The Public Health Policy and Boosting its Performance

The research methodology in health policy is based on the development of social needs and economic resources, through both a rational analysis sequence connected to reality, and the principles which we adopt for the development of this sector within the available means. This leads to the development of a practical strategy molded with reasonable targets and adequate risks; from which would emerge a practical implementation using the available means and capabilities. There is no room here to describe the health problems from a medical point of view, for this is a scientific affair which remains outside the scope of economic analysis. Further, the matter must be considered as one which must be adopted as is, i.e. in its comprehensiveness, and be processed from the economic, administrative, and social views, while avoiding medical details altogether in order to avoid any confusion.

Medical care in Lebanon is considered the citizens' first concern. For given the progress and development of health services, the citizen devotes a large part of his income to face the high cost of health services and hospitalization. This great progress and interest in health services and their latest technology have motivated many medical specialists and physicians with bright careers abroad to return home and practice the profession in Lebanon. The appeal attracts as well graduates of local universities affiliated with the most recognized medical centers in the world, which enjoy acclaimed scientific levels. Lebanon is distinguished by being an advanced medical center sought by many of the neighboring and other Arab countries. The public and private investment has enabled the establishment of hospitals and the import of the latest equipment. The number of beds and/or scanner equipment "scanner" and magnetic resonance imaging "IRM" with regard to the population number, is among the highest in the world.

The criticism in the medical field is limited to matters that concern administrative affairs. It appears from the statistics of the Ministry of Health that the administrative costs are still reasonable compared to the level of health services, as they do not exceed 8% of GDP (Table 1).

Table No. 1: Expenditure share on health from the GDP

	ASSESSMENT OF	2012	2014
		in Billion L.L.	in Billion L.L.
1	Ministry of Health	647.22	720.37
2	National Fund of Social Security (NSSF)	587.74	765.47
3	Cooperative of Employees	283.11	315.11
4	The Army	240.99	268.23
5	Interior Security Forces	97.87	108.93
6	State Security	9.49	10.56
7	Customs	7.35	8.18
8	General Security	18.45	20.54
9	Private Insurance	739.38	822.95
10	Mutual Funds	159.01	176.98
11	International Organizations	21.79	24.25
12	Families	1.735.23	1.931.35
	Total expenditure on health	4.674.63	5.172.92
	GDP	64.800.00	67.600.00
	Expenditure share on health	7.17%	7.65%

Source: Calculated pursuant to the website of the Ministry of Public Health

The average inflation rate of the expenditure on medical treatment reached 5.5% in recent years, since 2007. Accordingly, the unexpected increase since 2012 can be estimated, for various categories, as outlined in Table 1 above for the year 2014. However, this inflation is nominal, and the real rise will not exceed the resultant from the increase in the population number. Some savings actually happened in the last twelve months, which compensated for the rise in some of the cost elements of health care. For example, the medical bill for care inside hospitals has decreased by 19.89% year on year, i.e. from August 2013 to August 2014[1]. Table 1 addresses the expenses incurred by the population and the State.

(1) Institute for Research and Consultancy "Consumption Price Index" October 2014.

A large number of citizens of Arab countries come to Lebanon seeking medical services. This may be considered as additional revenues to the medical sector which are, however, difficult to estimate since they do not feature in the Treasury's budget or the families'. As it seems, the pace of medical services to foreigners is on a steady rise, as is the sectoral product as well, which confirms the advanced level of medicine in Lebanon. It is worth mentioning that a number of hospitals have concluded agreements with the most advanced health institutions in the United States, and a number of Lebanese medical doctors practice their profession in Lebanon and the United States.

However this does not preclude that a large part of the population reels under the weight of high costs, so people do not obtain the appropriate medical service unless they were well-off or beneficiaries of the available security funds available for limited categories of citizens. This raises the issue of the closed state hospitals, some of which containing the best equipment, however not having been able to attract the necessary human resources for years. This is not due to the lack of capabilities or to a weakness in the medical corps, but rather to the deterioration of the administrative system, for one reason or another, despite the presence of high calibers in its ranks.

The major active authorities in the health sector in Lebanon

The problem of health in Lebanon is confined to administrative insufficiency in health matters; this is due to known reasons unrelated to the professional competencies of the medical body and/or the costs faced by the citizen and the State. Three main parties that participate in the management of the sector are: The Ministry of Public Health, the National Fund for Social Security (NSSF), and the independent health care funds. Irrespective of their own importance, the other active parties, such as hospitals, insurance companies, and the medical corps, find themselves compelled to adapt to the decisions by the said main parties in their regular work. For the latter manage more than eighty percent of the funds allocated to health, and therefore entirely control demand.

1. The Ministry of Health

All citizens who are not subscribed to the NSSF or to a health care fund and/or do not benefit from medical insurance with an insurance company, are the responsibility of the State, particularly the Ministry of Public Health. This category is in excess of 30 percent of the population. In performing its role, the Ministry of Health (MoH) administers the admission of all patients who are on the State's responsibility to the hospitals; in addition, it follows up on their treatment, settles their dues, and dispenses

the medical drugs for intractable diseases as these are borne by the Government rather than the citizens. The matter is taken up to the Ministry's Director General, and sometimes to the Minister himself, when an exaggerated sum is claimed, or in the event of an altercation with an MoH official. Such cases frequently happen because of the prevailing mentality which is rooted in a right to privileges instead of natural rights which any citizen is entitled to obtain automatically. Due to the magnitude of the burden resulting from this role, MoH is rarely left with a meaningful time to carry out the research, planning, supervision, and development functions which are needed for the administration of the health sector in Lebanon.

The above begs the question: Which party can both handle the admission to hospitals and dispense medical drugs? Certainly not the Ministry, as it plays a leading role that cannot be carried out by any other part, and this role assumes:

a) A future vision illustrating the features of the expected development, which would be based on the available data at the Ministry, the change occurring in the country, and the progress achieved in medicine worldwide. This prospective change must take into account the priority which the ordinary citizen places on health care in Lebanon, and on seeing his wishes for social transformations and national solidarity come true;

b) Proposing to the Council of Ministers a submittal of effective policies and budget that fulfill the needs of the citizen, and make available to him a level of health care warranted by the average per capita income, which is his lawful right. The submittal would also indicate how it can be used to achieve a possibly higher rate of productivity;

c) To determine and adopt the strategies that achieve this vision within the available means, in addition to providing medical and hospitalization care to all regions as well, in particular to the most destitute regions in the country's extremities, and protecting all categories of citizens, in particular the weakest in terms of children and the elderly;

d) To prepare and execute programs that aim to expand the health care network to all regions, to supervise the professional training to all medical assistants, to continuously raise the level of human resources, and to attract the competent and promising elements in the profession;

e) To create a financial engineering that takes the priorities into consideration and ensures that expenses are made in a phased way whereby each expenditure incurred today would still

provide for an expected expenditure tomorrow. This clarifies the role of prevention. Moreover, an insufficient budget in most cases expresses the failure in organizing the expenditures;

f) Activating the partnership with the private sector to make good use of available medical capacity, as well as monitor all suppliers of medical and hospital services and maintain quality and cost control, in addition to verifying the conformity of execution to the programs set for the purpose of improving the health services to the citizens;

g) Paying attention to the risks associated with common or imported epidemics, and taking all precautions in a timely manner, thus warding off those risks away from the citizens. The open doors among countries, along with the heavy movement of people, have made the risk of contagion a threat to the whole world whenever an outbreak of an epidemic occurs somewhere on the globe;

h) Giving utmost importance to food, water and air safety, firstly to ensure the health of the citizens, and secondly to build a positive image for the country, especially that it relies on tourism in a fundamental way. For this reason, a clear plan must be drawn and be inclusive of specifications set together with a mechanism of monitoring their application and deterring any offense or violation. The plan would also determine the authorities competent to execute it and follow its implementation through;

i) To release the Ministry in the short term from directly securing the admission of citizens to hospitals and following-up on their treatment, in particular through establishing or assigning a third party administrative company to carry out this role (TPA). The Ministry should also be freed up from the task of importing and distributing the medical drugs whose cost the State shoulders on behalf of the citizens, by assigning a public or a private establishment to perform that role;

j) In the medium and long term, adopting flexible strategies which interact with the realities on the ground to create an integrated health care network over the whole Lebanese territory. Those strategies would also use the best medical and administrative means available, and streamline those resources by organizing the competition that takes place between the private sector suppliers and the public sector;

k) The establishment of a technical and administrative structure capable of playing this role, and monitoring its execution closely to come out with the highest possible level of success, thus making the much agreed upon citizens' wish about the priority of health come true.

2. The National Fund of Social Security

The National Fund of Social Security (NSSF) is one of the institutions that were established during President Fouad Chehab's term, and is perhaps the most important of them because of its direct role in the stability of the Lebanese society. The Fund was established in the mid 1960s, and it comprised of three branches: Sickness and Maternity, Family Compensations, and End of Service Indemnity. There is no doubt that the main fund, Sickness, was a candidate for continuity from the beginning.

The law establishing the fund mentioned that the end of service branch was temporary until the establishment of the pension system, which was anticipated to happen within a two-year period. Before the establishment of the fund, the employee received 20 months when reaching the retirement age — 64 years for men and 60 years for women — and had spent twenty consecutive years in a single establishment. If the employee had willingly moved to another establishment before the due date, he would lose his compensation. However, if the employee was discharged by the employer, then he was due one month of compensation for each year of work in the establishment. The National Fund of Social Security was established to ensure the compensation of the employee wherever his place of work, even if he had willingly left his first employer and without justification (often for a higher salary). This became legitimate, and without negative consequences on the employee, due to his adhesion to the fund's End of Service branch, and the opposite was true.

The fund lost a significant portion of its cash assets, and of the cash accumulated to subscribers to End of Service Indemnity as well, due to the collapse of the lira (Lebanese pound) in the 1980s as a result of the security incidents the country went through, in addition to its administration's lack of experience in investing funds, and the limitations of its governing law in matters of maintaining the value of its assets. So in exception to its inception law of its raison d'être, NSSF was forced to link the disbursement of compensation to the settlement of contributions. Along with that, the fund had to make separate account reconciliations with each employer that the employee had worked for throughout a certain period. But what actually happened is that the employee bore almost entirely the burden for the years that preceded the currency's depreciation, especially when the resources of his employer's establishment had dwindled due to the deterioration of the security and economic conditions, and the account reconciliation was consequently not carried out.

The Family Compensations branch raises a basic problem: Is it only the employees who adhered to the National Fund of Social Security who deserve allowances to help them raise their children? What is the status of the unemployed, who constitute today twenty percent of the labor force? What about those who are unable to work due to a work or security emergency or a handicap? What about the small craftsmen, and the owners of micro enterprises? It appears that the only reason for assigning NSSF with family compensations is to load the burden onto the employer. This undermines societal solidarity under the concept of 'one nation' in favor of a factional solidarity rather; so this compensation often remains theoretical, as most employers take into account, in advance, the cost of family allowances they would have to incur on behalf the employee's wife and children, and deduct it from his salary upon employment.

The Sickness and Maternity branch constitutes the main branch for which NSSF was created, and which must be developed and maintained until the State is able to resort to a more comprehensive system that insures all citizens. NSSF in general, and the health security branch in particular, suffer from several distortions which we mention from our concern to maintain it as an important social need:

- First: The administrative formalities: The medical examinations and admission to the hospital, as well as the reimbursement for the cost of medical drugs and other medical services that take place outside the hospital, require the citizen to get a prior approval from NSSF's administration and long hours of waiting at the institution's service counters, let alone weeks if not months to recover those costs; whereas it takes the privately insured individual only minutes to get all admission formalities processed upon entering the hospital or laboratory. This proves the statement made at the beginning of this chapter that the main problem in health care in the public sector stems from weak organization and administration.

- Second: Age categories registered in the fund: The age categories that belong to the health security branch are the youth (Table No. 2), which means that the cost of medical care is still low, and that each project that benefits the "new" retirees, i.e. each project that excludes the retired before its release may not face difficulty in funding and/or risk running into a deficit, due to the percentage of the number of retirees as compared to that of workers in the first coming years. The percentage increases significantly when the category of 41/51 years reaches retirement, i.e. after an average of twenty years. The situation evidently exacerbates in the following ten years, which requires a very astute administration of the health file.

Table No. 2 : Lebanese insured by age in end of 2012

Age category	Male	Female	Total
Under 20	5.626	6.430	12.056
From 20 to 30	82.526	80.288	162.814
From 31 to 40	83015	45.102.	128.117
From 41 to 50	86.370	38.793	125.163
From 51 to 60	63.381	22.065	85.446
From 61 to 64	13.889	3.272	17.161
Above 64	25.933	3.549	29.482
Total	**360.740**	**199.499**	**560.239**

- Third: The adherents to the Sickness and Maternity branch: The Sickness and Maternity branch includes around 594,000 insured (Table No. 3), 560,000 of them Lebanese and 34,000 foreigners. The total amount of beneficiaries i.e. the insured, is around 1,322,000.

Table No. 3: No. of insured by type of work in end of 2012

Type of work	Male	Female	Total
Regular employee	302.660	137.087	439.747
Elective	11.171	1.611	12.782
Bakeries	808	373	1.081
Newspaper salesman	46	0	46
Employed driver	4.443	10	4.453
Driver-owner	36.141	85	36.226
Student	23.127	33.665	56.792
Medical physician	5.708	1.308	7.016
Sea sector	91	0	91
Mayor	2.064	30	2.094
Teacher	6.061	27.416	33.477
Total	**392.220**	**201.585**	**593.805**

- Fourth: The establishments registered at NSSF: The number of establishments subject to an employer is around 47,000 establishments (Table No. 4): 39,000 micro enterprises, 5,000 small enterprises, 2,000 medium enterprises and a few hundred major establishments[2]. These enterprises comprise around 440,000 insured people who enjoy the fund's benefits together with their families.

It is common knowledge that the above-mentioned establishments pay subscriptions on behalf of around 300,000 insured out of the 440,000 registered in the fund who are affiliated to duly registered establishments, meaning that the third of the latter number i.e. around 140,000 registered do not pay their due subscriptions. This raises many questions.

Accordingly, we face a dual problem:

- The number of establishments subject to the Code of Commerce is estimated at around 180,000 establishments, only 47,000 of which are registered at NSSF (Table No. 4);

- Those establishments declare 440,000 employees to NSSF and pay subscriptions for 300,000 employees only.

Table No. 4: No. of establishments registered pursuant to the number of employees on 31/12/2013

No. of establishments	**No. of employees**
39.380	From one employee to 10 employees
3.472	From 10 to 20
1183	From 21 to 30
660	From 31 to 40
353	From 41 to 50
258	From 51 to 60
192	From 61 to 70
149	From 71 to 80
143	From 81 to 90
98	From 91 to 100
871	More than 100 employees
46.759	**Total**

Source: Website of the National Fund of Social Security

(2) Refer to the chapter titled "Advocacy for a Small Business Act".

- Fifth: Elective insurance: The elective health insurance includes elderly people who have expressed a desire to benefit in exchange for payment of subscription; they number 12,782 (Table 3). The law stipulates that NSSF is not obligated to pay its dues if a deficiency occurred in this section, contrary to the workers health insurance branch. For a certain time, the fund began to delay payments, until the wait stretched for years. It was a given that the insured must pay the subscriptions. In the face of this injustice, the administration of NSSF offered that one could pay the sum of one million Lebanese liras in exchange for cancelling the arrears and withdraw from the Fund.

- Sixth: Deficit of the fund for Sickness and Maternity and the Family Compensations branch: Since a few years, NSSF suffered from an accumulated deficit in the branches of Sickness and Maternity, and Family Compensations, which reached about 818 billion Lebanese liras by the end of 2011; we hope that the solution will not be in increased subscription values (Table 5). In the year 2011, the loss in the Sickness and Maternity branch amounted to 51 billion Lebanese liras. A balance is supposed to have been achieved after the ceiling was raised from 1.5 million Lebanese liras to 2.5 million Lebanese liras. NSSF financed the accumulated deficit from the surplus in the End of Service Indemnity branch. In principle, the owners of personal accounts hold title to this branch's money balance; however it is also common knowledge that a number of compensation owners have left their paid work and/or left the country before their indemnity became due, and lost a part of it. It is estimated that the value of the funds which do not belong to personal accounts that are able to claim them to more than the sum used by NSSF to close the deficit in its Sickness and Family Compensations branches.

Table No. 5: Financial Status for the three branches pursuant to the lump account of year 2011 (numbers in billion Lebanese liras)

Department	**Revenues**			**Charges**		**Results**
Sickness and maternity	Subscriptions	Interests (deficit)	Government payments	Allowances	Admin. expenses	
	495.838	(29.761)	80.699	554.753	42.999	-50.976
	546.776			597.572		
Total of accumulated deficit in the department of sickness and maternity as on 31.12.2011						**-438.802**
Family allowances	Subscriptions	Interests (deficit)		Allowances	Admin. expenses	
	288.636	(25.933)		271.894	301.920	-39.217
	262.703			301.920		
Total of accumulated deficit in the department of family allowances as on 31.12.2011						**-379.748**
Department of end of service indemnity	Subscriptions	Settlement sums	Interests	Allowances	Admin. expenses	
	561.457	67.729	486.064	257.534	32.750	824.966
	1.115.250			290.284		**7.893.611**
Accumulated sums in the department of end of service indemnity as on 31.12.2011						
Total of accumulated deficiency as on 31.12.2011 in branches of sickness and maternity and family allowances						**-818.540**

Source: Website of the National Fund of Social Security

- Seventh: The fund suffers from a rise in administrative expenses:

- The Sickness and Maternity branch: Out of subscriptions that reached around 496 billion Lebanese liras in 2011, the administrative expenses amounted to 43 billion Lebanese liras, at a rate of 8.66%;

- Family Compensations branch: In the same year, the subscriptions reached 263 billion Lebanese liras, and the administrative expenses amounted to 33 billion Lebanese liras, at a rate of 12.5%;

- End of Service Indemnity branch: Calculations in this department differ. The subscription is set at 8.5%, 8% of which is credited to the personal accounts and 0.5% allocated for administrative expenses. The latter percentage amounted to 33 billion Lebanese liras vis-à-vis the administrative expenses which reached 32.750 billion Lebanese liras. It appears that NSSF allocated for administrative expenses only the percentage set by the law.

Consequently, the average of administrative expenses throughout NSSF's three branches is about 10%, and the fund currently has 1100 employees on its payroll whereas its organizational structure allows for 2050 employees. Accordingly:

- What level would the administrative expenses reach in case NSSF decided to fill its personnel vacancies?
- Is it possible to make the necessary reforms with the number of current employees?

3. Independent funds

The specialists in the field of health attribute the high cost of medical care to the multiplicity of funds. On the one hand, some funds lack economies of scale; on the other hand, the disparity of services leads to growing complaints by those who do not enjoy the same rights. This is especially true with respect to the second class in hospitals or the first class even, at a time when the NSSF ensures a uniform class for all.

The accounts of National Health show that the current numbers in Lebanon are exaggerated, and that the basic problem that's obstructing medical services stems from weak administration which causes the main problems on the ground, these being: The concentration of medical and hospital services in some regions and their lack in others, the lack of fully equipped Government hospitals in human resources, the shortage in the number of male and female nurses, and the absence of reliable generics. These matters are not affected by the size of the fund, especially when it includes tens of thousands of insured, and sometimes hundreds of thousands. The development of information and communication technologies (ICT) made the units which benefit from economies of scale and optimum production capacity much smaller than two or three decades ago. Consequently, these small funds became relatively capable to compete and continue (Table 6).

Small funds are distributed among the cooperatives affiliated to the public sector, and comprise more than 14% of the citizens in addition to the mutual funds which have around 3.5%. The latter get established willingly by the insured and mostly under their management, and the State most often contributes to their funding. The independency which these funds enjoy has led to a wide variety in the medical terms used, as well as in the administrative procedures and benefits.

Table No. 6: Sources and financing funds of health in Lebanon (in billion Lebanese liras)

Ministry of Health	720.37	13.93%
National Social Security Fund	765.47	14.80%
Cooperatives affiliated to the Sector	731.55	14.14%
Cooperative of Employees	315.11	
Army Cooperative	268.23	
Interior Security	108.93	
State Security	10.56	
Customs	8.18	
General Security	20.54	
Private insurance	822.95	15.91%
Mutual funds	176.98	3.42%
International organizations	24.25	0.47%
Families	1,931.35	37.34%
Total	**5,7172.92**	**100%**

Source: Calculated pursuant to the National Calculations: Expense on Health – Assessment of 2014

Strengths pertinent to the multiplicity of the funds:

- Homogeneity of the insured to similar needs results in the improvement of quality and cost control;
- It also develops the sense of belonging and responsibility towards the fund;
- Takes into account the standard of living and provides the required services;
- A single environment enables speed in making decisions and implementation;
- Facilitates the monitoring of small funds, and controlling them at more reasonable cost.

Weaknesses pertinent the multiplicity of the funds:

- Special services cannot be provided for some, even with a higher subscription, when the Government contributes with the cost;
- The differentiated services lead to dissatisfaction of those who do not benefit from the higher categories; and to demand similar services for all;
- The fragmentation of the funds hinders the improvement of medical services due

to the differences in naming diseases and the designation of medical procedures, and the method of contracting and payment;

- Economies of scale will not always be taken into account when creating a cooperative or a mutual fund.

Pertinent Opportunities:

- The security funds, including NSSF, contribute only to one-third of expenditure on health (Table 6), which means that the field is open to insure the health of citizens. But it is difficult to expand the scope of the funds and/or increase their number before straightening their performance; therefore we reiterate that this only needs an improvement in their general administration.

- The standardization of procedures, descriptions and transactions constitutes one of the most important factors for activating the funds and developing the services they perform.

The risks faced by the Health Sector:

- Due to the unemployment in Lebanon, hiring relatives and followers became the main concern of some politicians. This phenomenon contributed to overcrowding public administrations, including Government hospitals, clinics and related centers, which led in many cases to the employment of incompetent elements who are also neglectful of the public interest in view of the immunity they enjoy;

- This situation caused pressure on the salaries and wages in the public sector, so the qualified paramedics started to seek jobs in the private sector or even outside the profession;

- The priority given by the Lebanese to health in general contributed to the evolution and diversity of health care services. This increased the size of additional charges i.e. deductions and other conditions imposed by insurance policies. And despite the low per capita income in the country, the awareness of the individual in Lebanon of health matters played a significant role in increasing the demand for health services. Moreover, despite the large influx of Arab citizens to hospitals in Lebanon which encouraged many bright Lebanese doctors abroad to return home, this situation had negative consequences as it exposed shortages in some areas, namely in terms of hospital paramedics, as well as the disparity among and with the existing hospitals. Most of those doctors had emigrated for education and specialization then settled abroad due to the prevailing conditions during the war.

The development in the field of health care services has to be matched at the administrative level in terms of unification of administrative procedures and the

descriptions of medical conditions, as well as in terms of medical and surgical procedures, medicinal drugs and other medical services and needs. Thus, total understanding between the suppliers of medical services and the contracting authorities cooperating together at the patient's service would be achieved, in order to reach the maximum possible degree of productivity.

As for establishing all kinds of funds, the criteria that must be adopted to integrate the medical discourse and achieve the highest degree of transparency, have to be decreed by law.

Effective health policy and standards

Health policy is based on three basic elements:
- Comprehensive health coverage;
- Facilitating the patient's benefit procedures;
- Improving the cost, quality and transparency.

1. Comprehensive health coverage

The Ministry of Health insures all citizens who do not benefit from health coverage by NSSF or by one of the cooperative or mutual funds and/or establishments in the private sector[3]. The number of beneficiaries from one of the funds is estimated to be around 53% of citizens. The distribution of the other half goes in principle as follows: 30% at the responsibility of the Ministry of Health, 12% at the direct responsibility of the patient's family, and 5% covered by mutual funds. This matter remains however theoretical, for not all reach treatment centers since hospitals and clinics are not present in all the country's regions, and doctor clinics are inexistent in the peripheries.

This vision is reinforced by the burden which befalls the Ministry of Health, which is in the range of 14% for the total expenditure on health, a very small percentage in comparison the volume of the beneficiaries. It is to be noted that the ratio of the number of doctors to the population is among the highest globally, for there are 35.2 doctors for each ten thousand individuals (Table 7).

(3) An additional insurance contract can as well be concluded with insurance companies, to cover the percentage that the fund leaves to be paid by the insured. Employers often take up the additional insurance policy at their expense as a grant or fringe benefit to the employee.

Table No. 7: The number of doctors by 10 000 persons

Cyprus	Finland	France	Lebanon	Germany	Italy
27.5	29.1	33.8	35.2	36.9	38.0

Source: International Statistics for Health – 2013

How can it be induced that a hospital be set up in a remote area?

And how can it be induced that a doctor's clinic elects practice in such an area, in order for health care to be available across the country?

Hospitals are located in most areas; unfortunately many of them are not operational despite being equipped with sufficient and modern medical equipment. This is due to the unavailability of human resources in those areas, first of all the doctors.

Arrangements can be made in collaboration with the union of doctors and/or the union of private hospitals to encourage doctors to work in rural regions before obtaining a job in the city's hospitals.

Further, the ministry would follow through on the programs for equipping the regions with medical centers if the inactive hospitals return to being operational, either by updating their construction or by stimulating the existence of private hospitals.

The ministry's role is evidently instrumental in covering the deficiency of hospital presence in the sparsely populated and/or poor regions, which the private sector does not invest in due to the lack of economic viability in those areas. Here, the rules of competition between the public and private sector play a key role in achieving the overall economic feasibility for the health sector: The Ministry actually achieves savings in the Treasury funds when the private sector ventures to establish hospitals and agrees to contract with the Ministry under appropriate conditions; or the Ministry builds a hospital when an economic feasibility is available in addition to providing for the region's needs. The same thinking can be applied at the administration level, where the Ministry can assign the public or private sector to manage new hospitals. Thus the forces of market economy could achieve the highest economic feasibility, the best productivity, and the good use of resources.

2. Facilitating the patient's benefit procedures

This concerns the difficulties that the insured experiences with NSSF in order to obtain prior approval to hospital admission and/or medical tests and/or medical treatments and the delays in collecting the value of the paid bills whether in clinics or pharmacies.

These procedures have become routine and done in minutes before hospital admission for individuals enjoying private insurance policies, through companies specialized in managing health files and payments (Third Party Administrators- TPAs). The citizen considers that the ease of these procedures is a key consideration. Therefore, it becomes imperative to facilitate the paperwork process, especially for residents of regions distant from the main cities, by establishing regional admission centers which would spare the patient the burden of traveling long distances to obtain the pre-approval and the required health services.

The administration of health files dictates ongoing supervision on the admission to Government hospitals, whether State-owned or affiliated to the Ministry of Health. This is done through a roll of permanently resident doctors, who would oversee the admission of those patients who are on the responsibility of the Ministry of Health, and would approve their treatment. There is no difficulty in hiring a sufficient number of doctors in the remote regions if the principle of mandatory practice for two years in the rural regions before working in one of the city hospitals is adopted.

It is also wise to require the patient to bear a limited percentage of the value of the medicines, in order to limit unnecessary use. For example, if a 5% contribution is imposed on the patient, to the ceiling of 10,000 liras depending on the annual inflation rate, the cost to the Ministry will be 91% and 92% at most, thus saving the Treasury 8% and the total public expenditure 3%.

3. Improving the cost, quality and transparency

The total cost of medical care, in its absolute terms, is set outside the scope of this study, because it is a technical issue dealt with closely by technical studies that determine the level of medical services that can be provided to the citizen in accordance with the possibilities available. On the contrary, that study deals with the budget that can be allocated by the State to meet the cost of medical care in whole or in part, in lieu of the citizens who are unable to meet those burdens by themselves. In our view, the level

of medical services is determined by the average income per capita at purchasing power parity (PPP) as compared with other countries (Table 8). The offerings can be compared with those in countries with the same per capita income, in order to determine the quality and cost of medical services that deserve support.

Iran	Bulgaria	Mexico	Lebanon	Malaysia	Croatia	Argentine
$ 12.800	$ 14.400	$ 15.600	$ 15.800	$ 17.500	$ 17.800	$ 18.600

Table No. 8: Average per capita income at purchasing power parity (PPP) for the year 2013

Source: The World CIA Fact Book

Existing projects and development in the right direction

In the mid-sixties, the National Social Security Fund (NSSF) established the end of service indemnity for a temporary period until the retirement scheme would be set. At that time, subscription to the three branches, End of Service Indemnity, Sickness and Maternity, and Family Compensations, became mandatory; and upon reaching the retirement age or requesting the payment of indemnity dues, the insured would exit the fund and lose the sickness security. The individual loses health coverage at retirement age, when he mostly needs it. Since the beginning, it was conceded that the system did not provide appropriate social coverage, but that it was better than nothing. Before NSSF's establishment there was no health coverage, and the employer used to give the employee a one month salary for each year of employment at a maximum of twenty years, which the latter received when he reached the retirement age (64 for the man and 60 for the woman), or if the employee decided to leave the job after twenty years of work for the same employer. The employee stood to lose his compensation if he left his job on his own before reaching the retirement age, or before the end of the mentioned work period. NSSF came to guarantee the salary or wage earner an absolute right to the accumulated subscription funds even if he moved from one job to another, or if he left the service before the retirement age or before working for a period of twenty years for the same employer. If he wanted to liquidate the compensation before the legal retirement age or before twenty five years of work (the period set by NSSF), then he would earn a partial compensation and lose the balance. Anyhow, he would be considered outside NSSF and would neither benefit from health insurance, nor from family compensations if he was married and has children. Often times the wage earner spent his end of service indemnity on medical services that he came to need after leaving NSSF.

1. Retirement plan and social protection

The unions and employers have been advocating this scheme since NSSF was established. Many such projects did not see the light, sometimes for fear of their cost on society, and other times to avoid giving credit to the political entity that proposed them. In the early 1990s, the Businessmen's Association presented a project based on three pillars: The first twice as equal as the minimum wage with mandatory adhesion of all concerned; the second under six times the minimum wage with mandatory adhesion as well; the third elective and addresses the people with high salaries. All adherents would benefit from health insurance. The first and second were built on the distribution system pursuant to the principle of community solidarity, while the third was based on the principle of capitalization, i.e. on private accounts as in private investment.

In 2001 the later Prime Minister Rafic Hariri drafted a project based only on capitalization as he was convinced that it would neutralize all argumentation and help in launching the project. Then the Government presented the project to the Economic and Social Council (SEC); it was unanimously approved within a month, after asserting that a first distributional part would be adopted as an expression of community solidarity.

The consecutive Cabinets made several amendments to the project, then it was presented to the Common Parliamentary Committee presided by MP Atef Majdalani, where deliberations took more than a year. When the Government of PM Najib Mikati came to power, the Minister of Labor, Boutros Harb, requested to reclaim the project. It was then discussed in detail with the representatives of the employers and labor unions in the presence of NSSF's administration and actuary specialists. This project ensures retirement after reaching the legal age with the continuity of health insurance for the retired and his family, same as when that individual was working. At that time, the subscriptions were set for an average of 13.5% to be borne by the employer, the insured, and the Government. But the discussions relative to increasing the subscriptions or decreasing the subjected salaries whenever there is a deficiency in the system were not completed. Before the Cabinet was changed, the Minister drew on the assistance of the International Labor Organization (ILO) which presented him with a study made by a Canadian consultancy firm that recommended relying on virtual subscriptions. In the latter's opinion, that system would satisfy both employment parties. The project came to a halt with the advent of the PM Tammam Salam's Cabinet.

2. The Project for benefiting the retired from health insurance

When the retirement project and social protection project got in trouble, the Parliamentary Committee looked for a project which would provide continuity of health insurance for the retired. All parties, the employer, the beneficiary, and the Government, each for 1% of the wage earner's salary with a maximum limit equivalent to the ceiling in effect at health insurance, which presently stands at 2.5 million Lebanese liras per month. The retired and his family members would benefit from the project as per the system in place at NSSF's Sickness branch, provided that the retired had contributed to the fund for a period of at least twenty years. The retired would later assume a 9% subscription from the existing minimum wage on the date.

The actuarial study showed it possible to maintain the rates of subscription until 2050, with the possibility that the system would be replaced before that by a retirement and social protection project, or by a comprehensive health coverage system for all citizens.

3. Comprehensive Health Project

This project was presented in 2012 by Minister of Labor Charbel Nahas at the time of PM Mikati's Cabinet. One of its advantages was that it did not exclude any person from health insurance. Practically, everyone would benefit from the NSSF's "insurance level" and whoever wished for higher class benefits had to contract private health insurance. This system would be funded by the State's budget and ensure solidarity among all members of society. However, the experience was that this system had met with serious deficits in several advanced countries; so some of them withdrew from it several benefits which were granted to the citizen, in order to limit its cost and ensure its continuity.

In modern history, when Dr. Jawad Khalifé was Minister of Health, he along with Dr. Karam Karam proposed an integrated vision of a comprehensive coverage. At that time, the Government was not prepared to face such an ambitious project, in view of the main obstacle being its funding. In principle, when a project covers all citizens, the adequate way to fund it would be through the State Treasury levying taxes. However, we must take into consideration the experiments in advanced countries where comprehensive health insurance became a source of cumulative and growing deficits. The main reason for deficit was the citizen claiming special and developed services while not being prepared to pay for their cost. In Lebanon there is a chance to provide for this funding through contributions from expatriates who wish to participate in the medical care

system by paying an annual subscription fee equivalent to the average tax paid by the beneficiary citizen[4].

The strategy of change

The term "strategy" is often used to indicate various programs which are not necessarily connected; in this case, the failure of one program could lead to the failure of the entire project. We rather mean by "Strategy of change" a set of programs which are coherently related to the objective. If one of them fails, another one takes its place, which does not preclude the ultimate achievement of the project. Therefore we propose a strategy built on three pillars: Management of change, phased change, and the role of budgeting in achieving change.

1. Establishing the management of change

Change requires an administration which is fully aware of the health policy's objectives and the available possibilities, and which is also capable of closely monitoring progress, anticipating demand, and monitoring the evolution of the quality and cost of medical services, as well as taking appropriate measures to straighten any deviation in the project's course.

In order for the Ministry to carry out this role, it has to relinquish the executive such procedures that exhaust the conduct of its activities as granting prior approvals for citizens' hospital admissions and dispensing free medical drugs. Alternatively, an independent regulatory authority must be established to handle the organization of the supply of health services; it would take care of granting permits to establish hospitals and clinics, and to import medical equipment and drugs, in addition to licensing the consumption of medicines, as well as authorizing the opening of pharmacies, setting their specifications, and monitoring their work.

2. Visualizing the stages of change

There is a relationship between the average per capita income and the level of services that the country can provide. The average per capita income in Lebanon is about 15,000 US dollars at purchasing power parity[5]. This determines the ability of the Government to spend on health, compared with countries that have similar per capita income.

(4) Details would be put forth upon acceptance of this principle.
(5) Purchase Power Parity.

This does not necessarily require the study of the level of medical services in similar countries since medicine is advanced enough in Lebanon, but to learn the direction which can be taken for spending on health in the future given the importance of this facility for the Lebanese people and their willingness to sacrifice in order to have an excellent medical service.

It should be noted that the adoption of the average per capita income at purchasing power parity, in comparison with similar countries, makes health services beyond the reach of a large segment of the population due to the disparity of incomes in Lebanon. However this is exactly the cost which falls on the shoulders of the Government to achieve community solidarity. The cost of these services are to be accounted for in the budget of the Ministry of Health and spent from tax revenues to cover low-income people.

Thus we would have identified the direction of health care, and the cost that the Government must bear; this can be implemented in stages until the set objective is achieved. The overall period may take from three to five years, during which the budget of the Ministry of Health may rise to provide adequate health services to the classes which are not well-off, at the level justified by the citizen's average purchasing power parity.

3. Linking the budget with achieving change

This entails a migration from one system to another. The present system is one where the operational budget of the Ministry of Health is determined by relying on the budget of the year prior, the number of its dependent citizens, and the installations budget, namely the establishment of hospitals and clinics pursuant to a plan based on the estimated needs or statistical studies of the expected needs. The move should be to a system based on "health power parity" which rests on the average purchase power parity of the per capita income, where its elements are distributed among the different needs as per a daily follow-up of health affairs where the right adjustments to the apparent needs are made, to the point where all Lebanese obtain the health services they aspire to and which the national revenues can warrant.

The prospective targets

We mention here the progressive targets which must be achieved in order to secure the required development in the field of health care. The adopted measures aim to improve the service and reduce costs.

1. Unification of the medical terms

Different terms are used to indicate the medical procedures, drugs, and services, depending on the multiplicity of references that contributed to the creation of health

care activities and the dissemination of medical culture in Lebanon, as they naturally had to rely on their own lexicons. At some time this was considered enrichment, but it became an obstacle in managing health facilities, organizing their work, and in unifying the discourse between the contracting parties interacting together in the medical field. This matter indicates the need to adopt common terms for dealing with each other.

2. Integration of administrative procedures

The Lebanese bureaucracy overshadows the administrative procedures in the medical field, as it's the fact in the various fields. The development of the health system needs to reinforce the relations and collaboration between the various insuring funds and suppliers of health services on the one hand, and the Ministry of Health and other relevant departments on the other hand. This requires the unification of the administrative procedures, in order to reach a rationally functioning system.

3. Bridging between the terms of benefit

The free economic system encourages disparity between the terms of benefit from the mutual funds that operate on principles similar to health insurance in the private sector. However, when the Government contributes to the financing of the fund and therefore assumes part of the cost, then special terms cannot be granted at the expense of the public money. That is, if we take for granted that the support of independent funds is righteous, instead of encouraging their members to subscribe in the National Social Security Fund.

The current and anticipated pressures

The multitude of funds is considered per se an invitation to compare benefits and claim similar terms, in particular at the expense of the Government. This is all the more the case when the classes of hospitalization vary.

1. Pressures resulting from conflict of interest

The employer, the employee, and the Government contribute to funding NSSF's Sickness and Maternity branch in different proportions. The parties consider that contributing is normal and rightful, as it improves the comfort level resulting from sickness insurance, in addition to work conditions and productivity. Moreover, the Treasury's contribution forms a direct expression of community solidarity. When the ceiling of subscriptions changes, the percentages remain the same, since they had been previously determined, semi-finally, by negotiations between the parties and as approved by the Government. The ceiling limits the sum of medical expenses on the

one hand, and the solidarity percentage among the wage earners on the other hand, as the legislator had considered that there was no need for the highly paid employees to pay subscriptions relative to their full salaries as long as the benefit is the same.

2. The pressures resulting from acquired rights

The disparity between the terms of benefit forms a source of dissatisfaction in reality, and feeds reciprocity demands by those who feel that their situation is not equivalent to that of others. This threatens the health sector's stability and causes the continuity of cost increase. The privileged refuse to retract the class benefits they obtained and consider these as acquired rights which cannot be relinquished. Therefore this matter must be treated early and not be allowed repetition in the next projects. Therefore the Government must not contribute in any fund that grants terms which vary from NSSF's.

3. The stagnation resulting from the impairment of possibilities

The economic crisis in the country, and the absence of growth in recent years, prevented the improvement of health affairs; further, the preservation of services became a difficult task. Each improvement during the current circumstances must be profited from, in order to work on closing the gap between the health services whose burden the Government assumes and contributes in, and on harmonizing the terms of benefit among the insured, in addition to limiting the practice of making analogies and claims.

4. The irregular situation caused by the displaced

Around 1.5 million displaced from Syria and Iraq currently live in Lebanon in difficult conditions, a large number of them in tents, where the risk of diseases and infections is increasing. This poses a double problem: Funding the necessary installations to face the emerging numbers, settling hospitalization bills, and paying up the providers of health services. It is true that the UN commission for refugees, UNRWA, and other international institutions contribute in medical costs, yet this is not enough to cover the actual requirements, which makes Lebanon humanely forced to cover costs that outweigh its capacity.

A special treatment is needed to confront this dilemma, beginning with an in-depth study of the needs and potentials. This basically raises the issue of international solidarity, since without it nothing can be done.

As for the level of installations, especially in hospitals and infirmaries, the plan to

equip the regions and rural areas could be accelerated in order to meet the needs of the displaced, and at the same time complete the expansion of the network of health services across the whole Lebanese territory. This means that a plan must be first prepared, so that the installations would fit the needs in the long run.

Instrument of change and the Ministry's Modus Operandi

The Ministry of Health (MoH) is the agent of change in regards to the sector, from its vantage point of handling the organization of the sector, and from having a clear vision of its future prospects and the goals that must be achieved for the vision to materialize. This makes it imperative to delegate the authority of executing many procedures which the ministry carries out today to executive administrators who are specialized in providing health services to the citizens. This particularly concerns controlling the admission of patients to hospitals, importing and taking over the distribution of medical drugs presently assumed by the Ministry. Alternatively, and in order to maintain the sector, a regulatory authority must be established and be vested with the powers necessary to practice this role.

1. The role of the Ministry in organizing the health sector

Whether the Ministry organizes the sector or the Government establishes a regulatory authority, the health sector needs to undertake the following tasks:

a) To set the executive program for contracting with hospitals;

b) To conclude contracts and follow-up on their execution;

c) To set an executive plan to establish Government hospitals, and help in the administration of the subcontracting process, execution control, and equipping the facilities;

d) To supervise all health services suppliers;

e) To monitor the offerings of the insuring funds;

f) To grant, and withdraw, the permits to practice the profession to all the establishments that deal with medical services, with the exception of those organized by the law;

g) To take the necessary actions to straighten the course of the health sector whenever necessary; Etc…

2. Compatibility and coordination between the insurance parties

The consolidation of medical terms and administrative procedures presumes the prior understanding among the insurance entities, and agreeing on the terms granted

to the insured, in particular if the concerned fund benefits from the Government's contribution. In this case, the terms and benefits should not be different than those which are in practice by NSSF.

This warrants the consolidation, from the administrative and economic sides, of the sickness funds which benefit from the contribution of the Government. NSSF must perform this role as a prelude to the comprehensive medical coverage system. As for the funds existing at the expense of the insured, or the insurance schemes existing in the private sector, where the contribution constitutes an indirect increase to the salary subject to tax, it is the closest to private sector insurance and must be organized by the law which authorizes its establishment.

3. Role of the budget of the Ministry of Health in activating the sector

When preparing its budget each year, the Ministry must:

- Prepare a study of the expected volume of the treatments that will be made at the expense of the Ministry, based on historical data from previous years; with details of the contracts concluded with the private sector's hospitals;

- To prepare a study of the Government hospitals. While including those which are operational, it would also include those which are not operational, whether fully or partially, together with the reasons why. It would also comprise the anticipated volume of the treatments that must be carried out;

- To prepare a Program Act budgeting for the installations and equipment that will take more than one year, while determining the expected cost in the annual budget under preparation;

- To prepare a list of purchase and/or import of medical drugs, together with indications of the procurement sources.

Mechanism of coordination and development

The organization of the sector needs a system that connects all the service providers in order to ensure their proper inter-communication at the service of the patient. This is prevalent in all advanced countries since many years, particularly since the spread of the Internet in Europe twenty years ago. It is considered an important rule for medical work and for the implementation of administrative procedures as well, toward keeping the patient in a comfort zone.

1. Personal Medical Records

All hospitals currently save a personal file for each patient they treated, and put it under his disposal. These files gain a significant importance in emergency cases. They also constitute an important scientific reference when the patient is examined, and saves repetition of laboratory tests. Consequently, hospitals must be linked to one electronic center or server, thus allowing doctors to retrieve a patient's file for reviewing his medical history, provided that this action is made upon the latter's authorization.

2. The electronic center

Connecting public health departments, hospitals, pharmacies, and other providers of medical services together requires a central system or network shared by all concerned parties, so that they could immediately communicate with each other in order to carry out all the actions needed by the health system. Of course, the ministry must carry out this project and monitor its implementation and maintenance, as well as determine how to access it. Examples abound the world over in regards to such a link, and how to use it scientifically and administratively while maintaining the highest degree of medical ethics. Determining the best networking system available nowadays, and implementing it with the most suitable hardware and software, would make it possible to upgrade the health services across the whole Lebanese territory to a twenty-first century level.

3. The financial approach for the project

The equipping of medical facilities and linking same to the electronic network is not a costly operation, because most hospitals nowadays used the most advanced technical methods which can be linked directly to the network and owns most of the tools needed for this purpose. Consequently, this project can be immediately applied.

The executive program for the Health Policy

A practical program can be extracted from what has been presented to develop the health sector in Lebanon depending on its capabilities and the will of the Lebanese who give the health aspect a priority in their daily lives:

1. This paper's summary indicates that the level of medicine in Lebanon is advanced, and that it is sought by many patients from neighboring countries and the Gulf region and matches medicine in advanced countries. What is needed now is the generalization of a good health service at the same level in all the country's regions and to all social classes, in particular to those individuals who are marginalized and are treated on the expense of the "Ministry of Public Health".

2. Therefore, the Ministry of Health must take action in the management of the sector, especially in taking the measures aiming to provide the same level of health services in the regions and rural areas as those which the citizen receives in the capital's hospitals and doctor clinics. This requires the Ministry giving up its direct administrative responsibilities, in particular hospital admission as well as monitoring treatments and settling obligations, in addition to the distribution of medical drugs directly by the Government to the citizens.

3. As well, it should also focus on good management in order to achieve equality among regions, and for the deprived social groups. This leads to working on the value chain in the health field which consists of the Ministry of Health, doctors, security funds, hospitals, laboratories, pharmacies, and other providers of medical services.

4. This program aims to improve the productivity conditions for establishing the foundations of a quality value chain in various areas of health care and in the Lebanese territory: - Operating an adequate number of hospitals in the regions, at the level required - The use of an adequate number of doctors, and encouraging the opening of clinics - Encouraging the work of paramedics and all the providers of medical services.

5. The ministry executes the program through a "healthy" competition between the public and private sectors; and sets the parameters between establishing hospitals funded by the Treasury, and contracting with private hospitals to apply the Ministry's policy for the regions. This contracting can be carried out in part, thus leaving a floor of the private hospital for the doctors to invest in at the service of the well-off class. The Ministry would as well collaborate with the Order (Union) of Medical Physicians, the Order of Private Hospitals, and the Order of Pharmacists and other representatives of the medical services providers, to create an appropriate investment climate in the medical field over the whole Lebanese territory.

6. The average per-capita income at purchasing power parity determines the level of health care which the economy faces in a given country. This average represents the hypothetical rights derived from citizenship. Moreover, the difference between the rights derived from citizenship, and the actual capabilities of the working social groups, represents the margin of community solidarity.

7. Routine works must not continue, as in granting prior approval for the patient's hospital admission, monitoring his treatment, paying the dues and other medical and

laboratory procedures, and/or providing the patient with the medical drugs, directly on the responsibility of the Ministry. It is necessary to assign a third party administration company (TPA) to carry out these tasks, as is the case in the private sector, in order for the Ministry to carry out its main duties at the service of the health sector overall.

8. This also applies to the security funds, with NSSF in the forefront, where the administrative procedures require a long time and a big trouble, in addition to the long wait to collect the dues, whereas the TPAs provide these services to insurance firms in the private sector in an immediate fashion, earning them the respect of both corporations and individuals.

9. In the long run, all citizens must be included in the comprehensive health care program of the public budget, and of course on NSSF terms, i.e. what is known as "NSSF Class". Private insurance remains for the well-off in all classes. In order to avoid the deficits that occurred in several countries, we must totally separate between the comprehensive health insurance and private insurance.

Lebanon can easily rectify the health services due to the progress it made in the medical field; it can also rectify all anomalies that the citizen suffers from by applying administrative procedures tested in Lebanon and abroad. These will give immediate results and develop the health sector in Lebanon in the medium run. We do hope that the pertinent decision of adopting the afore-mentioned program will be made, for the good of the country and its citizens.