Chapter Seven

HEALTH FINANCING REFORM AND STAKEHOLDER ANALYSIS

1-HISTORICAL OVERVIEW

When it was established in 1963, the NSSF[1] was intended to cover progressively all the Lebanese population in all its social and occupational categories (employees, civil servants, agricultural workers, self-employed, etc…) according to a three-stage plan. This staging was designed to allow assessing the demographic and epidemiological status, and evaluating the ability to pay of the concerned population category at each stage, in order to define benefit packages and set fair contribution rates. It was supposed to give enough time to recruit and train qualified personnel, and to build administrative capacities[2].

Four decades later the fourth phase of the first stage, which implies the coverage of work place injuries and occupational diseases, has not achieved yet. What is even more peculiar is that, one month after the creation of the NSSF, and before allowing for the enrollment of the civil servants, the CSC was created by the

decree # 14273[3]. The fourth article of this decree stated that the CSC has to perform its duties "until the NSSF becomes capable of covering the civil servants". This provided a legal cover to the political, social and perhaps confessional reasons lying behind the creation of this separate fund. These same reasons are still prevailing presently. Similarly, the same questions that are arising now about unifying public funds into one agency have always been raised[4].

Historically, to be eligible for the MOH coverage, a certificate of indigence was requested[5]. The decision of issuing an insurance card for eligibility to MOH coverage was made in 1967 by Minister Nassib Barbir[6]. In 1971, Minister Emile Bitar took the decision of issuing a health card based on a system of identification of the poor among the uncovered population[7]. None of these decisions were put into practice, and overlapping of the MOH coverage with other funds persisted. Over and above, the certificate of indigence, considered as violating human dignity, was abolished later in 1971[8]. This decision opened widely the door to all citizens including the well off, to benefit from the MOH coverage.

Many experts' reports have been written on the Lebanese health sector financing, always recommending the merging of all public funds. The most well-known, dating back to 1983, are the reports of WHO and USAID missions, which recommended that "Public sector reimbursement should be consolidated within a single public sector agency: The National Health Security System; NHSS"[9].

Based on these reports, a serious and pragmatic plan was proposed[10] consisting of covering all beneficiaries of the NSSF, and the CSC, as well as the dependents of military forces' members, by a single public agency. Enhancing the political feasibility of this proposal was sought by acknowledging the specificities of military forces as deserving a special scheme. It was suggested to set contributions proportional to electricity consumption, considered as a proxy for the financial status. It was

proposed, to integrate contributions collection with the electricity bills collection system.

The aim was to overcome major technical and administrative bottlenecks hindering the expansion of the NSSF coverage. These are related mainly to the difficulty of identifying the poor, and of setting contribution rates compatible with beneficiaries' financial abilities, in addition to the major collection problem. Unfortunately, citizens' ability to pay their electricity bills is decreasing, and the Electricity of Lebanon itself has always been encountering serious collection problems[11].

Since the Jeffers report (USAID, 1983), the NSSF has not been able to expand its coverage, the financing system is getting more and more complicated and fragmented with all the repercussions explained earlier in chapters III, IV and V. Many financing reform scenarios have been developed. Besides the expansion of the NSSF that is still a serious option to consider, many variants of the public funds merger model have been proposed. Recently, the success of the Third Party Administration in the private insurance industry has been an inspiration to develop TPA model options. Redesigning the financing system remains the cornerstone of reforming the health sector, for the impact it has on all other components of the health system.

2-HEALTH FINANCING SCENARIOS: ADMINISTRATIVE, FINANCIAL AND LEGAL IMPLICATIONS

Three main scenarios are identified: the first consists of expanding the coverage of the existing National Social Security Fund to all the population. The second proposes a Third Party Administrator, the so-called Interface and Resource Body (IRB) to undertake operational functions on behalf of all public financing agencies. The third relates to establishing a National Health Authority (NHA) managing all the public money, to ultimately replace all existing public funds.

The elaboration of the 3 main reform options was made by a team under the Health Sector Rehabilitation Project (HSRP). The financial impact of each option was estimated[12], based on available information with the HSRP team, and legal implications were developed[13] following a thorough review of related legislation.

2.1 Major Characteristics of the Current System

2.1.1 Administrative and Organizational Aspect

- Six public funds, each with its own regulations, covering hospital care (direct payment to hospitals), and ambulatory care (reimbursement of users).
- Unregulated private insurance.
- Mutuality funds with ill-defined mission.
- The uninsured (52.3% of the population) are eligible to the MOH coverage for hospital care and catastrophic illnesses.
- Ill-organized primary health care in both NGOs and public centers.

2.1.2 Financial Aspects

Total Health Expenditures represent 12.46% of the GDP, with a heavy burden on households (out-of-pocket fee for service makes up 60% of the total).

Table VII-1: 1998 National Health Accounts for the entire population (billions L.P.)

	Total	Hospitals	Non-Institutional	Pharmaceuticals	Other	Admin
OOP	**1,199**	146	786	250	17	0
MOH	**311**	227	28	21	22	13
NSSF	**296**	108	42	48	59	40
Other Public Funds	**189**	105	42	18	3	21
Private Insurance	**392**	54	127	110	7	94
Total	**2,387**	**639**	**1,025**	**447**	**108**	**168**

2.2 Option 1/NSSF Proposal

2.2.1 Administrative and Organizational Aspects

The NSSF will extend its coverage incrementally until it covers all Lebanese residents, in accordance with existing legislation. In parallel, the role of the MOH as an insurer of last resort would be phased out progressively.

In the first step, the NSSF would expand its coverage to persons 65 and older.

2.2.2 Financial impact

Out of pocket expenditures would decrease, whereas overall national expenditures would increase by 8% (190 billion L.P.).

Table VII-2: Profile Matrix for covering the population 65 and older (billions L.P.)

	Total	Hospitals	Non-Institutional	Pharmaceuticals	Other	Admin
OOP	**1,008**	100	686	201	20	0
MOH	**215**	159	19	16	13	9
NSSF	**296**	108	42	48	59	40
Other Public Funds	**189**	105	42	18	3	21
Private Insurance	**235**	32	76	66	4	57
New Plan	**634**	123	261	155	9	86
Total	**2,577**	**626**	**1,126**	**504**	**109**	**212**

2.2.3 Legal Implications

The implementation of this NSSF reform option will not require any new laws. However, some new decrees ought to be developed by the Council of Ministers to detail the procedural steps needed.

Table VII-3: Legislative texts to be canceled, amended or issued for the implementation of Option 1

Legislative texts to be canceled	Legislative texts to be amended	Legislative texts to be issued
None - The execution of some texts, such as law articles on public health assistance or drugs would be halted progressively, as a consequence of the progressive extension of the NSSF coverage to new segments of the population.	- Amend the first alinea of article 4 of the decree 14272 dated 29/10/63 (establishment of the civil servants cooperative) to transfer the coverage of civil servants to the National Social Security Fund	- Promulgate necessary decrees, to include new segments of the population in the National Social Security Fund - Issue a decree setting contributions, and allowing their collection from people that are not governed by the Labor Law or the Public Sector legislations. - Promulgate decrees to transfer necessary credits from the Ministry of Finance (or the Ministry of Public Health) to the National Social Security Fund.

2.3 Option 2/IRB Alternative

2.3.1 Administrative and Organizational Aspects

Under this proposal, current public funds would remain and preserve their autonomy. All of them however would deal with consumers and providers through one Interface and Resource Body within a common framework (multiple funds/one system).

The MOH will continue to finance hospital care and catastrophic illnesses of the uninsured, and will ensure universal accessibility to Primary Health Care, through a national network of PHC centers, in collaboration with NGOs and municipalities. More details on this option are provided in the annex.

2.3.2 Financial impact

Out-of-pocket expenditures would slightly decrease, whereas, the overall national expenditures would increase by 5.7% (137 billion L.P.). These estimates do not include however, the effect of increasing the accessibility to PHC services, on both the OOP and the overall spending.

Table VII- 4: The IRB Profile Matrix (billions L.P.)

	Total	Hospitals	Non-Institutional	Pharmaceuticals	Other	Admin
OOP	**1,130**	146	717	250	17	0
MOH	**84**	78	0	2	1	3
NSSF	**288**	106	41	47	58	37
Other Public Funds	**184**	102	41	18	3	18
Private Insurances	**382**	53	124	108	7	89
New Plan	457	143	233	19	21	42
Total	**2,524**	**628**	**1,157**	**444**	**107**	**190**

2.3.3 Legal implications

There would be a need for administrative decrees allowing public bodies to subcontract management services. This can be done at the level of the Council of Ministers. No new laws would be needed.

Table VII-5: Legislative texts to be canceled, amended or issued for the implementation of Option 2

Legislative texts to be canceled	**Legislative texts to be amended**	**Legislative texts to be issued**
None	None Financial by-laws of the Civil Servants Cooperative and the National Social Security Fund should be amended to cope with unified procurement procedures and establish a unified tender document	Get the approval of the Council of Minister on the unified tender document

2.4 Option 3/The Social Health Insurance Program (SHIP)

2.4.1 Administrative and Organizational Aspects[14]

This option proposes a universal and mandatory insurance to be managed by a National Authority with a high degree of autonomy. All citizens will be covered for hospital, ambulatory care including dental care and catastrophic illnesses. There will be a standard minimum coverage with individually-purchased supplementation for all except for low-income population.

Four categories would be eligible for SHIP based on Social and occupational status:

1-Employers, professionals, self-employed and employees in the informal sector.
2-Employees currently covered by the NSSF, military, civil servants, municipalities
3-Retirees from category 2.
4-Unemployed, poor, institutionalized, handicapped, welfare program participants.

The population of category 4, defined according to strict eligibility criteria, would continue to be entitled to the MOH coverage for a basic benefit package. Each beneficiary of this category has to register with a PHC accredited center that constitutes for him/her the entry point to the health system, and from where referral to higher levels of care can take place.

Public funds would continue to collect contributions from adherents and continue to cover their currently defined eligible even after retirement

(categories 2 and 3). The population of category one pays premiums to the insurance of their own choice.

Whereas people in category 4 can only obtain the basic benefit package, those of categories 1, 2 and 3 may choose a wider coverage in return for additional contributions.

The long-term objective of SHIP is the merger of all public funds devoted to health.

2.4.2 Financial impact

Out-of-pocket expenditures would significantly decrease, whereas the overall national expenditures would increase by 13% (314 billion L.P.).

Table VII-6: The SHIP Profile Matrix (billions L.P.)

	Total	Hospitals	Non-Institutional	Pharmaceuticals	Other	Admin
OOP	768	92	496	169	12	0
MOH	35	24	4	3	3	1
NSSF	237	86	34	38	47	32
Other Public Funds	151	84	34	15	3	16
Private Insurance	314	43	102	88	6	75
New Plan	1,195	267	552	211	36	130
Total	**2,701**	**596**	**1,220**	**524**	**106**	**255**

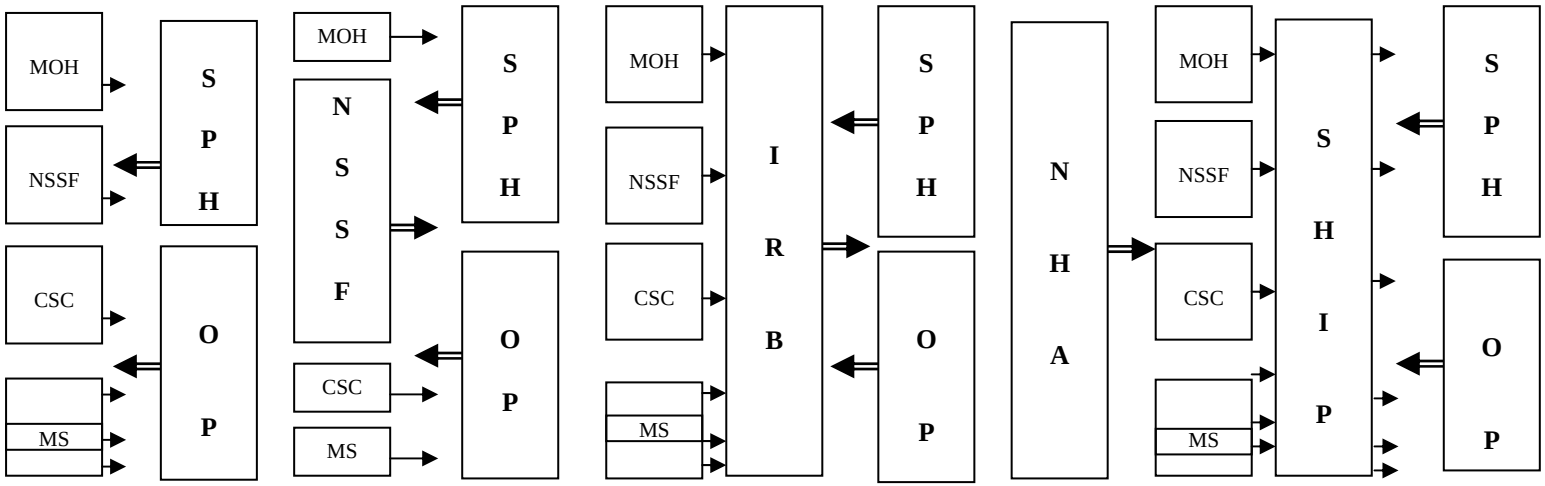
2.4.3 Legal implications

New legislation need to be enacted by the Parliament to allow for the establishment of the National Authority.

Table VII-7: Legislative texts to be canceled, amended or issued for the implementation of Option 3

Legislative texts to be canceled/(no amendment is proposed)	Legislative texts to be issued
The NSSF code (law of 26/9/1963): • Cancel the first part in the second book of the code. • Remove other texts that are not relevant to the new system. • Modify accordingly the financial by-laws. The Civil Servants Mutuality (decree of 29/10/1963): • Cancel alinea one of article 4 related to health coverage. • Cancel related financial by laws. The Ministry of Public Health (decree 8377 of 30/1/1961): • Cancel alinea 4 of article 2, related to Public Assistance. The National Defense (law decree 102 of 16/9/1983): • Cancel article 68 related to the medical care of the armed forces. Internal Security Forces (Law 17 of 6/9/1990): • Cancel articles 146 to 158 related to the medical care of ISF members. General Directorate of the General Security: (law decree 139 of 12/6/1959): • Cancel article 33 related to the medical care of General Security members. General Directorate of the State Security (decree 2661 of 3/9/1985) • Cancel article 21 related to medical care of State Security members.	- A law establishing the "National Health Care Authority" should be enacted. - Application decrees setting organizational and financial rules for the NHA and the appointment of the Board of Directors and other necessary decrees to include different segments of the population in the new system under the NHA, need to be issued.

Fig VII-1: Health Financing Reform Options: Bargaining power of different stakeholders



CURRENT SYSTEM | **NATIONAL SOCIAL SECURITY FUND (NSSF) OPTION** | **INTERFACE AND RESOURCE BODY (IRB) OPTION** | **SOCIAL HEALTH INSURANCE PROGRAM (SHIP) OPTION**

MOH	Ministry of Public Health	**CSC**	Civil Servants Cooperative	**MS**	Military Schemes
SPH	Syndicate of Private Hospitals	**OP**	Orders of Physicians	**NHA**	National Health Authority

3-STAKEHOLDER ANALYSIS

A stakeholder analysis[15] was conducted aiming at identifying the position of different stakeholders in the Lebanese health care system towards health financing reform options.

Six groups of stakeholders were identified: public funds, physicians, private hospitals, mutuality funds, NGOs involved in the health sector, and private insurance offering medical schemes.

Target groups' members were identified on the basis of formally elected representatives wherever applicable. Those are: board members of the Order of Physicians, board members of the Syndicate of Private Hospitals, board members of the Health Mutual Funds Technical Union. The public funds group gathered the Directors General of the MOH, the NSSF and the CSC and Heads of the Army Medical Scheme and the Internal Security Forces Health Department. NGOs representatives were those delegated for follow up with the MOH, and the private insurance group included CEOs of major companies offering health insurance.

Options for reform were introduced in a general meeting held in Rotana Hotel on October 10, 2000. All stakeholders, as well as former Ministers of Health were invited by the Minister of Health. International and national health and finance experts attended the meeting as well, and participated in the discussion.

Available results of the NHHEUS and the NHA, were exposed as well as organizational, financial and legal implications of the proposed reform options. A round table discussion followed the presentation. A first questionnaire intended to identify issues of revelance for the reform and to rank them by priority order was distributed and completed in this meeting. The administration of this questionnaire did not take into consideration respondents' membership in various interest groups. Therefore, the analysis of

this questionnaire was based on individuals' perceptions, opinions and positions, irrespectively of their adherence as stakeholders.

A second questionnaire was distributed, aimed at assessing the position of stakeholders towards financing reform, considering separately the feasibility and the sustainability of each option. Feasibility is tackled from different perspectives: political interests, legislative amendments, organizational changes, availability of resources and the public reaction. Whereas, sustainability considers administrative and political dimensions, affordability on the long run and compliance of providers. Questionnaire 2 was introduced to each group separately and was administered by stakeholder's groups.

Stakeholders were given a brief presentation about the purpose and the methodology of the study and were asked to complete the data collection tool on the spot. Completed questionnaires were collected immediately.

Results of the first questionnaire (part I) indicated that 30 issues were considered of high priority by more than 50% of the respondents. These are exposed in the table VII-8.

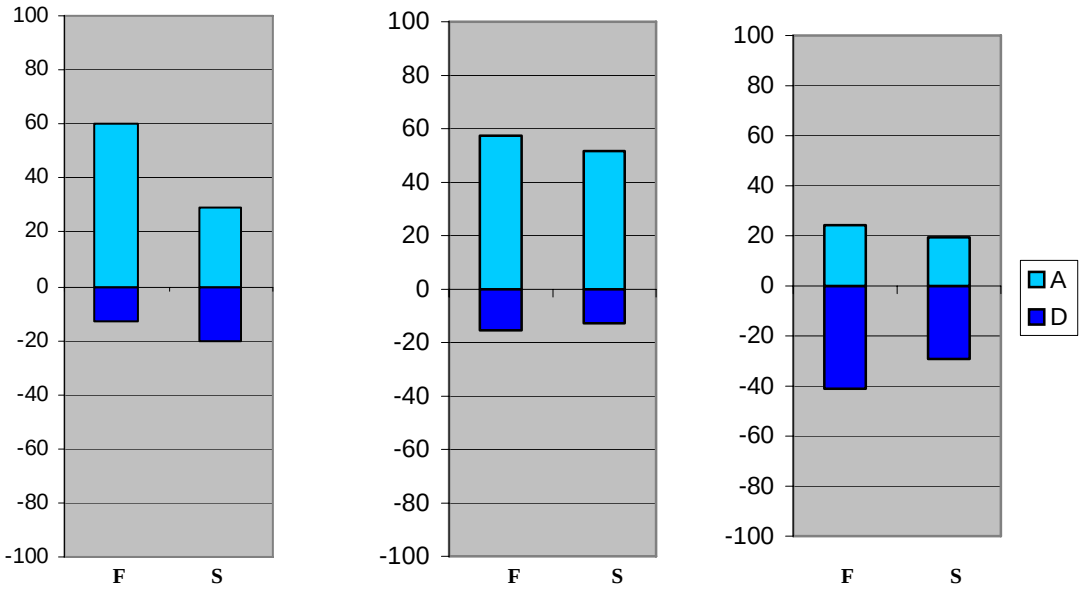
Results of Part II are presented with different stakeholders given the same weight. Considering the overall ranking of stakeholders' positions, fig VII-2 shows that options (1) and (2) were perceived as relatively more feasible and sustainable than option (3). About 60% of participants agreed on the feasibility of option (1) compared to 57.5% and 24.2% for options (2) and (3) respectively. Only 29.4% agree on the sustainability of option (1), compared to 51.6% and 19.4% for option (2) and (3) respectively. Disagreement responses were the highest for option (3) (41.1% for feasibility and 29.3% for sustainability).

Table VII-8: Issues identified by more than 50% of respondents as being of high priority to be addressed by the reform

	Health Reform should address in priority:	High Priority Answers (%)
1	Aim to limit the cost of pharmaceuticals	90.3
2	Attend to the quality of pharmaceuticals	87.1
3	Attend to the quality of inpatient services provided by government hospitals	85.2
4	Emphasize preventive / promotive health services	83.6
5	Emphasize emergency medical services	81.6
6	Commit to consolidation of the multiple funding bodies for health services owned and / or controlled by the public sector	79.6
7	Attend to the issue of accountability of government owned and controlled health financing funds	77.8
8	Attend to the issue of accountability of public hospitals and dispensaries	77.8
9	Attend to the issue of accountability of physicians	75
10	Expand the sense and feeling of security among patients	74.5
11	Attend to the issue of accountability of pharmacists	74
12	Attend to the cost of medical services in government hospitals	72.7
13	Expand the sense of satisfaction among patients/clients	70.4
14	Attend to the cost of medical services in large hospitals	69.8
15	Attend to the issue of accountability of private hospitals	68.5
16	Attend to out of pocket expenditures on medical services in large hospitals	68
17	Attend to the cost of medical services in the private sector	67.9
18	Attend to the issue of accountability of nurses	67.3
19	Attend to the issue of accountability of insurance companies and related cooperatives	65.4
20	Attend to the quality of inpatient services provided by large hospitals	61.8
21	Attend to the issue of accountability of paramedical staff	61.5
22	Attend to out of pocket expenditures on medical services in the private sector	60.8
23	Enclose the use of generic medications where possible	60
24	Expand the sense of satisfaction among physicians	59.3
25	Expand the sense and feeling of fairness in financing of health services among all concerned	58.8
26	Attend to the quality of inpatient services provided by small hospitals	58.2
27	Attend to the issue of accountability of non-governmental dispensaries	56.9
28	Attend to the quality of outpatient/ambulatory care services by governmental dispensaries	54.7
29	Attend to the issue of accountability of privately owned diagnostic facilities	53.7
30	Expand the sense and feeling of security among physicians and other providers	52.7

Most of those who did not agree with the IRB (option 2 for reform), were rather not sure (fig VII-3 and 4). "Disagree" responses were spread in the lower half of each feasibility and sustainability diagram (fig VII-3b and 4b). The absence of aggregation in the "disagree" responses indicates that, in case IRB is adopted, a strong coalition of opponents is unlikely to happen.

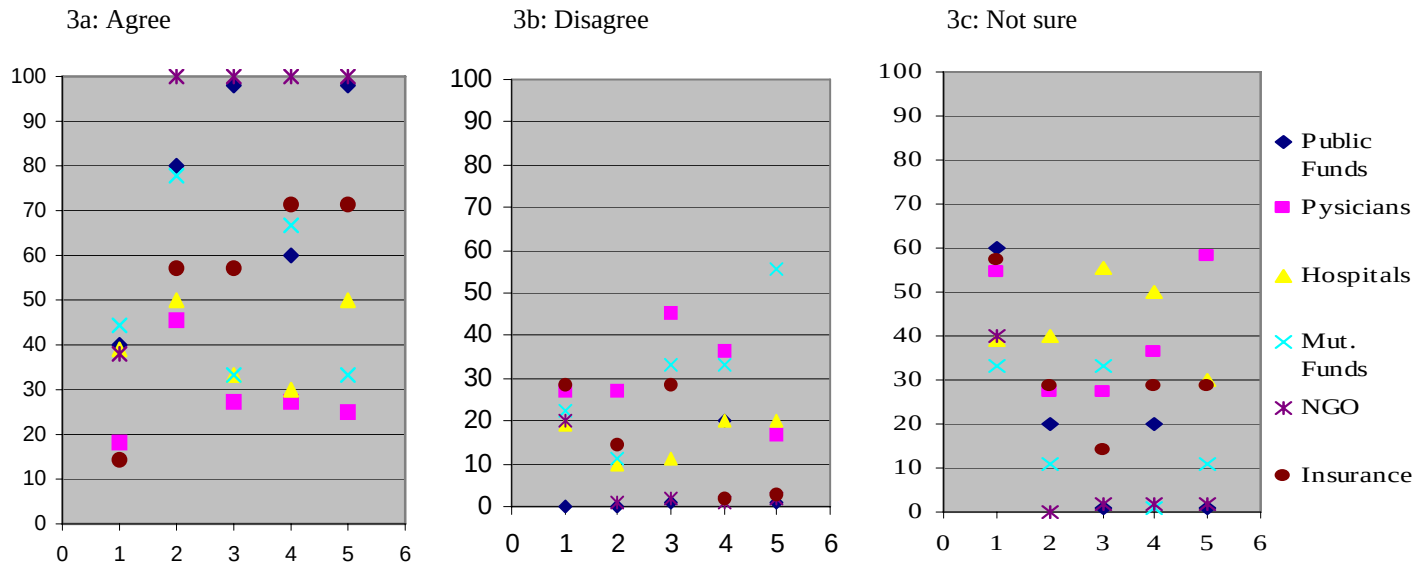
Fig VII-2: Assessment of the feasibility and sustainability of reform options (all stakeholders)



F: Feasibility **S**: Sustainability **A**: Agree **D**: Disagree

Figures VII-3a and 4a show the lay out of agree responses, that suggest possible future supportive coalitions, whereas the analysis of "not sure" responses revealed the elements that are arousing suspicion, to be considered in the reform strategy (fig VII-3c and 4c). It indicates also the indecisive stakeholder groups that could be targeted if a promotion campaign is decided for persuasion.

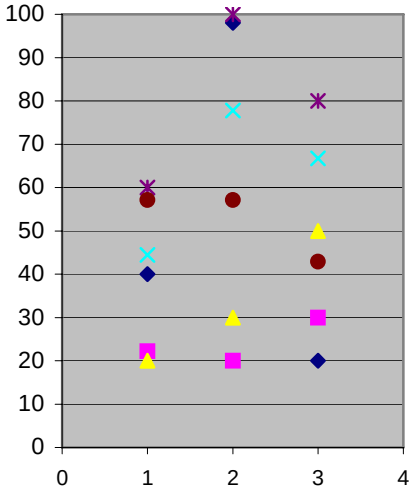
Fig VII-3: Stakeholders positions towards option 2 feasibility elements



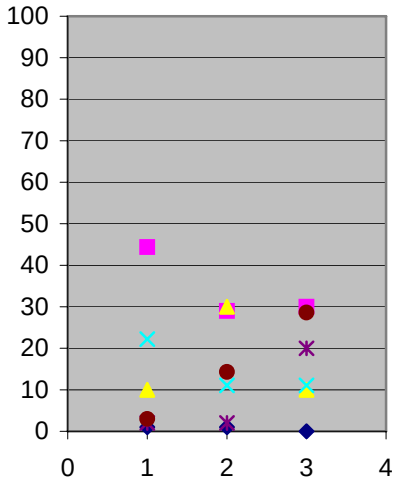
1: Political interest would be supportive
2: Legal changes are doable and applicable
3: Organizational changes are doable and applicable
4: Financial resources to launch this option are affordable
5: The public would welcome this option

FigVII-4: Stakeholders positions towards option 2 sustainability elements

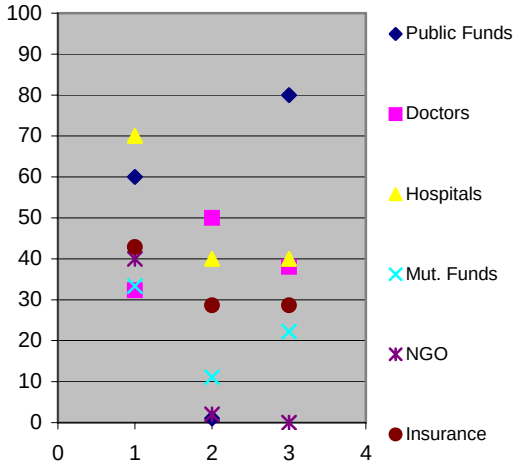
4a: Agree responses



4b: Disagree responses



4c: Not sure responses



1: The new organizational structure would be administratively and politically viable
2: The country would be able to afford the new system on the long run
3: Physicians and hospitals would support the new system and comply with rules and regulations

More detailed results are available through MOH including tables, bar charts, and scatter diagrams reflecting "agree", "disagree" and "not sure" responses of stakeholders, regarding each option's feasibility and sustainability. The overall result was in favor of both options (1) and (2) with a relative advantage of the latter (IRB).

Consumers were not included as such in this stakeholders analysis, which represents a serious limitation of the study. In the absence of a formal Consumer Association at that time, the Socio-Economic Council's position was sought. This council includes representatives of civil society organizations, including professional associations and trade unions. A brainstorming session was held with the Health Committee of the Council. Following deliberation within the Council, Committee members sent an official letter to the MOH giving support to the IRB option.

4-THE POSITION OF POLITICAL DECISION-MAKERS

For a long time, ambiguity has surrounded the political decision-makers' positions. Merging of public funds became a political slogan for successive Ministers of Health since the 1960s. The political support for the NSSF has been always explicit, while implicit criticism and suspicions prevailed on many occasions. The IRB proposal was formulated under the direction of Minister Frangieh in 1997. This option was welcomed by the Interministerial Committee for Reform in its meeting on April 14, 2000. Minutes of this meeting (Registered on May 18, 2000 # 4090/7945 C)[16] signed by the Prime Minister (President of the Committee) and Minister of Health (vice-president) stipulates that after a thorough discussion, agreement was reached on 4 issues. The first was "Establishing a public funds' beneficiaries database within the MOH in collaboration with all concerned ministries, to be updated electronically by an automated system through a network that involves all the public funds". This constitutes a first step towards the implementation of the IRB option. The fourth

point stipulates “Investigating further the possibility of delegating to the private sector, through a bidding procedure, specialized functions contributing to establishing a unified system". This includes: “conditions of contracting with hospitals, tarification, bills auditing and quality assurance”.

These decisions indicate clearly a high level of political willingness to adopt the IRB option, through investigating further its feasibility, and at the same time starting the implementation of the very important first step of establishing a unified beneficiaries database for all public funds. This step is also a prerequisite for the bidding. It is worth mentioning, that for some political leaders, the IRB option is considered as an important and necessary step by itself for the implementation of option 1, and they gave their support with this perspective.

When Minister Frangieh took office again in the MOH in October 2000, he declared his commitment to the IRB option, and assigned to the Director General the follow-up on the issue with the new Ministers of Economy and Finance. By December 18, 2000, both Ministers endorsed the IRB proposal considering it feasible, sustainable, and compatible with the Government plan.

Following political endorsement, marketing of option 2 is conceivable, aiming at enhancing the support of all stakeholders and neutralizing opponents. In order to be better targeted, the marketing strategy should be based on a thorough analysis of stakeholders’ positions as revealed by the up-mentioned study.

5-CONCLUSION

Reforming the health financing system in Lebanon has already gone beyond declaring intentions and raising political slogans. A pragmatic approach has been sought, and a scientific sound process initiated. Three main scenarios were identified, and for the first time, a stakeholders' analysis was conducted aiming at determining pros and cons vis-à-vis each scenario from the feasibility and sustainability perspectives.

This allowed excluding the third option (SHIP) that was perceived as not feasible for launching, and unsustainable on the long run, by the majority of respondents.

Stakeholders' opinions were mainly divided between supporting option 1 (NSSF) and option 2 (IRB), with a relative advance of the latter.

The IRB alternative is strongly supported by main political decision makers involved in the Health Sector in general and in Health Financing in particular.

The analysis of study results revealed that no major opposition would face an eventual government plan for implementing option 2. Stakeholders' analysis allows the Ministry of Public Health to promote such a plan by targeting specific topics among identified indecisive or conservative stakeholders. Engaging in option 2 could be considered as setting the ground for expanding the NSSF coverage, should the Government decide in the future to reach this objective.

Finally, despite declared positions and good intentions, one should not underestimate the momentum of the current system and its inertia potential. The lesson drawn by Kahn and Pollack[17] from the history of health financing reform failures in the USA, is that "proposed changes to health care financing can easily alarm stakeholders, who may then erect roadblocks". The authors underlined that "the players came to the political process with strong convictions in support of their first-choice proposal. For each of these groups, their second-favorite choice was the status quo. And indeed, the ultimate result of those efforts was the status quo …".

In our case, option 2 got a slightly higher score than option 1 which represents an optimistic expectation about the evolution of the current system. Eventhough option 1 states that the NSSF would cover all the population, it could be easily reduced to maintaining the status quo. Hence, the status quo remains the major competitor of the IRB option.

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