the structure of businesses. They primarily access dispensary and primary care facilities.

Specific efforts to expand coverage have not been successful over the years. Several draft laws to regulate agricultural employment, including provision of social insurance have been developed in recent years, but have not progressed. A decree to include fishermen within the NSSF was drafted in the late 1990s, but was subsequently shelved. Moreover, the draft decree was reported to set the contribution rate beyond fishermen's capacity to contribute (FAO 2019).

Fragmentation inhibits concerted action across the sector and reduces bargaining power. This is the case of fishermen organizations, which are small and fragmented in five syndicates and 33 cooperatives.

5.5. Construction workers

The social security law of 1963 mandates the NSSF to cover all construction workers under the three insurance branches at same contribution rates as permanent employees in private sector. In practice, coverage is not effective for non-permanent workers since the decree regulating their coverage has not be issued.

As a result, health coverage in the construction sector is also patchy since it includes a wide range of categories of workers. Large companies such as cement or concrete companies employ mostly formal workers. Companies working directly on construction sites on the other hand have suffered from economic stagnation and employ informal workers. They also contract firms employing informal workers themselves (through subcontracts), which makes it difficult to identify workers and employers.

Most jobs in the construction sector are temporary, with high level of sub-contracting and high share of non-national workers (Jill 2018). Previous ILO study has shown that for selected infrastructure projects in Lebanon, unskilled labor represented 41 to 56% of all jobs created for highway and primary roads and 36 to 62% for secondary and rural roads. Moreover temporary positions represent 60% to 80% of direct employment created, while permanent jobs represent only 20% to 40% of direct employment (World Bank and International Labour Organization 2018). As explained earlier in this report, this exposes workers to poor health insurance coverage.

Although coverage for work accidents is an employer's liability, obligations are difficult to enforce under informal employment relationships. When accidents happen it was reported to be difficult to identify clearly the employer and enforce the liability. According to stakeholders, the vast majority of construction workers are not covered by any health insurance mechanism, occupational health services and employment injury insurance. Yet construction is a particularly hazardous sector and occupational safety and health (OSH) on construction sites is reported to be a challenge.

In this context, emergency care remains an uncovered area. When accidents happen outside of work, workers have to bear all emergency/hospital services costs themselves, when possible. Stakeholders also pointed at clientelism. Poor patients would for example go to religious or political leaders to pay for them. Others would take loans.

Construction workers incur in excessive medical fees since they mainly access primary care services, such as dispensaries and charities/NGO centres, even for emergencies. Workers, for example, attend dispensaries to get stitches following an occupational accident, paying a high price compared to their income. If more care is needed, workers reported applying for the MOPH programme and having to wait for up to a year to obtain hospital services.

The need for an enhanced health insurance mechanisms is clearly expressed by workers. Construction workers mentioned that some medical services can be offered by dispensaries or through charity organization, they highlighted the need to have a mechanism in place to alleviate related costs. Their preference towards NSSF was expressed. Trade Unions expressed the will to play a role in informal workers registration to social security (including identification of enrolees).

5.6. Tourism and hospitality workers

In big cities most workers in tourism and hospitality are employed annually and therefore benefit from formal NSSF coverage. Big companies report covering all, even their seasonal workers. Roughly 135,000 hospitality workers are enrolled in NSSF, as estimated by stakeholders.

However, outside of Beirut, workers are mainly employed on a seasonal basis under 2-3 months contracts during the summer. Moreover stakeholders mentioned that many tourism businesses are small and may not register their employees and estimated 60,000 to 70,000 workers may not be registered.

5.7. Domestic workers

Domestic work represents almost 110 000 jobs in Lebanon (LFHLCS 2018/19), predominantly occupied by migrant workers on *kafala* type employment schemes (sponsorship of private households). Domestic work is excluded from the scope of application of the Labour Law (according to article 7). Hence, domestic workers are not mandatorily affiliated to NSSF. It is up to their employer to contract a private health insurance scheme for them and / or cover their medical expenses as they arise.

Individual households, as employers, are directly responsible for the living conditions of domestic workers and their residency status. The employment relationship is further facilitated by the involvement of recruitment agencies. Concretely, recruitment agencies send invitations to workers before they enter the country, so that they can obtain a work permit. Upon their arrival in Lebanon their identification papers are being handed over to their sponsor.

Having a health insurance at least in case of accident is a precondition to obtain a work permit for workers migrating on an oversee employment scheme. Migrant workers therefore have *some* private health insurance coverage upon entry. However it is generally limited to emergency services and the package is very small. It can cost around 40 USD.

Domestic workers can benefit from a private health insurance policy if the employer subscribes for them. However, stakeholders reported that such schemes are usually provided only for accident insurance. In addition, domestic workers reported having to come to the hospital with their sponsor in order to be accepted. Moreover, the benefit package is limited even in case of accident – in particular tests and drugs seem not to be included in many instances. Domestic workers also reported experiencing gaps in coverage when their private health insurance failed to be renewed.

S**ome employers can pay for other health services when needed, but they are not legally obliged to.** Similarly the purchase of drugs is left to the goodwill of the employer. Workers reported having to collect money from friends to pay for those services. In some cases they had to experience adverse health outcomes due to financial barrier to access services.

5.8. Coverage of non-national workers in the NSSF

Non-nationals make up a fifth of the labour force and most of them are informally employed. Almost 90% of non-national workers hold informal jobs as per the LFHLCS 2018/19. Options for non-

nationals to access formal employment are very restricted, both because of legal restrictions due to their migration status and, more generally, because they tend to work on contracts and sector of employment that are not covered by the NSSF. An important share of non-nationals in Lebanon are Syrian and Palestinian refugees. Syrian refugees are estimated at 1/4th of the Lebanese population[15]. Non-nationals, depending on their migration status, access health coverage differently. Despite being covered they can face stigma and discrimination preventing them to effectively access services and see their needs met. [16]

5.8.1. Non-national workers that are formally employed

Provided they have regular status and a work permit, non-national workers that are employed in the formal sector are required to contribute to the health care schemes of the NSSF.[17] However in most cases they are not eligible to receive benefits from the health care scheme unless they are nationals from one of the few countries that have established a bilateral social security agreement. Indeed, the NSSF law (Art 9.4) include a reciprocity clause that requires that countries of origin treat Lebanese citizens according to the "principle of equality of treatment in matters of social security". The Law tasks the NSSF board, in consultation with the Ministry of Foreign Affairs, to determine the list of countries that fulfil such principle and for which branches. Palestinian workers are subject to a special regime for EOSI but not for health care.[18]

The principle of equality of treatment is interpreted in the narrow sense that health care benefits can be accessed only provided the existence of a bilateral social security agreement with the country of origin. To date only 4 countries have concluded bilateral social security agreements with Lebanon (France, UK, Belgium, Italy). Considering workers with valid work permits belonged to 72 different nationalities in 2019, it is clear that the vast majority of workers are denied health benefits – despite contributions are made on their behalf.

Large amount of resources are contributed on behalf of non-Lebanese workers into the NSSF medical scheme and do not translate in any benefit to them, leaving large numbers of actively contributing workers unfairly uncovered for their health risks. A conservative estimate base on official data from MoL indicates that approximately 50,000 foreign workers with regular work permits (excluding Palestinian and refugees workers) should be subject to NSSF contributions as of December 2019.[19] At least 93% of them would be denied benefits because of the absence of a reciprocity agreement. The theoretical contribution made on behalf of these workers by the NSSF would amount to at least 40b LBP ($30m at the official rate)[20] every year, part of which originating from direct deductions from employees' wages. Contributions made on behalf of non-national workers are facto utilized to subsidize the health care system for Lebanese workers. Looking more specifically at the matter of Palestinian workers, an assessment of the financial implications of providing Palestinian refugees working in Lebanon with health coverage through the NSSF shows that the currently registered Palestinian workers have accumulated unused contributions worth around US$ 14 million between 1992 and 2011 (ILO, 2012).

15 The UNHCR reports a number of 929,624 registered Syrian refugees in Lebanon as of 30 June 2019. Palestinian and Syrian refugees add up to the already important number of informal economy workers (Tiffin et al. 2017). It is estimated that 86% of Syrian refugees work with negligible benefits or protection (Mufti 2018)

16 For example, in spite of UNHCR efforts, limitations on the number of Syrian refugees admissions in hospitals leaves an important need for hospital care unmet (World Bank 2017a)

17 The situation is different for pension benefit (EOSI) as workers from countries that do not have a reciprocity agreement with Lebanon are not subject to contributions for the EOSI scheme and therefore logically do not benefit from it. While this may appear fairer, the outcome is unsatisfactory on two levels: 1) it denies non-national workers right to pension benefits, 2) it distorts labour market as it implicitly reduces the total labour cost for non-national workers compared to national workers who are subject to the EOSI contribution. The matter is expected to be resolved as part of the legal reforms associated with long overdue reform of the EOSI into a long term pension system.

18 In 2010, amendments to the Lebanese Labour Law gave Palestinians who had work permits and were registered with the NSSF the right to benefit from end-of-service indemnity. Palestinian Employees are subject to contributions and can benefit from EOSI. Although they make full contributions to NSSF, Palestinian refugees working in the formal economy and registered with the NSSF are still excluded – like all other nationalities except those with reciprocity agreement – from the sickness, maternity and family allowances benefits under the policy of reciprocity of treatment, notwithstanding their exemption from the reciprocity injunction under the Social Security Law, as amended in August 2010 (ILO, 2012)

19 The analysis is based on official MoL data on distribution of work permits by nationality and sector (Dec 2019). Domestic workers and agriculture workers have been excluded from the analysis

20 A conservative assumption is used that all non-national workers would be contributing at minimum wage salary level.

Even when legal coverage is granted, effective access is not automatic and there are concerns of discrimination at the point of service. Workers highlighted that in their experience, even when they showed a work permit, they had to pay before accessing services that should be covered under NSSF's scheme. Stakeholders mentioned the need to be covered for screening services, as well as doctor visits, tests, and dispensary services, highlighting their main needs are for primary health care coverage.

On this issue, the following points should be considered:

Collecting contributions while preventing access to benefits is not in line with the principles of fairness and equity: "*where non-nationals, including migrant workers, have contributed to a social security scheme, they should be able to benefit from that contribution or receive their contribution if they leave the country*" (UN Committee on Economic, Social and Cultural Rights, 'General Comment No 19 "The Right to Social Security" E/C.12/GC/19, 2008). From the perspective of ILO standards, member States can apply a reciprocity clause for the application of social security to migrant workers under certain conditions. Namely: i) migrant workers cannot be liable to pay contributions if they cannot avail themselves of the benefits; and ii) this reciprocity clause cannot apply to refugees who by definition cannot avail themselves of the protection of their country of origin.

The reciprocity clause was created as part of ILO instruments with a view to guarantee the portability of benefits across countries, an essential feature for long-term benefits (such as old age or disability pensions). The principle of equality of treatment should be applied more flexibly in the case of short term benefits, considering differences in health financing regimes around the world, and differentiating short term health care from long-term health costs. It is important to note that the Social Security Law does not require the existence of a bilateral social security agreement in order for the principle of equality of treatment to be demonstrated.

Pragmatically, it does not make sense to exclude migrant workers from social security coverage from a risk pooling and health financing perspective, especially when it comes to short-term benefits such as health care, sickness or maternity. From a public health perspective, it creates further risks to exclude people from accessing the health system without hardship on the basis of migration status. From a financing perspective, the cost of providing health care for migrant workers is effectively shifted from the NSSF - who collects revenue for this purpose - to other stakeholders who have an implicit responsibility to provide care: international agencies such as UNRWA and UNHCR, the health systems in countries of origin, and ultimately workers themselves through higher out-of-pocket expenditure. From a labour market perspectives national and non-national workers should be subject to the same social security contribution rates, so to avoid incentives for employers to hire workers that come with lower total wage cost.

Overall the exclusion of workers from NSSF on the basis of migration status is a barrier to extending coverage, including to a population with contributory capacities. In agriculture, construction and tourism mentioned above, a sizeable share of the workforce is also composed of migrants and their exclusion may be an important barrier to extending coverage meaningfully to those sectors. Groups such as domestic migrant workers have formal labour contracts and the contributions that their employers could make to the NSSF are made to private insurance companies instead. Lastly, refugees under the protection of UNHCR are also not covered under NSSF, which is a missed opportunity to reinforce pooling and raise more public resources for health (see section below).

5.8.2. Refugees under UNHCR and UNRWA protection mandate

Access to health care, including prenatal and postnatal care, is the first guarantee of social protection floors for all. ILO instruments such as the Equality of Treatment (Social Security) Convention, 1962 (No. 118) and the Employment and Decent Work for Peace and Resilience Recommendation, 2017 (No. 205) acknowledge the importance of ensuring that displaced persons and refugees are covered by social protection mechanisms.

Refugees who are registered with UNHCR and UNRWA benefit from the two organizations' respective coverage arrangements that are separate from any public social health protection

scheme. In line with their humanitarian mandate and in view of the fact that no public institution was ready to integrate refugees in their scheme, UNHCR and UNRWA provide refugees under its care with:

- Primary care either through direct provision or by subsidizing health services and medication, including vaccinations, at primary health care centers, hospitals and mobile health services.[21]
- Coverage of the cost of life-saving and emergency interventions, and
- Reimbursement of secondary and tertiary care.

UNHCR provides refugees with subsidized health services and medication, including vaccinations, at primary health care centres, hospitals and mobile health services. In 2018, covered 78,000 PHC consultations and 79,000 secondary and tertiary health care interventions. Almost four out of five (78%) were referrals of female patients and 60% of these referrals were for reproductive and maternal health, reflecting the high proportion of obstetric care. Although the system offers primary and emergency care, refugees with conditions requiring long term, specialized and high cost treatment -such as cancers, chronic hematological, endocrine, immunological and neurological conditions- are not covered. Very few other actors assist refugees with such conditions. Some specialized procedures are carried out at out-patient level, but non-urgent health conditions are generally not covered.

UNRWA operates 28 primary health care facilities, providing nearly 931,000 general consultations and over 23,000 dental screening consultations each year to more than half the Palestinian refugees in the country. All Palestinian refugees are eligible to access UNRWA primary health-care services. UNRWA has formed an arrangement with Palestine Red Crescent Society hospitals to guarantee equity for Palestine refugees in access to secondary health care. In all other fields, a referral and reimbursement scheme is in place for secondary and tertiary care (UNRWA 2020).

Refugees reported having to forgo tests and interrupt treatment because of lack of resources. For example, an informant reported having to pay a medical test (X-ray) at hospital. Even for services supposed to be free (such as medication), availability can limit access. A 2017 UNHCR study shows limited utilization of maternal and child health for refugees, highlighting the necessity to cover for these services in priority (UNHCR 2017). Some workers reported the UNHCR registration as “useless” as numerous health services they need are not covered by UNHCR.

The UNHCR operates a parallel system that contracts a third party administrator for profit company to act as an Health Management Organisation responsible for buying secondary and tertiary care for the refugees. UNHCR contracts hospitals to provide health services and favours public hospitals where possible. Due to the health system which relies heavily on private hospitals for service provisions, substantial international aid money is flowing to private hospitals and to the third party administrator instead of the national public system. While this can be seen as a lost opportunity - both regarding dependable contributions for a large population group as well as system strengthening efforts that do not always benefit the public system - , there are also positive indications that innovations in health financing and management that are tested in the context of the refugee response can be transferred to government systems.

Some countries, as Iran or Rwanda, have decided to integrate refugees into their national social health insurance schemes. Initially, cost were shared with UNHCR, but progressively countries increased their own contribution. The integration was done with a view to reinforce their system through improved revenue collection, pooling and bargaining power with providers. At the same time, integration ensured greater equity in access to health care without hardship (See more in Box 3 further below).

21 Child and maternal health, sexual and reproductive health, care for non-communicable diseases and mental health services

6. Key considerations for achieving UHC in Lebanon and the role of NSSF in extending coverage

6.1. Perspectives on UHC in Lebanon[22]

Despite some differences in opinion and priorities between stakeholders, the assessment found a large degree of consensus amongst individuals and organizations about the main challenges facing the health system. These are centred around the inefficiencies and inequities associated with the fragmented health financing system which is skewing expenditure towards costly hospital care and not providing adequate coverage for a large proportion of the population. Pursuing UHC is a primary policy objective.

There is no one agreed path or formula to achieving UHC. Strategies for implementing UHC reforms will depend on specific country contexts, existing health system arrangements, the fiscal capacity of the country and public values (Carrin, et al 2008) Local decisions have to be made on key aspects such as coverage, benefit package, financing mechanisms and administration. This section of the report does not intend to prescribe one particular strategy for achieving UHC in Lebanon, but rather makes proposals related to coverage, benefit package and financing mechanisms, based on the review of the current health system context in the country.

6.1.1. Population coverage

The first priority of health system reforms in Lebanon should be to ensure that the entire population is covered by a cost-effective package of services with consumption of services allocated according to people's health needs – not their willingness or ability to pay. This would require an initial focus on providing a package of PHC benefits to *all* residents who are currently not insured, not only the poorest or otherwise most vulnerable among this group. This equitable approach to reach full population coverage was advocated by the 2013 Lancet Commission "Investing in Health" in which they named it: progressive universalism (Jamison et al 2013 and Kutzin 2012).

The strategy should entail moving rapidly to full population coverage with universal entitlements, as opposed to creating separate insurance schemes with complicated means testing arrangements. This package of universal services could be provided through the MoPH public facilities and contracted private facilities. The expansion of those entitled to a package of PHC benefits must be accompanied by a campaign to monitor and advertise the quality of PHC provided in public and MoPH-contracted facilities, to ensure increased coverage results in increased utilization of these services (Nicholson et al 2015). To ensure fair use of covered health services, this scheme should only be available to individuals residing in Lebanon and not to the roughly four million Lebanese living abroad. Dependents of Lebanese working abroad should still have access to the services. Registration and personalized health cards are one possible strategy for monitoring use.

6.1.2. Benefit package

The WHO offers guidance on benefits that should be provided in a comprehensive PHC benefit package. According to the Alma Ata Declaration on PHC, this benefit package should include at minimum: "education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases, prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs". However, the specific package of PHC benefits should be tailored to health priorities in Lebanon. The WHO benefit package

22 This section draws extensively on an unpublished ILO report "Developing a roadmap to Universal Health Coverage in Lebanon" prepared by Adriana Murphey and Robert Yates under the supervision of Ursula Kulke

resembles the package currently provided to a targeted population under the WB-MoPH project described above, but the key consideration should be that the package of benefits should be made available to *all* non-insured Lebanese. Given the increasing burden of non-communicable diseases such as cardiovascular disease and cancer in Lebanon, and the high level of expenditure on treatment of these diseases in secondary and tertiary facilities (Yassoub et al 2014 and Ammar 2009b), the PHC package should emphasize cost-effective primary prevention interventions that have been shown to reduce the risk of more costly acute events, such as management of cardiovascular risk factors such as high blood pressure and cholesterol (WHO 2013 and Gaziano et al 2006).

6.1.3. Financing

Health financing reforms are of critical importance to achieving UHC as achieving UHC requires creating a health financing system whereby wealthy and relatively healthy members of society cross-subsidize services for the sick and the poor (WHO 2010 and Savedoff 2012). As a system dependent on private voluntary financing mechanisms (user fees and voluntary insurance) cannot deliver this outcome, it is necessary for governments to step in and replace private health financing with compulsory public mechanisms. The sources of these funds tend to be from general taxation and from compulsory social health insurance contributions and most countries, including Lebanon, are using a mixture of these mechanisms.

The priority in Lebanon should be to formulate and implement a national health financing strategy with a view to reaching UHC. This should be based predominantly on scaling up funding from public sources, whilst acknowledging that private financing (including private insurance) will continue to play a complementary role in providing additional coverage for the better off. The right to access to health care without hardship is one of the four guarantees of a national social protection floor and it is an important contribution in reaching UHC. This issue needs to be tackled and agreed upon at national level as it requires to be supported by the Government budget.

As Lebanon is already raising a large proportion (15%) of its THE through NSSF contributions, one potential strategy to increase funding from public sources may be to expand membership of the NSSF and increase contribution. Any increases in contributions should be linked to improved services and/or the removal of co-payments for some services, for example PHC services, in order to ensure popular support. However, if the objective is to reach full population coverage of a comprehensive package of services (focusing on PHC) then it is unlikely that NSSF members will be willing or able to raise the additional funds required to cover the 50% of the population who are not members of existing insurance schemes. It will therefore be necessary to increase levels of tax financing to cover the entire informal sector, recognizing that it will be extremely difficult as well as expensive to collect regular insurance contributions from people not in formal and full employment.

In order to maximize efficiency (by reducing administration costs) and increase the scope for cross-subsidies to the poor and vulnerable, it would be preferable for social health insurance funds in the NSSF and MoPH funding (from general taxation) to be combined in one single-payer pool. This could either be within the NSSF or the MoPH or perhaps a new third-party purchasing body created by merging elements of these two institutions. One example of such merging is the case of South Africa where the planned National Health Insurance programme intends to combine tax financing and social health insurance contributions in this way (Republic of South Africa Department of Health 2015). The institution chosen to manage this pool of resources should take on a strategic purchasing role in order to improve both the allocation and technical efficiency of public health financing. This could include revising provider payment mechanisms, for example funding primary care providers (in both the public and private sector) through capitation payments rather than a fee-for-service basis.

6.1.4. Other factors to consider

The above outlines some potential strategies for working toward UHC in Lebanon. Decisions about how to implement UHC must be informed by a consideration of other important context-specific questions.

Among these is whether or not the necessary political will and stewardship exist to implement radical reforms. This question is of particular relevance to Lebanon due to political stalemate, and which, in addition to the refugee crisis, is experiencing an economic recession. Implementation of UHC will require a political champion who believes in the fundamental right to good health and health care access, has a long-term view of the impact that UHC reforms will have on health care expenditure, utilization and outcomes, is able to recognize and co-operate with diverse political interests and secure support for wide-ranging reforms.

Also important to consider in tailoring implementation of UHC reforms are the norms and values of a society, and in particular, the degree to which solidarity is valued. To establish an effective system of financial protection from catastrophic health expenditures, some degree of risk pooling from cross-subsidization (i.e. from rich to poor or low-health risk to high- health risk) is required (Carrin 2008). The degree of cross-subsidization required in Lebanon is likely to be high, given the degree of income inequality in the country, and public support for such an arrangement will depend on the value placed on equality and solidarity.

6.2. How to extend coverage of the NSSF health insurance scheme?

The below sections look more specifically at the key prospective features for extending the health care scheme of the NSSF.

6.2.1. Scope of population coverage

Legal coverage: From the perspective of the legal feasibility of coverage extension, the Social Security Law provides sufficient flexibility to extend the personal scope of legal coverage to other categories of workers as Article 9 of the Lebanese Social Security Law does permit the Government to extend social security to any group it feels is necessary to benefit. Therefore simply issuing decrees would enable de-jure extension to groups that are currently excluded.

Defining the scope of coverage by sectors of activity through a positive list usually leaves an entry door for omissions and gaps in population coverage. The NSSF has adopted a number of sector specific regimes (See detail in Annex 5), this however has led to a high degree of fragmentation. The proliferation of different mechanisms and modalities of coverage increases confusion on rights and obligations for workers and employers. It also adds to the complexity of management and administration of different schemes (some for very small groups) and increases transactional costs for the NSSF. Mechanisms of internal cross-subsidization across these multiple sub-populations and schemes are also not transparent.

From the perspective of the NSSF, it is questionable whether the extension should continue to be sector based approach and it would be preferable to proceed with integration of uncovered groups based on type of employment status, adopting same regimes of coverage to workers that have same forms of labour market engagement (e.g. temporary, part time, casual, self-employed, etc.) across different sectors.

Nature of enrolment (voluntary/mandatory): international experience shows that mandatory registration is the most effective way to extend coverage. The implementation can be progressive, but voluntary schemes should be avoided in view of both the need to provide SHP as a right for all and the risk of adverse selection threatening the financial viability of the scheme. In this context it is important to note that in many countries mutual funds or Community Based Health Insurance (CBHI) schemes that were of a voluntary nature and not supported by the Government have not been able to reach scale and avoid adverse selection, due to their voluntary nature, the limited size of their risk pool, and often the limited benefits deriving from it (Alkenbrack, Jacobs, and Lindelow 2013).

Mandatory enrolment can be progressively implemented even in countries with very high informal employment. For example, in Rwanda, the government decided to implement a social health protection scheme directed at the informal economy whereby people needed to register either on a contributory or non-contributory basis depending on their means to contribute (see Box 3). At first enrolment agents at community level facilitated the process. Progressively health facilities

started requiring registration (facilitating it at the point of service when people would come to seek care). And after the scheme had spread widely the national social health protection card started to be a requirement for a number of administrative formalities (i.e. for all schooled children, for driving licenses, etc.).

Coverage of non-national workers: it can be anticipated that the current exclusion of migrant workers from the scope of coverage will be an important barrier to the extension of coverage. As mentioned in Section 5.7.1 above, in the current system, migrants, including workers, refugees under UNHCR protection mandate, are either included if they are in formal employment (paying contributions) but denied benefits or they are simply excluded. Such exclusion can contribute to creating a public health risk or result in a diversion of funds from public revenues for health into the private sector, where alternative means of coverage are sought. Allowing contributing members to benefit from short term health benefits even in the absence of a bilateral social security agreement and channelling financing for humanitarian aid for health care for refugees through national systems would ensure that contributions are covered according to ability to pay, benefits are accessed without unfair discrimination, public health risks are reduced and national systems are strengthened.

Many countries around the world are extending health care for non-nationals. In Thailand, for example, the growing cost of subsidizing migrant workers' health care, through exemption of user fees on a humanitarian basis, prompted the government to initiate a health insurance scheme for migrant workers. Now, Thai nationals and migrants who contribute to the social security system have equal rights of access to social security benefits, including health services (Sumriddetchkajorn et al 2019). See also the case of Extending social health protection to refugees in Rwanda (Box 3).

Box 3: The example of Rwanda: Extending social health protection to refugees

The national social health protection system in Rwanda comprises several schemes addressing different professional and socioeconomic groups. In 2017, the Rwandan Government pledged to integrate refugees gradually into the national social health protection system, namely the community based health insurance (CBHI), which is a public social security scheme administered by the Rwandan Social Security Board (RSSB). A technical feasibility study was conducted by the ILO and UNHCR the following year. The enrolment of urban refugees began in September 2019 along with the issuance of identity cards by the Rwandan Government. The feasibility study effectively revealed close links between legal protection measures for refugees, such as access to identification documents in the host country, and administrative barriers to accessing social protection and care.

Just over 6,200 refugees are covered by CBHI by the end of 2018. The short-term goal is to enrol the 12,000 refugees living in urban areas into the CBHI, with this coverage to be extended to those living in camps at a later stage if feasible. Any adaptations are discussed in the context of a memorandum of understanding between the ministry responsible for refugees, CBHI and UNHCR, with the aim of ensuring that refugees can access conditions similar to those enjoyed by host communities. In particular, this will require a contribution categorization system and registration and membership renewal process for refugees that is similar to the one available to Rwandan households operating in the informal economy. It is envisaged that progressively the cost of health coverage will be shared between refugees and UNHCR depending on refugees' capacity to contribute.

Source: ILO & UNHCR 2020

6.2.2. Benefit package and benefit level (co-payments)

The benefit package should be comprehensive rather than focused on particular risks. In the context of the NSSF, the focus on prevention and PHC, as well as strong gate-keeping, are recommended. This is valid for the extension of coverage but also in the context of the current population covered by NSSF.

In line with the principle of equity of access and in order to ease scheme management, it is not recommended to create a distinct benefit package specifically for extending to new groups. In many countries where this was done, it then required additional work to eventually merge the packages. Thailand, for example, has recently condensed its multiple schemes into three and aligned their benefit packages. This has led to better value for money from providers and increased the services that the population can access under (see Box 4).

The network of health care service providers contracted to deliver the benefit package should guarantee effective access to quality services. In particular, as primary care seems to be a specific need in Lebanon, the NSSF might want to investigate how PHCs could be part of a potential NSSF network. This is an element to be considered in the specific case of the extension of coverage to uncovered groups but also more generally. When considering extending to agricultural workers, it would be important to assess geographical accessibility of contracted facilities as well as transport costs in the case of referral.

Box 4: The example of Thailand: alignment of benefit packages

Before the UHC law in 2002, Thailand's health coverage was a patchwork of arrangements for different population groups, which missed a large share of the population working in the informal economy.

The government's attempt to merge all the schemes was met with resistance from beneficiaries who feared a reduction of their entitlements. Moreover, the formal sector opposed merging with the civil servant scheme, which has run a deficit and faces high costs per capita due to their lack of strategic purchasing methods. A compromise, once reached, resulted in the national health insurance being overseen by three different schemes: (i) the civil servants' medical benefit scheme under the finance ministry, covering 5.7 million people; (ii) the social security scheme (SSS) under the labour ministry, covering 12.3 million people; and (iii) the universal coverage scheme (UCS) under the public health ministry, covering 47.8 million people. Thailand's financing for UHC is predominantly non-contributory, financed by general government taxation.

Every Thai citizen is now entitled to essential health services at all life stages. The UCS has increased access to health services and reduced the incidence of catastrophic health expenditures. The benefit packages between the three schemes have been aligned. Especially the SSS and UCS have progressively aligned both their benefit packages and purchasing practices, which has facilitated the SSS to get better value for money from providers. This has also increased services that the population can access under both schemes.

Source : Sumriddetchkajorn et al. 2019

It is not recommended to use additional co-payments in the context of the extension of coverage. Co-payments should be considered only to a level avoiding hardship and behaviors that would prevent accessing care, and not for maternity care. This is rooted in the idea that co-payments should only be used as a means of avoiding over-consumption induced by the beneficiary if there is indication that it can be a concern. In this sense, ILO standards do not view co-payments as a financing tool for health care but rather a mechanism to control cost escalation and moral hazard, if needed. It is widely recognized that copayments, even when set at a very low level, can act as a deterrent of health care access. Considering the needs of uncovered workers at the moment, it seems that the implementation of a strong third-party payment mechanism, including at primary care level where it is currently missing, would be key. South Korea provides an interesting example (see Box 5).

Box 5: Country example of South Korea: Decreasing co-payments

The National Health Insurance Service (NHIS) was first established in 2000. Prior to this there were several social health insurance schemes later merged into a single national health insurer, the NHIS. The NHIS now covers roughly 97% of the population with a comprehensive service package. The system sets out co-payments according to the type of health care institution, with higher co-payments for more specialized facilities.

In 2004, the Korean government started gradually decreasing co-payments for catastrophic illnesses covered by the NHIS. Protection mechanisms, such as ceilings on OOP payments and reduced cost sharing for the poorest, chronic conditions and children under 6, were implemented by the NHIS to protect its beneficiaries from the financial burden of seeking health care. In case of communicable diseases, co-payments are covered by government budget to remove barriers to diagnosis and treatment.

Source: ILO 2020

Looking beyond the health care scheme, it is important to note that the absence of a sickness cash benefit, occupational injury and maternity cash benefit are important gaps in the current NSSF system. While these benefits are under the labour law in the form of an employer liability, they are not financed based of a national social insurance system, which creates challenges with regards

to coverage, enforcement and limited solidarity in financing. Such short-term benefits are not only indispensable to prevent workers going to work when sick or in recovery after child birth, but they are also highly attractive benefits within processes of extension of coverage. Their introduction/activation should be considered within the plans for extending coverage.

6.2.3. Pooling and Financing

The first step for NSSF would be to consider whether creating a separate risk pool in the context of the extension of coverage is pertinent. As mentioned above, Lebanon already has a very fragmented social health protection system, with many different risk pools managed separately and sometimes overlapping while leaving a large share of the population uncovered or not adequately covered. In this context. This discussion relates or echoes the broader discussion that should take place at national level on reducing fragmentation (see section 6.1). In this perspective, the following elements can be laid out:

- **NSSF could envisage to first** start the extension on a contributory basis for groups who have contributory capacity **and can be identified as relatively easy to reach. This way, risk pooling will be facilitated with the current pool of beneficiaries.**
- **In any case, even if there are various risk pools for different type of population groups in the country, it is possible and advisable to** create cross-financing mechanisms ensuring solidarity in financing**.**

The legal framework pf the NSSF foresees the extension of coverage on a contributory basis, but it does not address the issue of coverage for those without a contributory capacity who cannot be covered as dependents. In any society, there are always persons who, at one point or another of their lives, are not in a position to contribute. Hence, it is crucial that at national level the right to social health protection coverage be considered in a comprehensive manner and that the legal framework foresee protection for all, including those who cannot contribute in the context of a national approach to (see section 6.1). NSSF can consider in a first instance extending its coverage on a contributory basis while partaking in the wider discussion at national level on the extension of coverage on a non or partially contributory basis, which will be essential to effectively reach universality.

Extending coverage to the informal economy, and more specifically the self-employed, will require either subsidization through Government budget or cross-subsidization from high-income earners. This is unsurprising as self-employed do not have an employer who can share the burden of contribution with them. The current approach to mandatory or voluntary coverage of certain categories of self-employed workers within NSSF are based on an implicit cross-subsidization model, as contribution rates for these workers are lower and the benefit package is the same. However the financial implications of this approach on the sustainability of the scheme are not clear and there are limits to the extent of cross-subsidization that can be achieved within the NSSF system without injection of resources from the general budget. This will require a combination of financing sources between social security contributions and government budget, ideally within a unified risk pool (see section 6.1).

International experience shows that over time governments tend to create single national health insurance institutions and single risk pools in order to rationalize administrative costs, improve purchasing strategies, and improve equity and solidarity. Several countries have taken this path, some of them from the initial stages of coverage extension (i.e. South Korea, France, Costa Rica) and others more recently by merging various existing schemes and mechanisms (i.e. the Philippines, Indonesia, Mexico) (see Box 6 and Box 7).

Box 6: The example of the Philippines: one pool with various entry points

The Philippines have gradually expanded coverage of social health insurance beyond workers in the formal economy to workers in the informal economy through a rights-based approach. Several reforms have been implemented to increase coverage of Filipino citizens, reaching a population coverage of 92% in 2017. The expansion was aided by sin taxes earmarked for health. A large share of workers in the informal economy - more than 25 million and 19% of PhilHealth members and their dependents - are covered by PhilHealth. PhilHealth collects contributions and other revenue transfers from government budget, pools risks, determines the services in the benefit package, accredits health providers, ascertains the cost of services, negotiates prices, and pays providers.

Members of the informal economy are divided into voluntary contributors based on salary and sponsored members from the lower income segment of the informal economy. Contributions to the informal economy category are based on annual income and can range from USD 47 to USD 70 per annum based on proved income. Individually paying members they may be paid monthly, quarterly, or semi-annually at any accredited collecting partner of the PhilHealth including banks. The high share of workers in the informal sector covered by PhilHealth arguably comes from a combination of clear and simplified membership categories, an aligned benefit package, exigence at the point of service, adapted/subsidized contribution rates, flexible contribution payment schedules and innovative, user-friendly technologies for payment of contributions.

Source: ILO (2020)

The level of contributions is generally difficult to determine for informal economy workers, as there is limited information on revenues and their declaration can be easily over or under estimated (see Box 7). For the self-employed in particular, high contributions would constitute a financial barrier to enrolment while on the contrary low contributions could lead to the reduction of the benefit package and/or limited financial viability of the scheme.

- For informal economy workers such as the self-employed for whom it is difficult to have accurate information on revenues, the establishment of a flat amount of contribution was adopted by a number of countries. This method loses the progressivity aspect of social contributions, which means that it is often accompanied by a subsidy or part of a tiered contribution system.
- Tiered contribution systems are supposedly more equitable but they require important transaction costs as it requires data on status and/or income of the enrolees.

For certain categories of workers (e.g. casual), the base of contribution may have to be calculated in a different way than in relation to monthly/hourly wage, given the difficulty in recording accurate wage information for high turnover short-term contractual workers. Already for certain populations (e.g. bakers, port workers) the NSSF utilizes a measure of volume of production as a basis to calculate contribution levels. In a proposal for extension of coverage advanced by agriculture worker it is envisaged that contribution levels could be determined on the basis of the size of productive land.

Box 7: The example of Indonesia: Contributions by different population groups

Indonesia has committed to achieving universal health coverage by 2019 through a coordinated approach of contributory and non-contributory schemes. Indonesia's national health insurance scheme Jaminan Kesehatan Nasional (JKN) was launched in January 2014 by consolidating previously fragmented health insurance schemes and assistance programs at national and provincial levels. An important factor in the launch of the integration national scheme was the pressure to integrate vertical programmes such as HIV/AIDS in a broader approach to financing the health system. JKN is funded predominantly by member contributions but the government also fully subsidizes contributions for the poorest 40% of the population through the health insurance subsidy system. Contributions for workers in the informal economy are based on a defined regional minimum wage. As the minimum wage is often higher than actual monthly income, particularly for rural economy workers, informal worker's contribution rates are very high (6.3% for an individual and 9.3% for a family for full social protection coverage), calling for subsidization to be sustained.

In May 2019, JKN covered 83% of the population and is offering one single benefit package. The government started membership expansion with integrating all previous schemes into the new JKN. As a next step, after 2014, the government expanded membership among formal workers from large, medium and small corporations as well as self-paid workers. The second phase also expanded coverage to foreigners working for a period of at least six months in Indonesia.

Source: ILO (2020) and ILO (2008)

6.2.4. Administrative systems for extension of coverage

Extending coverage to new population groups usually requires reliable and adapted administration of social security benefits. Two important components to be thought through: i) ensure trust and participation in the system, including ensuring high quality of service and ii) adapting administrative procedures and outreach to ensure accessibility of the scheme. In this respect, administrative simplification as well as the use of new outreach strategies are being used in a number of countries. In Indonesia, for example, an innovative mobile application helped people access services and also significantly reduced the administrator's workload and in-person visitors at the administrative branches (see Box 8).

Modalities and periodicity of contribution collection may have to be adjusted depending on the revenue patterns of the groups to be covered. Due to a high degree of uncertainty in income and irregular earnings, many countries have adapted their schemes to the pattern of self-employment in particular (Vilcu et al. 2016), through the collection of yearly contributions on harvest for example in the case of agriculture. A detailed analysis of the revenue pattern and channels (i.e. banking, other...) in place within the population to be covered is needed to inform the adjustment process.

Administrative reforms also need to focus on improvement of compliance systems. Extension of coverage to informal workers within formal companies requires improvement of compliance, inspection and law enforcement mechanism, similarly to when extension is done through the formalization of sectors based on wage labour, compared to self-employment.

Box 8: The example of Indonesia: Mobile application to expand coverage

Jaminan Kesehatan Nasional (JKN) is covering over 80% of the population in Indonesia, making it the biggest single-payer social health insurance system in the world. In an effort to further expand membership and improve services, the National Health Insurance Administrator launched Mobile JKN, a mobile application that allows people to register, view billing information, pay monthly contributions, select or change the primary healthcare provider, set appointments with healthcare providers, and file complaints, all from their cellular devices. The application was especially designed to expand coverage to the non-poor informal sector.

In a vast country like Indonesia, an innovative mobile application has not only helped people to access services, but also significantly reduced the administrator's workload and in-person visitors at the administrative branches. The administrator's collaboration with local governments and service providers is essential for improving outreach and usability of Mobile JKN. For this, clear guidelines, sound monitoring and data protection measures are required.

Source: ILO (2020)

7. Key Findings and Recommendations

The primary focus on the report is to support strategic decision making by NSSF on the extension of coverage of its health insurance scheme, including to workers in the informal economy. In doing so the report necessarily touches on three closely related issues:

- It discusses the relationship between NSSF and other financial health protection mechanisms in ensuring UHC in Lebanon;
- It identifies priorities for strengthening and improvement of the health insurance model run by the NSSF, including for the currently ensured.
- It assesses options for better access of non-national workers including refugees, to financial health protection through the NSSF and the health system in general.

Key findings and recommendations are therefore structured along these 4 areas.

7.1. Key findings and recommendations in regards the national health financing system and strategies to achieve Universal Health Coverage

Key findings

- A large proportion of the Lebanese population lack effective health coverage, which makes Lebanon an outlier for a middle-income country.
- Current health expenditure at 8.2% of GDP is relatively high – so an overall lack of health financing is not the main problem.
- There is not a shortage of capacity in the health system and if anything there would appear to be an over-supply of doctors, especially specialists, and medical equipment. Geographical access to services is also not a major problem in Lebanon.
- However Lebanon's lack of progress towards UHC reflects an imbalance between public compulsory financing and private out-of-pocket financing, which at 32.7% is high for a middle-income country. The bulk of OOP payments are being made for ambulatory care – especially medicines.
- There is also a clear imbalance between hospital services and primary care with far too much healthcare activity and expenditure taking place in the former relative to the latter and absence of referral system. This was even acknowledged by owners of private hospitals.
- The health financing system is extremely fragmented involving at least 4 public health insurance systems and numerous private schemes. This is inefficient due to high administration costs and lack of purchasing power and inequitable as it inhibits cross-subsidization of poor and vulnerable groups in society.
- Despite some differences in opinion and priorities between a few stakeholders, it was encouraging to see overall that there was a large degree of consensus amongst individuals and organisations interviewed about the main challenges facing the health system. This centred around the inefficiencies and inequities associated with the fragmented health financing system which is skewing expenditure towards costly hospital care and not providing adequate coverage for a large proportion of the population.

Recommendations

Formulate a comprehensive social protection strategic framework inclusive of social health protection. The policy should articulate health care and cash benefits in case of sickness or maternity, contributory and non-contributory enrolment of beneficiaries as well as coordinated measures for formalization of the informal economy. This strategy needs to define rights-based entitlements promoting equity, solidarity in financing, and universal population coverage.

Formulate a comprehensive policy framework for health financing guaranteeing social health protection to all. Coordinated action among the different actors who currently finance health and provide social health protection entitlements is needed to move further towards UHC. This means aiming towards mandatory, universal coverage, a comprehensive benefit package and complimentary

contributions from workers and employers based on the ability to pay as well as tax-financed contributions. This discussion should go hand in hand with a dialogue on concrete ways to reduce the current fragmentation of the system and especially of the purchasing function which damages schemes' ability to negotiate with providers.

Reduce fragmentation at all levels. The system is currently facing inefficiencies due to fragmented stewardship of different ministries and institutions regulating health expenditures as well as a corollary fragmentation of institutions in charge of implementing social health protection schemes (pooling and purchasing). The overlapping mandates of the institutions hinder effective decision-making and are reflected in the numerous social health protection pools covering different population groups, while leaving a large share of the population uncovered. In this framework a double path needs to be followed:

1. **Strengthen NSSF as the institution with the legal mandate to provide social health protection to the population,** through the gradual integration of smaller schemes and risk pools.
2. **Foster a national consensus on how to cover in an equitable way the population with no or little contributory capacity on a similar basis as the coverage offered by the NSSF** rather than only an "insurer of last resort" mechanism as currently implemented by MOPH due to the important coverage gaps of NSSF. In this perspective, the country would need to decide how to coordinate those two main purchaser and ensure progressively a single risk pooling mechanism, any important element to foster equity and solidarity in a country with a relatively small population and high heath supply.

As Lebanon is already raising a large proportion (15%) of its THE through NSSF contributions, one potential strategy to increase funding from public sources may be to expand membership of the NSSF and increase contribution rates (see below). However, if the objective is to reach full population coverage of a comprehensive package of services (focusing on PHC) then it is unlikely that NSSF members will be willing or able to raise the additional funds required to cover the 50% of the population who are not members of existing insurance schemes*. It will therefore be necessary to increase levels of tax financing to cover all of the informal sector recognizing that it will be extremely difficult (and expensive) to collect regular insurance contributions from people not in full time employment.*

In order to maximize efficiency (by reducing administration costs) and increase the scope for cross-subsidies to the poor and vulnerable, it would be preferable for social health insurance funds in the NSSF and MoPH funding (from general taxation) to be combined in one single-payer pool. This could either be within the NSSF or the MoPH or perhaps a new third-party purchasing body created by merging elements of these two institutions. The institution chosen to manage this pool of resources should take on a strategic purchasing role in order to improve both the allocation and technical efficiency of public health financing.

Move towards strategic health financing mechanisms with a focus on PHC. Progressively align purchasing methods, at least among public purchasers, moving away from passive fee-for-service mechanisms for secondary and tertiary care and including a strong primary care component which should play the role of gate keeper. In this perspective, it will be crucial to reinforce the regulatory power of the MOPH. Tariff unification and pooled procurement of medicines should be considered. Apart from purchasing mechanisms, cost-containment in the health system could be improved by strengthening primary care and introducing incentives or obligations for patients to seek treatment in lower level facilities. A gate-keeping role for primary care should be considered and referral mechanisms need to be strengthened. In this perspective, the main public purchasers (especially NSSF, MOPH and to some extent UNHCR) could learn a lot from each other and share good practices in order to reinforce their negotiation power and purchasing techniques. This should be high in the priorities of all institutions managing health schemes.

7.2. Key findings and recommendations in regards to improving NSSF health scheme design and operations

Key findings

- NSSF's decision-making is hampered by its institutional and governance structure. NSSF's central administration and local branches' capacity is stretched.
- There is no strategic management of the providers' network, the payment mechanisms are highly inefficient and there are insufficient cost-saving measures.
- Financial management is weak and both funding and services are skewed towards costly hospital care, and not providing adequate coverage and primary care for a large proportion of the population. There is no referral mechanism to play a gate-keeping role and prevent inappropriate or overutilization of services.
- Registration and contribution collection is slow since they are paper-based and caseloads are unevenly distributed across branches.
- Pre-approval procedures are heavy, tasks for the coverage of inpatient services and administrative capacities across public schemes are duplicated at hospital level, and beneficiaries struggle with lengthy processes to claim and obtain reimbursement.
- As a result, employers' organizations seek supplementary private insurance for their senior staff to top up the health care coverage of NSSF.

Recommendations

At NSSF level, a two-pronged strategy should be purposed aiming at improving scheme operations and on extending coverage (see 7.3). Both objectives are interlinked given that extending coverage without improving current scheme operations is unlikely to be feasible. The two objectives should be pursued in parallel.

The benefit package of NSSF health scheme needs to be re-balanced towards primary care and generic drugs. A general reorganization of the system from curative to preventive, primary care should be envisaged. Covering primary care in dedicated facilities located near the covered population is crucial as the current design of the benefit package induces a bias towards secondary and tertiary care, which is both cost ineffective and not aligned with everyday health needs of the covered population. At the moment, the NSSF benefit package is very broad and does not allow for earmarking of essential or cost-effective services. Including generic drugs in the benefit package needs to be considered to contain costs further.

NSSF should move towards strategic and active purchasing methods. A stronger focus on primary care translates into contracting a wider network of providers, payment on a capitation basis, the implementation of third party paying mechanisms and the enforcement of a referral system. Such a system has proven highly cost-effective in countries where a shift was operated between primary and higher levels of care (with typically much higher costs). Similarly, case-based payment for secondary and tertiary care needs to be explored and piloted. In this process, learning from other public purchasers in Lebanon and aligning purchasing policies should be explored.

The current administrative reforms needs to be urgently scaled-up and rolled out. At the moment, capacities at all levels seem to be overstretched, which would make an extension to a greater volume of beneficiaries difficult to process. Simplifying processes could reduce some burden on the already stretched capacities. This is especially true when it comes to claim management and reimbursements. Automation of medical claims as well as digitalization on both NSSF and hospital level could improve the claim processes. Further, the exclusion of dispensaries from the provider network is leading to difficult processes for beneficiaries to obtain reimbursement of the medication they buy, including control processes whereby patients have to bring empty medication boxes to their NSSF branch. Integrating dispensaries as part of the provider network could alleviate burden on claims processes. In order to build up administrative management capacities, critical positions that are currently vacant should be filled and capacity development measures should be introduced. Further improvement could come from collaboration with other public purchasers.

As a pre-requisite to any significant improvement in the operations of the health insurance scheme, a reform of NSSF governance structure and processes should be pursued as lack of decision-making at the highest level has prevented NSSF from implementing necessary reforms. Focus on a leaner board with expert participation and improving transparency in sharing of financial information and reports are amongst the key priorities.

In order to improve the financial management of the scheme, it will also be important to set up a unit dedicated to economic and actuarial analysis and for the NSSF to adopt monitoring and modelling tools to anticipate, analyse and adjust the impact of reforms. Such capacity would allow the NSSF to further anticipate not only parametric reforms to the scheme but also the impact of integrating new population groups into the scheme.

7.3. Key findings and recommendations in regards to extending coverage of the NSSF health scheme

Key findings

- Health coverage in Lebanon is patchy as a result of multiplicity and fragmentation of schemes, insufficient legal framework for coverage and poor compliance with existing legal provisions.
- Currently, the NSSF has 696,992 enrolees in the health care scheme covering for 848,761 additional dependent family members. Yet, most of workers are not covered by the NSSF and half the population has no health insurance coverage.
- The NSSF is a mandatory scheme for only certain categories of employees: permanent employees of the private formal sector, employees in government-owned corporations, contractual and wage earners of the public administration that do not benefit from the Civil Service Cooperative scheme, and private schools teachers.
- Temporary and seasonal workers are excluded from the scheme and coverage of part-time employees is limited.
- Self-employed workers are allowed to pay voluntarily contributions to the NSSF, but the scheme is poorly designed and most choose not to contribute.
- The NSSF has adopted a number of sector specific regimes, which have led to a further degree of fragmentation. Numerous mutual funds or Community Based Health Insurance (CBHI) schemes have not been able to reach scale and fill NSSF's coverage gaps.
- Workers in informal employment especially agriculture, construction, tourism, domestic and non-Lebanese workers, lack access to social health protection. The country does not have a strategy to expand health insurance coverage and progressively protect all people living in Lebanon.
- Defining the scope of coverage by sectors of activity through a positive list usually leaves an entry door for omissions and gaps in population coverage.
- International experience shows that mandatory progressive registration is the most effective way to extend coverage, even in countries with very high informal employment.

Recommendations

A strategic plan for extension of coverage should give concrete implementation to the original NSSF mandate to cover the entire population of Lebanon. As noted earlier, part of the feasibility for such an endeavour lies in the capacity of the Lebanon government to adopt a conscious and active strategy to reduce fragmentation as well as the subsidization of contributions for the groups of population who do not have (or not enough) contributory capacity. This means that the NSSF needs to prioritize its strategy for extension of coverage in such a direction while getting fully involved in the development of a coherent national health financing approach and strategy to achieve UHC.

The NSSF should seek to avoid a piecemeal approach that looks at specific sectors and sub-sector schemes. Instead it is recommended to establish modalities for workers to enter a single risk pool, and differentiate according to broad employment types rather than sector wherever possible. It is also recommended to determine transparent/explicit mechanism of subsidization of contribution when this is necessary.

Such a strategy could include a gradual extension of coverage of the NSSF health insurance scheme with several incremental steps, which would leave some time to improve scheme operations in parallel.

- **Step 1: Ensure coverage to all wage employees in the formal sector, regardless of contract length, contract type, sector or nationality**. This requires an explicit strategy to enhance compliance among existing companies affiliated to NSSF, introduce long overdue regulatory mechanisms for coverage of temporary and seasonal employees, improve awareness and incentives for workers and employers to register all employees, beyond permanent staff (e.g. part time workers), enhance, tailor and target inspection mechanisms to maximize impact on enforcement of social security obligation (including through data sharing with others institutions). It would also be important to look at the current affiliation of dependents into the scheme as at the moment the number of dependents registered per contributor is low in comparison to household average size in Lebanon. See next section for specific recommendations in relation to coverage for non-national employees.
- **Step 2: Extend coverage to populations groups who are currently contributing to mutual funds.** Progressively merge mutual funds into one more consolidated scheme to enhance risk pooling and efficiency. This will require an agreement with said funds to ensure that NSSF becomes the automatically primary coverage for all enrolees. Mutual funds could remain involved as implementing agents for the front office operations in exchange of a small administration fee.
- **Step 3: Extend coverage to groups that may require some adaptation of the scheme parameters and administration but still have sufficient contributory capacity or for whom contributions can be sponsored.** Those include:
  - Some categories of high-income self-employed and empolyers that are not currently covered in mutual funds, and
  - Other for whom contributions can be sponsored, for example domestic workers, for whom the employer currently contracts a private health insurance policy rather than funds being channelled into solidarity based national health financing system. A similar approach could be taken to sponsor the inclusion of refugees in national health insurance system (see next section).
- **Step 4: Extend coverage to all workers in construction and agricultural sectors regardless of the type of engagement in the sector, including casual workers.** Demand is high but subsidization may be needed. For this step a study on ability and willingness to pay, which is linked to the quality of services, and specific parametric features and administrative mechanisms needed to foster enrolment may be needed, as well as innovative modalities to determine the contribution base for casual workers.
- **Step 5: Further assess options for extension of coverage to other groups with more modest contributory capacity,** for whom substantial subsidized funding would be needed.

Steps 1, 2 and 3 can be low-hanging fruits for NSSF and require feasibility and preparatory work that can be led by the NSSF itself without requiring larger scope decisions at government level. Steps 4 and 5 need to be fully included into a wider discussion on the national policy on social health protection and the subsidization of coverage for groups who cannot contribute or not fully. As long as there is no governmental tax-based subsidization, it will be difficult for NSSF alone to cover those groups. It is important that the question of extension of health protection to all groups remains a priority, to overcome the limitations of the current dual systems where large parts of the population benefit from legal entitlements and others are by-law and de facto excluded, fostering inequity in access to care.

All steps will require consideration of good international practices highlighted previously in the report in regards to the adaptation of key scheme parameters from the perspective of type of coverage, benefit package, contribution level and base, administration, etc. In addition to extending legal provisionsfor individual coverage and the scope of benefits, this requires wide encompassing reforms at the policy administration level:

- to set appropriate **contribution levels**, taking into account specific needs and capacity to contribute and bearing in mind the principle of solidarity in financing of the social security system between workers and employers;

- to devise more **flexible and accessible means for registration** and contribution and more effective mechanism for compliance monitoring;
- to enhance **awareness and transparency** of the social security system.

See detailed recommendations and references on these matters in Section 6.2.

7.4. Key challenges and recommendations in regards to coverage of non-national workers and refugees

Key findings

- Most non-Lebanese nationals work in the informal economy or have seasonal, temporary or domestic jobs and are therefore not legally covered by social security provisions, including in the area of financial access to health.
- Only foreign nationals from countries that have established a bilateral social security agreement with Lebanon can benefit from the health care scheme of the NSSF; only 4-5 countries in Europe have this
- The reciprocity clause was created as part of ILO instruments to guarantee the portability of benefits across countries, an essential feature for long-term benefits such as old age or disability pensions, not to prevent individuals from accessing basic services such as quality health care
- Formal non-Lebanese employees contribute to NSSF but do not access benefits. In effect the NSSF is using contributions made on behalf of non-Lebanese workers, to subsidise health insurance for Lebanese nationals.
- Refugees under the protection of UNHCR and UNRWA have dedicated systems for health care and there are opportunities to align international support with the strengthening of national systems, including in the area of health insurance.

Recommendations

Measures to regulate access to labour market amongst non-nationals should translate in practice into enhanced enjoyment of social protection rights and improved access to a core set of social protection benefits, including in areas of access to health care and employment injury compensation. Avoidance of social protection obligations (and associated costs) will otherwise continue to cause labour market distortions, and cause detriment to workers' wellbeing with long-term fall-back cost on social support systems in host countries as well as countries of origin. Addressing health needs of migrant workers and refugees and early on through preventive and primary care lowers costs for the health care system in the long run, improves pooling, and enables more efficient management of scarce resources bringing some efficiency gains and supporting the strengthening of national systems.

Efforts to enhance social protection amongst non-national workers can only be pursued in the context of a national agenda on extension of social protection amongst all informal economy workers in Lebanon, regardless of nationality. In pursuing the development of a roadmap for the extension of coverage to the informal economy, the following issues should be considered specifically in relation to non-national workers:

- Extend legal provisions of **coverage for non-typical work arrangement** (e.g. self-employment, casual and seasonal work) in critical sectors (e.g. construction, agriculture, domestic work) – see previous sections
- Removing **barriers that discriminate between national and non-national workers** in accessing social security benefits.
- Assessing the **role of private insurance vis a vis the use of national social security mechanisms** and systems in ensuring adequate levels of protection
- Seeking opportunities to better **align humanitarian support** provided by the international community with national social protection systems

In particular, **NSSF should review the current practice of denying benefits to non-nationals who are contributing to social security, which is not in line with the principle of equality of treatment.** This could take different forms:

The most logical and desirable option would be to be to waive the requirement of reciprocity for the case of health coverage and provide access to the NSSF package to non-national workers that are subject to NSSF contributions on basis of equality of treatment**.**

At a minimum non-national workers and their dependents should be provided essential health services at all life stages, including preventive, curative and palliative care as long as they are legally resided in Lebanon. Extension of access to the health scheme after leaving the country indefinitely could remain subject to the existence of a reciprocity principle, which is generally introduced and intended in relation to long-term benefit.

It is also important to facilitate the recognition of the health coverage reciprocity principle even in the absence of a bilateral social security agreement. The law does not require the existence of an agreement. Several countries de facto provide Lebanese nationals access to health, for example through public or employment liability schemes, with different levels of coverage. In all these cases the existence of reciprocity could be recognized and coverage extended to their citizens currently living in Lebanon. In addition NSSF should support efforts to extend bilateral agreements with social security institutions, including in neighbouring countries, to ensure enjoyment of long term benefits in countries of origin and can contribute to return.

In case (or until) the above option does not materialize, non-nationals should be exempted from paying NSSF health care contributions (and other short term insurance schemes) if they are not allowed to benefit from the scheme. This however is not advisable. Exempting non-national from social security contributions would lower labour costs of employing a non-national worker formally hence generating labour market distortions in favour of hiring non-nationals. More importantly it would leave workers' rights to social health protection and employers obligation to partially finance unmet.[23]

In addition, Lebanon should also continue to seek opportunities to better align humanitarian support provided by the international community with national social protection systems, including in the area of health and employment injury insurance. Resources provided by international organizations to provide health care services to refugees should be increasingly channelled through national health financing and delivery systems. For example NSSF contributions for refugees could be subsidized by UNHCR (and UNRWA), rather than operating through private TPAs or health insurance models. Like in other countries (see Section 6.2 above), extending coverage to refugees through national systems would improve revenue collection, risk pooling and enhance bargaining position in purchasing, while contributing to reducing fragmentation in the sector. Good practices and innovative models currently adopted by international agencies in the area health financing, contracting and purchasing for the refugee population could also be gradually transferred to the NSSF and other national stakeholders.

23 An alternative could be to introduce employer liability for an alternative health insurance scheme, but this is far from desirable as will further weaken national systems and fragment health financing landscape.

Box 9: Further areas of possible ILO support to tripartite stakeholders in Lebanon

The ILO can support NSSF to improve operations in complementarity with the existing support provided by the EU project. In particular, the ILO can support the purchasing and financing arrangements towards a strategy focused on primary care, including contracting, provider payment method, referral system and third party paying mechanism. It can also support a costing exercise: capitation for PHC and case-based for hospital care, which would be a basis for negotiation with providers. ILO can further support the sharing and documentation of experiences with other public purchasers.

On **financial management**, the ILO can support NSSF's adoption of the ILO-HEALTH model, build capacity and conduct an actuarial analysis. This analysis should be part of a boarder effort to create an actuarial and economic analysis unit within the NSSF. A fiscal space analysis can be supported as needed to address the issue of government contribution to the scheme. Further support on administrative reforms beyond the EU project can be discussed if needed

To **extend coverage**, ILO can support the formulation of such strategic plan or roadmap. For each new population group, ILO can facilitate social dialogue processes, the definition of scope and possible needs to revise regulations or laws, profiling the population and surveys on contributory capacity as needed, simulations of impact on the financial sustainability of the scheme and administrative considerations. The piloting as well as monitoring of roll-out and recommendations for adjustments can be supported as needed

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Annex 1: List of key stakeholders consulted during the preparation of the report

Name	Function
ABBAS, Hassan Ali	Agriculture trade union
ABDALLAH, Castro	President of FENASOL
ABOU NASSIF, Chawki	Financial Director, National Social Security Fund
ACHKAR, Pierre	Lebanese Hotel Association
ALAWIEH, Sadek	Legal advisor of the General Confederation of Lebanese Workers
AL-CHERIF, Rajaa	Director of Finance, Ministry of Finance
ARBID, Charles	President of the Economic and Social Council
AMMAR, Walid	Director General, Ministry of Public Health
CHAHINE, AdbuRahman	General manager of Cedards Medicare, outsourced by the Mutual Fund for NSSF employees
DAOU, Ghassan	Président des Mutuelles de Santé – Liban
FAKIH, Hasan	Acting President of the General Confederation of Lebanese Workers
GIGNAC, Emmanuel	Deputy Representative UNHCR
HLAYHEL, Fouad	Head of Admin Control on Hospitals Department, NSSF
KAAKOUR, Said	Project Manager, EU project for reinforcement of the NSSF in Lebanon
KARAKI, Mohammad	Director General of the National Social Security Fund
MANSOUR, Fouad	Head of Department, Contracts and Relations with TPPs, Hotel Dieu de France
RADY, Alissar	Head of Technical Unit, World Health Organization
OUEISS, Sahar	NSSF Bourj Hammad Branch Manager
SOUBRA, Rabih	Beirut Arab University Healthcare Center (BAUHC), Director
Dr. ZAKIA, Tobie	Président du Conseil d'Administration NSSF

Annex 2: Focus group discussions methodology

Research objectives

The proposed research question leading the focus group discussion (FGD) is "What are healthcare coverage needs and preferences of informal economy workers ?". These focus groups are not meant to give a comprehensive picture of the health insurance extension design, but to:

- *Point at needs that should be addressed by a potential SHP mechanism;*
- *Identify key services to be potentially covered;*
- *Get potential beneficiaries views on health insurance and the design that would suit them;*
- *Get a sense of beneficiaries ability to pay.*

Willingness and ability to pay could be further investigated during a follow-up mission, through households surveys.

Methods

Qualitative methods will be used. 5 focus groups, arranged by counterparts of ILO Lebanon, will be held in a timespan of 2 weeks. The sample will include different categories of informal economy workers. They comprise:

- *Agriculture workers (arranged via CGTL);*
- *Small businesses (arranged via the chamber of commerce);*
- *Construction workers (arranged by the ILO);*
- *Domestic workers (arranged by the ILO);*
- *Other specific sector(s) as arranged by the Trade Unions.*

Each focus group will include a moderator and a note-taker and should last about 90 minutes. The number of participants will depend on arrangements made with counterparts.

Various countries are moving into the extension of coverage to the informal economy populations. One of which is Kenya,[24] which assessed the current utilization and readiness for the expansion of coverage to the informal economy. Based on the situation assessment, the following conceptual framework can be supportive in guiding the focused group discussions and interview:

1. Care-seeking behavior and priority services

- Where do most people in the informal economy around here go for medical services?
- Kind of services that informal economy workers receive at the providers

2. Most common methods of paying for the services

- Utilization of SHP schemes and awareness of them
- Borrowing/loans others

3. Insurance understanding, willingness to prepay for health care and preferred prepayment design

- Understanding of insurance mechanism
- Willingness to contribute to a scheme
- Preferences on different health insurance schemes

4. Views on health insurance and ability to prepay for health care

- Ability to (regularly) contribute to access healthcare services
- Barriers to prepayment
- Expected challenges in trying to persuade the informal economy to pay for health care in advance

24 Okungu, V., Chuma, J., Mulupi, S., & McIntyre, D. (2018). Extending coverage to informal economy populations in Kenya: design preferences and implications for financing policy. BMC health services research, 18(1), 13.

Following this framework, a discussion guideline was established. It includes open-ended questions and was inspired from both Kenya methodology and the ILO/STEP India Workshop report.[25]

Potential limitations

- *Sampling is organized by counterparts and not organizers of the focus groups. Therefore representativeness might be limited and results should be interpreted with caution.*
- *Language might be an issue and should be discussed in advance. Translation and interpretation errors should be avoided.*
- *We will be mindful of potential respondent order effect and dominance bias (Marlowe Jr 2000).*
- *Other typical bias such as recall bias will be acknowledged.*

Proposed Guideline

1. Identification of Group Members

Number of persons in the group
Age of persons in the group
Family composition
Children under 5
Occupational status (one or several occupations)
Main occupational classification (monthly employee OR employer hiring wage earners, self employed, employee paid hourly, daily, weekly or on a productivity basis, family workers with or without wage, apprentice, trainee…)
Sector of occupation

2. Care-seeking behaviour and priority services

Discuss the kind of health risks you think informal workers could be facing.

When ill, do they generally seek health care access and if yes, where do they go?

What kind of services do you access most often? What services you think are the most important to your health and your family's health?

25 International Labour Organisation (2006). Building up Tools for Awareness, Education and Participation" in Health Insurance for the Poor. Workshop Report. New Delhi.

3. Most common methods for paying for services

When you sought care, did you have to pay to access services?

List the kind of (other) costs you would have to meet to access health services.

Has the cost of health care services ever been an obstacle for you to access them?

Did you benefit from a SHP scheme? Do you know which one?

If you had to pay for services, how did you finance health related costs?

4. Insurance understanding, willingness to pre-pay and preferred prepayment design

What kind of outside support you think would be helpful to you (NGO, MOPH, NSSF, private insurance community... etc.)

What do you know of insurance? Can you give some examples of insurance products and risks covered?

According to you, what would be the appropriate mechanism that could be used for the payment of this contribution?

Would you be ready to regularly contribute to a fund paying for your healthcare services? According to you who should be contributing as well?

Would a (small) co-payment at facility level act as a deterrent for them to seek care?

What type of support do you think could be provided by the NSSF?

5. Views on health insurance and ability to prepay for health care

What amount would informal workers be able to engage to enrol in such insurance?

What kind of services should be covered and at which providers?

How / where would you prefer to enroll and how would you prefer to pay for such insurance?

What do you think could be barriers to prepayment and to regular contributions of informal workers?

Should your relatives be covered as well ?

What do you think could be challenges to persuade informal workers to enroll?

Annex 3: Key Characteristics of main Health Financing Schemes in lebanon

Name of Scheme/ Programme	Name of the institution administering the scheme/ programme	Coverage						Mandatory or voluntary coverage (by law)?	Population groups legally covered			Scope of legal coverage									Extent of legal coverage				Level of legal coverage				Contributory/ non-contributory
		Maternity / Paternity	Children	Employment Injury	Health care	Food and Nutrition	Other support/ assistance n.e.c		Population group(s)	by age group	by geo area	General practitioner care	Specialist care	Pharmaceutical supplies	Hospitalization	Dental care	Rehabilitation	Delivery, ante & post natal care	Long-term care	Exclusions (list)	Exemptions / opt-out options?	Voluntary affiliation for specific categories of population?	Coverage of dependents?	Coverage of Self-employed?	Co-payment level	Is delivery FREE?	Choice of health service provider	Referral system	
Ministry of Public Health	Ministry of Public Health				X			Voluntary	Population with no insurance	All ages	All areas			X	X		X				No	Yes	No	Yes	Yes	No	Yes	No	Non-contributory
Sickness and maternity insurance	National Social Security Fund	X			X			Mandatory	Private sector workers	Working age	All areas	X	X	X	X			X			Yes	Yes	Yes	Yes	Yes	No	Yes	No	Contributory
Health Fund	Civil Servants Cooperative			X	X			Mandatory	Public sector workers	Working age	All areas	X	X	X	X	X					Yes	Yes	Yes	No	No	No	Yes	No	Contributory
Army - Medical Brigade	Ministry of Defense				X			Mandatory	Other, Army	Working age	All areas	X	X	X	X				X		Yes	Yes	Yes	No	No	Yes	Yes	No	Non-contributory
SSF Health departments	Ministry of Interior				X			Mandatory	Other, SSF	Working age	All areas	X	X	X	X		X				Yes	Yes	Yes	No	No	Yes	Yes	No	Non-contributory
Health coverage for customs workers	Government				X			Mandatory	Other, Customs workers	Working age	All areas			X	X						Yes	Yes	Yes	No	Yes	Yes	Yes	No	Non-contributory
Mutual Funds Public	Chamber of Commerce, Industry, and Agriculture of Tripoli and North Lebanon				X			Voluntary	Employed	Working age	All areas				X						No	No	No	Yes	Yes	No	Yes	No	Contributory
Mutual Funds Private					X			Voluntary	Employed	Working age	All areas				X						No	No	No	Yes	Yes	No	Yes	No	Contributory
Private Insurances					X			Voluntary	Anyone	All ages	All areas			X	X	X		X			No	No	No	Yes	No	Yes	Yes	No	Contributory
International Organizations					X			Voluntary		All ages	All areas			X	X						No	No	No	Yes	Yes	No	Yes	No	Contributory
Household expenditure					X			Voluntary	Anyone	All ages	All areas	X	X	X	X	X	X	X	X		No	No	No	Yes	Yes	No	Yes	No	N/A
Hospital Insurance	AFHIL - Amernian Mutual Fund				X			Voluntary	All employed	All ages	All areas				X						Yes	No	No	Yes	Yes	No	Yes	No	Contributory
Health coverage	Caisse Mutuelle Laique - CML				X			Voluntary	Anyone	All ages	All areas				X						Yes	No	No	Yes	Yes	No	Yes	No	Contributory
Health Insurance Fund and benefit	Order of Physicians				X			Voluntary	Physicians	All ages	All areas		X		X						Yes	Yes	Yes	Yes	Yes	No	Yes	No	Contributory
Health Insurance Benefit	Order Of Engineers and Architects				X			Mandatory	Engineers and Architects	All ages	All areas				X						Yes	Yes	Yes	Yes	Yes	No	Yes	No	Contributory
Nurses Mutual Fund	Order of Nurses in Lebanon	X						Voluntary	Nurses	All ages	All areas							X			No	Yes	No	Yes	Yes	No	No	No	Contributory
(Emergency) National Poverty Targeting Programme (E-NPTP)	(Emergency) National Poverty Targeting Programme (E-NPTP)		X		X	X	X	N/A	Poor population	All ages	All areas			X	X						N/A	Yes	No	Yes	Yes	No	No	No	Non-contributory
LDA Mutual Fund	Lebanese Dental Association (LDA)				X			Voluntary	Dentists	All ages	All areas	X	X	X	X						Yes	Yes	Yes	Yes	Yes	No	No	No	Contributory

Annex 4: Coverage under the National Social Security Fund (NSSF)

	Type of Coverage			Branches			Worker / Employers Contribution Rate			Comments /Notes
	Mandatory	Voluntary	Mandatory, not implemented	EOSI	Health Care (Funeral Grant)	Family Allowance	End of Service Indemnity	Health Care Coverage	Family Allowance	
Employees (Lebanese Nationals)										
Private sector permanent employees	X			X	X*	X	8.5% (all employer)	11% (3% worker, and employer 8%) within a ceiling of 2,500,000 LBP per month	6% (all employer), within a ceiling of 1,500,000 LBP per month	As stipulated in the social security law of 1963, Article 9
Employees of public institutions and independent offices / government owned corporations who are not subject to civil service	X			X	X	X	As in general case	As in general case	As in general case	As stipulated in the social security law of 1963, Article 9 Employees in the public sector are the ones who works on a basis of a contract but not on a fixed appointment and are not covered by the Civil Service Cooperative Scheme.
Teacher in private school	X				X			As in general case		As stipulated in the social security law of 1963, Article 9
Trainees	X			X	X	X	As in general case	As in general case	As in general case	As stipulated in the social security law of 1963, Article 9 There is a category of trainees not covered i.e. those enrolled for a training related to education programme (part of the university programme or technical schools)
Permanent agriculture employees who work in an agricultural institution or company	X			X	X	X	As in general case	As in general case	As in general case	As stipulated in the social security law of 1963, Article 10 Special reference in Law 8/1974 and Decree 7757 of 1974
Part-time private sector employees	X			X	X	X	As in general case	As in general case	As in general case	Specific Eligibility condition is stipulated in Article 16 of the social security law of 1963 To benefit from health care coverage the insured would need to have worked during 3 months in a total period of 6 months. To benefit for family allowance coverage the insured should have worked full time at least half a month during a month.
Private sector temporary employees (Those employed in a company or who have an employer)			X							By law they should be covered by the three branches (with same contribution rates as employees in private sector). In fact, this is not being implemented given that a decree should be issued so that they can be covered. As stipulated in the social security law, Article 9, item 1, sub para (a), and the sub para (c) stipulates the conditions for eligibility shall be based on an issuance of a decree.
Private Sector seasonal employees (Those employed in a company or who have an employer, and their work depend on seasonal factor)			X							By law they should be covered by the three branches (with same contribution rates as a permanent employees in private sector). In fact, this is not being implemented given that a decree should be issued so that they can be covered. As stipulated in the social security law, Article 9, item 1, sub para (a), and the sub para (c) stipulates the conditions for eligibility shall be based on an issuance of a decree.

	Type of Coverage			Branches			Worker/Employers Contribution Rate			Comments /Notes
	Mandatory	Voluntary	Mandatory, not implemented	EOSI	Health Care (Funeral Grant)	Family Allowance	End of Service Indemnity	Health Care Coverage	Family Allowance	
Employees of bakers making Arabic Bread	X			X	X	X	As in general case	As in general case	As in general case	Special agreement made between NSSF and the Baker Union covers only 500/600 workers. Flat rate contribution based on the quantity of flour used to produce Arabic bread. For each 1 ton of flour spent the employer contributes 25,000 LBP to the NSSF and those payment go to the special accounts to cover NSSF contributions for all employees.
Other categories – Mandatorily Covered (Lebanese Nationals)										
Dock workers not employed by a specific employer they work for several employers at the same time	X			X	X	X	8.50%	11% -> (3% worker, and employer 8%) and the government pays separately 1% to NSSF	6% of the salary, within a ceiling of 1,500,000 LBP per month	As stipulated in the social security law of 1963, Article 9 Every month the company on the port submit the lists of workers working for them and NSSF register the name and number of days that they worked, and calculate the amount required to be paid by the employer. NSSF keeps track of the number of days the dock workers worked and make calculation for needed contributions.
Taxi Drivers and owner of a Taxi Car	X			X	X*	X	• Owner of Taxi car: 8% from the minimum wage • Taxi driver: 8.5% from two times the minimum wage	• Owner of Taxi car: 5.5% from the minimum wage is paid by the taxi driver and government pays 6.25% from two times the minimum wage • Taxi driver: 9% from two times the minimum wage	• Owner of Taxi car: taxi driver contribute 5.5% from the minimum wage and the government pays 3.25% from two times the minimum wage • Taxi driver: 6% from two times the minimum wage.	Under NSSF there is two types under this category i.e. a taxi driver who does not own the taxi car, and another owner of the taxi car Decree No 4886 of 1982 for taxi driver Law No. 1 of 1989 for taxi drivers owner of taxi car
Newspaper sellers	X			X	X*	X	8.5% from two times the minimum wage	9% from two times the minimum wage	6% from two times the minimum wage.	Decree No. 4885 of 1982
Mayors	X				X*			9% from two times minimum wage salary for the health care branch. the mayor pays 1/5 from share and 4/5 of the share is paid by the government.		Law No. 225 of 2000
Doctors approved at NSSF	X				X			9% from a fixed wage of 1,100,000 LBP		Decree No. 4822 of 2001
Lebanese Students	X				X			30% from the minimum wage, this is paid once a year by the student		As stipulated in the social security law of 1963, Article 9 Mandatory covered on a condition that they are not covered under any other scheme or through their parents already insured under NSSF.
Workers not employed by a specific employer working for several employers at the same time (including in construction daily/ non-permanent workers)			X							By law they should be covered by the three branches (with same contribution rates as permanent employees in private sector). In practice, this is not being implemented given that a decree should be issued so that they can be covered. As stipulated in the social security law, Article 9, item 1, sub para (b), and the sub para (c) stipulates the conditions for eligibility shall be based on an issuance of a decree

	Type of Coverage			Branches			Worker/Employers Contribution Rate			Comments /Notes
	Mandatory	Voluntary	Mandatory, not implemented	EOSI	Health Care (Funeral Grant)	Family Allowance	End of Service Indemnity	Health Care Coverage	Family Allowance	
Self-employed (prior to suspending the scheme for this category)		X			X			Flat rate of 90,000 LBP per month		As stipulated in the social security law of 1963, Article 11 and Decree n 7352 of 2002 Given inability to predict the salary of the self-employed NSSF has fixed a ceiling at 1,000,000 LBP and calculated 9% for contribution to the health care scheme
Employers (prior to suspending the scheme for this category)		X			X			Monthly contribution of a flat rate amounting to 135,000 LBP		As stipulated in the social security law of 1963, Article 11 Given inability to predict the salary of the employer NSSF has fixed a ceiling at 1,500,000 LBP and calculated 9% for contribution to the health care scheme
Lebanese working abroad	X			X	X	X				Applies only to national working abroad but signed the contract in Lebanon, provided the employer has a main office/branch in Lebanon. If he/she is benefiting abroad from similar scheme as of NSSF, will exempted from NSSF. In case he/she does not benefit from similar scheme abroad, the same general NSSF conditions and contribution shall apply. Regulated under social security law of 1963 Article 9, para 2)
Lebanese worker who got relocated to work abroad		X		X						Provided the employer has a main office/branch in Lebanon
Non-Lebanese Nationals										
Permanent employees, part-time employees and trainees in the private sector, with a valid work permit (from countries that have reciprocity agreement with Lebanon)	X			X Contribute and eligible to benefits	X Contribute and eligible to benefits	X Contribute and eligible to benefits	8.5% (fully paid by the employer)	11% (3% worker, and employer 8%)	6% (all paid by the employer)	
Permanent employees, part-time employees and trainees in the private sector, with a valid work permit (Palestinian employees)	X			X Contribute and eligible to benefits	X Contribute but not eligible to benefits	X Contribute but not eligible to benefits	8.5% (fully paid by the employer)	11% (3% worker directly deductible from his salary and employer 8%)	6% (all paid by the employer)	
Permanent employees, part-time employees and trainees in the private sector (other nationalities)	X				X Contribute but not eligible to benefits	X Contribute but not eligible to benefits		11% (3% worker directly deductible from his salary and employer 8%)	6% (all paid by the employer)	
Students	X				X Contribute and eligible to benefits			30% of minimum wage, once a year		By law they should be covered by the health care branch only according to a bilateral agreement. So far only French students benefit from the health care coverage under NSSF.

Annex 5: SWOT Analysis of Sickness and Maternity Scheme

Strengths	▶ Long tradition and vast experience in provision and administration of social health insurance are one of the main strengths of NSSF. It is the institution with the longest experience in health insurance in the country. ▶ Corporate memory of NSSF is accumulated through more than 50 years of health insurance operations. ▶ The network of branch offices is distributed throughout the country. It serves, both, as a contact point for current beneficiaries and an entry point for new beneficiaries. ▶ Its contribution collection function assures high level of compliance, even though there is always a room for improvement. ▶ A comprehensive and reliable database is one of the prerequisites for effective governance, but it is still not sufficiently exploited to provide support for effective decision-making and management. ▶ The ICT System's N-tier application architecture can be upgraded, and flexible and reusable applications can be developed without the need to rework the whole ICT system. ▶ Standardised administrative procedures and processes would enable quick automation to accelerate claims processing and improve monitoring and evaluation mechanisms. ▶ Key NSSF operations are ICT supported. ▶ A high number of the NSSF staff is computer literate, which is a basic requirement for the smooth and successful implementation of ICT system improvements.
Weaknesses	▶ The current Provider Payment System does not enable effective cost control due to no or weak cost containment mechanisms. ▶ Direct reimbursement of beneficiaries increases the likelihood of system abuse, financial fraud and corruption. ▶ The 6 months limit for processing of claims hinders effective budget planning for the fiscal year. ▶ Cumbersome reimbursement procedures are an obstacle for quick and efficient processing of claims. ▶ Weak key health financing functions and inability to forecast expenditures has a negative impact on budget planning and financial management. ▶ Moderate "bargaining power" undermines NSSF's negotiating position with the Government, the providers (health care facilities, pharmacies, laboratories, etc.) and other relevant stakeholders. ▶ Lack of a policy document (strategic plan) hinders the reform process, because the absence of clearly defined goals and objectives doesn't enable the development of Key Performance Indicators (KPIs). ▶ The fragmented ICT system has a negative impact on communication flows (horizontal and vertical), management, decision-making and governance. ▶ The reporting system is mainly limited to compulsory annual reporting and specifically requested reports. ▶ KPIs are missing, which undermines effective Monitoring and Evaluation (M&E). ▶ The large number of staff vacancies negatively affects the efficiency of NSSF operations. ▶ There is a lack of skilled staff, especially with an adequate background in health insurance, health financing and health economics. ▶ There is an absence of tailored education programs aimed at improving the knowledge, skills and abilities of NSSF staff. ▶ Relatively weak enforcement measures lead to the evasion of health contributions payment, which reduces generation of revenues.

Opportunities	▶ Ensure that all currently eligible individuals are enrolled into the sickness and maternity benefits scheme and pay contribution. This would generate additional revenues and improve the financial stability of the sickness and maternity fund. ▶ Pooling of public funds for health care would enable more efficient management of scarce resources and bring some efficiency gains/savings. ▶ Enhance and intensify policy dialogue with key stakeholders to assure broad support for implementation of the reforms. ▶ To benefit from technical assistance and expertise provided by EU within the framework of the current Project in the following areas: Strategic Planning, Social Health Insurance (Sickness and Maternity Benefits Scheme), End of Service Indemnity, Family Allowances, Business processes and procedures, ICT, Human Resources. ▶ Establishment of an Unemployment Fund to assure an additional source for the stable generation of revenues that could be used for the extension of the sickness and maternity benefits to unemployed individuals registered with National Employment Office (NEO). ▶ Design new and attractive health insurance schemes for the groups of population currently not covered by any of NSSF schemes (farmers, temporary and seasonal workers, etc.) and supplementary insurance for those who are interested to pay for additional bene- fits (elective treatments in private hospitals, dental care, etc.). ▶ MoPH's commitment towards the achievement of Universal Health Coverage is the overall goal of the Health Strategic Plan. ▶ Intensify public relations activities and increase its presence in electronic media regarding the ongoing reforms would help improve NSSF's public image.
Threats	▶ Conservative policy dialogue among key stakeholders could hinder a holistic approach to the identified problems and undermine the implementation of the reforms. ▶ Discontinuity of budget planning process at national level has a negative impact on financial stability and sustainability of NSSF due to a significant amount of outstanding payments from the Ministry of Finance (MoF). ▶ Fragmented health care system with insufficiently integrated primary health care, pro- motion and prevention, and inappropriate system of referrals drives health expenditures up. ▶ Coding of health services, procedures and tests is not unified and updated. ICD-10 codes are not included in outpatient prescriptions. ▶ Fragmented administration and no pooling of public health funds leads to duplication of administrative and management costs and increased total health expenditures. ▶ Some of the legal provisions are not favorable for the implementation of reforms. ▶ A lack of secondary legislation and regulations especially in domain of health care provision hinders effective governance and has a negative impact on NSSF's operations and its financial stability. ▶ Strong competition in health insurance market due to relatively easy entrance for new insurers and predominantly private health care provision. ▶ Lack of public trust in NSSF undermines its negotiation position regarding the extension of the sickness and maternity benefits scheme coverage. ▶ Limited health management knowledge and skills, especially among managers of public health care facilities at primary health care level. ▶ Lack of comprehensive actuarial analysis hinders appropriate planning of financial and other resources for health (human resources, equipment, buildings, etc.) and for the extension of the sickness and maternity benefits coverage.

Source: EU-OMSAR, Reinforcement of the National Social Security Fund (NSSF) in Lebanon, 2018