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A Roadmap to Parity in Mental Health Financing: The Case of Lebanon

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Abstract

Background: Inadequate access to mental health (MH) services in Lebanon, where prevalence is noteworthy, is a concern. Although a multitude of factors affects access to services, lack of financial coverage of MH services is one that merits further investigation.

Aim of the Study: This study aims at providing a systematic description of MH financing systems with a special focus on Lebanon, presenting stakeholder viewpoints on best MH financing alternatives/strategies and recommending options for enhancing financial coverage.

Methods: A comprehensive review of existing literature on MH financing systems was conducted, with a focus on the system in Lebanon. In addition, key stakeholders were interviewed to assess MH organizational and financing arrangements. Finally, a national round table was organized with the aim of discussing findings (from the review and interviews) and developing an action roadmap.

Results: Taxation and out-of-pocket payments are the most common MH financing sources worldwide and in the Eastern Mediterranean Region. In Lebanon, all funding entities, except private insurance and mutual funds, cover inpatient and outpatient MH services, albeit with inconsistencies in levels of coverage. The national roundtable recommended two main MH financing enhancements: (i) creating a knowledge-sharing committee between insurers and MH specialists, and (ii) convincing labor unions/ representatives to lobby for MH coverage as part of the negotiated benefit package.

Discussion (and limitations): There are concerns regarding the equity, effectiveness and efficiency of the MH financing system in Lebanon. The fragmented system in Lebanon leads to differences in MH coverage across different financing intermediaries, which is inequitable. The fact that one out of four Lebanese suffer a mental disorder throughout their lives and very low percentages of those obtain treatment signals a problem in effectiveness. As for efficiency, the inefficient fragmentation of MH financing among seven intermediaries is a problematic characteristic of the healthcare financing system as a whole. Moreover, the orientation of the general healthcare system towards curative rather than preventive care is reflected in MH financing as well. Limitations of the study include the lack of access to data about the MH expenditure of every financing intermediary in Lebanon; therefore it was not possible to calculate a total annual MH spending on a country level. Another limitation was the inability to map the sources of funding with the MH service provision sector, as more extensive data about the MH services provided by each of the public, private, voluntary and informal sectors is needed.

Implications for Health Policies: Providing a clear description of the current MH financing system helps policymakers recognize the disparities present in the coverage of MH, guiding them into making informed decisions on allocation of funds. This study therefore constitutes the first step towards achieving more equitable and socially just coverage, advances knowledge and provides well-needed locally relevant research. Findings are expected to inform policymaking and have already contributed to influencing a change in the policy of the Internal Security Forces Health Fund. As a result of the roundtable discussion and follow up that ensued, the fund has removed the suicide attempt exclusion from its insurance policy.

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Background

Mental disorders are a major cause of long-term disability. Worldwide, neuropsychiatric conditions are responsible for a quarter of all years-lived-with-disability. Among all non-communicable diseases including cardiovascular disease and cancer, neuropsychiatric conditions contribute the biggest share (a third) of all disability-adjusted-life years.[1] Moreover, mental health (MH) problems make up 12% of the global burden of disease, and this number is expected to increase to 15% by 2020.[2] Yet, MH systems remain severely underdeveloped in many parts of the world and facing enormous challenges.[3]

One such major challenge is ensuring an equitable and effective financing system. Financing MH services, as other health care services, is a major factor affecting access and health outcomes.[4] Countries differ in the financing sources for MH services. In most high-income countries, MH services are financed from a mix of taxation, social health insurance (SHI) and private health insurance (PHI). On the

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other hand, a considerable proportion (40%) of low-income countries depend on out-of-pocket (OOP) payments as the most common financing method; public funding is limited and often complemented by donations and grants.[2] This is of concern as it implies that benefits may be distributed according to ability to pay and hence results in inequitable access to care and risk of catastrophic costs.[2,5]

The Mental Health Care System in Lebanon

In Lebanon, a middle-income country located in the Eastern Mediterranean region, a national study found that one in four Lebanese adults have suffered at least one mental disorder throughout their lives.[6] Similarly, another study found alarming results indicating that 17% of the population has suffered from at least one mental disorder in the past year.[7] While these figures from Lebanon are in line with those of developed countries, the difference lies in the wider treatment gap. Studies of treatment patterns have reported that only 10.9% of people having suffered a mental illness in the past year in Lebanon obtained treatment,[7] and treatment delays ranged between 6 years for mood disorders and 28 years for anxiety disorders.[6]

Financing MH services in Lebanon is not different from that in other low- and middle-income countries. According to the World Health Organization (WHO) MH Atlas of 2011, MH expenditures by the ‘‘government health department/ministry’’ make up 4.8% of the total health budget in Lebanon, with 54.2% of that going to mental hospitals.[8] The main reported source of financing was OOP payments, a change from 2005 where tax-based funds were the most dominant.[4] There are no specific budget allocations for MH, which means financial resources are never secured.[4,8,9] Moreover, MH services are explicitly excluded from private insurance coverage.

Mental health services in Lebanon are provided mainly through the private sector. There are 3 mental hospitals and 5 psychiatric units within general hospitals, with a total of 43 psychiatric beds per 10,000 population. The Ministry of Public Health contracts with the private hospitals in order for needy patients to receive inpatient mental health care. The system suffers from imbalance, with a lack of preventive and community-based services, and a concentration of the available mental health services in the capital, Beirut. There is an essential list of psychotropic drugs which includes anti psychotics, antidepressants, anxiolytics, mood stabilizers and antiepileptics, that are supplied for free to Primary Health Care Centers by the Ministry of Public Health. As for mental health professionals, Lebanon suffers from a shortage of psychiatrists, with 1.5 psychiatrists per 100,000 population, the majority of whom work in private practices and for-profit mental health facilities. Two thirds of other psychosocial staff work for public facilities.[9,10] According to the WHO-AIMS Report of 2010, the ratio of mental-health provider per 100,000 population is: 2.2 psychologists; 0.2 other medical doctors; 1.8 nurses; 0.5 social workers; 1.2 occupational therapists; and 7.5 other mental-health workers. Mental health is not yet well integrated into the primary health care network of Lebanon; centers lack assessment and treatment protocols with only a few centers referring patients to specialized mental health clinics when needed.[9,10]

In light of the dearth of information, beyond what was mentioned above, this study aims to provide a systematic review of the current situation of MH coverage in Lebanon, as a first step in the efforts towards parity of mental health. Parity, in this context, is referring to reducing, and then removing, limitations on MH benefits to render access to MH care comparable to that of general medical conditions.[2,11] Specifically, the objectives of the study are: (i) to review MH financing systems internationally and regionally, (ii) to explore and describe how MH services are financed in Lebanon, and (iii) to evaluate the MH financing system in Lebanon and recommend options for moving towards parity through consensus generated from a national roundtable with key academic, governmental and private stakeholders.

Methods

A literature review and national consultation were conducted to identify and explore the most common MH financing mechanisms internationally, regionally and in Lebanon. The consultation involved a series of key informant interviews and a roundtable discussion.

Literature Review

To describe how MH services are financed in different countries, a search, limited to years 1996-2013, was conducted in MEDLINE, Cochrane and Google Scholar to identify articles related to MH financing systems. The keywords used included: mental health, mental health services, psychiatr-y/ic, psycholog-y/ic, mental disorders, economic(s), cost(s), financ-e/ing, insurance, Middle East, Arab, and North Africa. Scholarly articles were retrieved. WHO reports, including the WHO Mental Health Atlas, were reviewed in-depth as they provide a description of the MH care system in every country and categorize information by WHO Region and by Income Groups. The websites and reports of the Lebanese Ministry of Public Health and other Lebanese financing intermediaries were also examined.

Key Informant Interviews

Due to the limited information that could be found in the literature on MH financing in Lebanon, key informant interviews were conducted. Purposive sampling was used to select informants from public and private funding agencies. The sample consisted of 11 key officials in the 9 main health funding entities in the country:

1. Ministry of Public Health (MOPH)
2. National Social Security Fund (NSSF)
3. Civil Servants Cooperative (CSC)
4. Technical Union of Mutual Funds
5. Army Medical Brigade
6. Internal Security Forces (ISF) Health Department

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7. General Security Forces (GSF) Health Department
8. State Security Forces (SSF) Health Department
9. Association of Insurance Companies in Lebanon (ACAL)

Prior to the interview, permission was obtained from the director of every organization to visit the site and conduct an interview with the key informant. A cover letter was also sent explaining the purpose of the project and outlining the questions to be discussed. A face-to-face semi-structured interview was then carried out at the organization using an interview schedule. This approach was beneficial in reducing interviewer variability, easing the data processing and providing the flexibility to probe further into significant responses.[12] No audio or visual recording was made to ensure participants' confidentiality; instead, detailed meeting minutes were taken to record responses.

Roundtable Discussion

The researchers prepared a background paper summarizing the preliminary findings of the literature review and key informant interviews. The paper was presented to the participants of the roundtable held in Beirut (Lebanon) to inform the discussion on achieving parity in MH financing. The roundtable grouped key stakeholders from diverse backgrounds: governmental agencies, professional associations representing providers and insurers, experts in health care finance and non-governmental organizations. The purpose was to explore and identify options for reforming the MH financing system in Lebanon. The discussion focused on: i) disparities in public MH financing; ii) the lack of private insurance financing; and iii) identifying steps and commitments for continued action.

Data Analysis

To analyze data from international and regional literature, the most common sources of MH financing were listed by WHO region and income groups (international), and by country (regional). Other details were listed in the same format when available, such as MH budget allocations, disability benefits for the mentally ill, and % of mental hospital expenditure out of total MH expenditure.

As for the key informant interviews, the following steps were taken for data analysis: (i) thematic analysis to describe the MH coverage (or lack thereof) of the financing intermediaries, with the themes being: specific budget allocations, inpatient coverage & limitations, outpatient coverage & limitations, exclusions and annual expenditures; (ii) comparison of every fund's MH coverage with its standard health coverage to highlight any inequities or disparities against MH; and (iii) analysis of emerging themes.

The roundtable discussion was also analyzed thematically, with the themes being: (i) description of private and public experiences with MH coverage; (ii) identified options for improving public and private coverage; (iii) and commitments expressed by stakeholders for continued action.

Results

Literature Review

MH Financing Internationally

Prior studies have reported that almost 30% of countries worldwide do not have a specific budget allocated for MH.[4,13] In the World Health Organization (WHO) Eastern Mediterranean Region, 71.4% of countries do have a specific budget; however Lebanon is not one of them.

When examining countries according to the World Bank income groups, it is evident that the two most common methods in the Higher Middle Income group which Lebanon belongs to are taxation and Social Insurance. Unfortunately, in Lebanon OOP payments were reported to be the primary source of MH financing, a change from 2005 where tax-based funds predominated.[8]

MH Financing Regionally

In most Arab countries, data on MH expenditure as percentage of total health expenditure is not available.[14,8,4] Counseling and psychotherapy visits are usually either not covered or the cost sharing for such services is considerable.[14] **Table 1** compiles the data available on MH financing systems in Arab countries. Ten out of 18 Arab countries (56%) have a budget allocated specifically for MH, while 7 do not. In over 55% of the 18 countries, data on the Governmental Health Department's MH expenditure as a percentage of the total health budget is not available.

In 3 out of 5 countries, mental hospital expenditures take up a huge portion of the total MH spending, constituting 94% in Syria, 81% in Algeria and 54% in Lebanon. This signals an orientation towards curative rather than preventive care in MH, which can cause the country to miss out on opportunities for cost savings achievable through early diagnosis, treatment and prevention in outpatient settings.[15] Finally, disability benefits for people with mental disorders are provided in 16 out of 18 (89%) Arab countries; however, the benefits offered differ among the countries, as there is no consistent package. In Lebanon, Law #220 which protects the rights of the disabled (among whom are MH patients) has been issued since 2000 but not yet implemented.[16]

Key Informant Interviews

Thematic Analysis Results for Lebanon

Specific Budget Allocation

In Lebanon, none of the financing intermediaries have specific budget allocations for MH (**Table 3**). In cases where coverage is offered, expenditures on MH are part of the total health budget of the fund. This finding is supported by the literature.[4,8,9] According to the MOPH, the lack of specific budget allocations for MH does not constitute a problem since this is the case for all illnesses. However, such absence implies that there is no regular and secure source of funds leaving MH to compete with many other health priorities in the country.[13]

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Table 1. MH Financing in Arab Countries

Country	Specific budget for MH	Governmental health department's MH expenditure/Total health budget[8]	Mental hospital expenditure/Total MH expenditure[8]	Sources of financing (in descending order)[4]	Disability benefits for individuals suffering from mental illness[4]
Algeria	No	7.37%	81.44%	Taxation	Yes
Bahrain	No	3.96%	N/A	Taxation, OOP	Yes
Egypt	Yes	2.29%	59%[14]	Taxation, OOP, Social insurance, Private insurance	Yes
Iran	Yes	3.60%	16.69%	Taxation, OOP, Social insurance, Private insurance	Yes
Iraq	No	N/A	N/A	Taxation, OOP	Yes
Jordan	No	N/A	N/A	Taxation, OOP	Yes
Kuwait	Yes	N/A	N/A	Social insurance, Private insurance, OOP	Yes
Lebanon	No	N/A	54.17%	Taxation, OOP, Social insurance	Pending implementation of law #220
Morocco	Yes	N/A	N/A	Taxation, Social insurance, OOP, Private insurance	Yes
Oman	Yes	N/A	N/A	Taxation, Private insurance, OOP	Yes
Qatar	Yes	N/A	N/A	Taxation	Yes
Saudi Arabia	Yes	3.89%	N/A	Taxation	Yes
Sudan	Yes	N/A	N/A	Taxation	Yes
Syria	Yes	2%	93.59%	N/A	Yes
Tunis	No	4.95%	17.79%	Taxation, OOP, Private insurance, Social insurance	Yes
Turkey	No	N/A	N/A	Social insurance, Private insurance, Taxation, OOP	Yes
UAE	N/A	N/A	N/A	N/A	N/A
Yemen	Yes	N/A	N/A	OOP, Taxation	Yes

N/A: Data not available.

Inpatient and Outpatient Services

All intermediaries, except private insurance and Mutual Funds, cover inpatient and outpatient MH services. However, limitations for coverage differ widely across the intermediaries (**Table 3**). For inpatient services, some intermediaries are bound by the annual ceilings specified for contracted hospitals, and only the CSC places a limit on the length of hospital stay. For outpatient services, the variability in coverage across intermediaries is even wider. There is large inconsistency in the reimbursement rates of MH outpatient visits and drugs, and in the services included in coverage; some only dispense drugs free of charge, some cover consultations and psychotherapy sessions whereas others cover consultations only.

Exclusions

The ISF excludes self-injury and suicide attempts from coverage. The NSSF excludes services provided by psychologists and psychoanalysts. Even though the CSC and ISF cover consultations, they do not cover therapy sessions. Such exclusions are paradoxical because by covering consultations the patient may be diagnosed with a mental illness, however, he/she would be deprived of access to the therapy needed to treat/manage the illness.

Annual Expenditure on MH

Only two funds provided data on annual MH expenditures: MOPH and GSF. The MOPH's spending was calculated using data for the two last available years, which includes expenditure on psychotropic drugs, advanced drugs and MH inpatient admissions (**Table 3**). With the budget of the MOPH in 2011 equal to $351.9 Million,[17] the percentage of its spending on MH services out of its total health spending is 2.97%. As for the GSF, the annual expenditure on MH services in 2012 amounted to $83,270.67, with $61,898 going to inpatient services and $21,372 to outpatient (**Table 3**). Examining the data that the MOPH and GSF provided, it is evident that over 70% of the mental health care spending of each is going to inpatient services (**Table 3**).

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Table 2. Thematic Analysis- MH Coverage by Financing Intermediary

Financing Intermediary	Enrollment % of the population	Specific Budget Allocation	Mental Health Coverage: Inpatient Coverage	Inpatient Limitations	Outpatient Coverage	Outpatient Limitations	Exclusions	Annual MH Expenditure
MOPH	16,29,015 enrollees → 43.15%	No	Yes	Short term care: annual ceiling for contracted hospitals Long term care: 24,000 LBP per day	Yes	Psychotropic and advanced drugs for free through Karantina dispensing center & PHCs	–	15,656,648,700 LBP
NSSF Maternity and Sickness Fund	1,077,683 enrollees → 28.55%	No	Yes	40,000 LBP per day (psychiatrist's fees) & procedures are reimbursed based on predefined rates (coefficient K=7500 LBP) 90% of psychotherapeutic drugs	Yes	50,000 LBP per psychiatrist's consultation (+15,000 for 1st visit), & 15,000 LBP for follow-up within 2 weeks (contracted providers) 80% of psychotherapeutic drugs	Services by psychologists and psychoanalysts	Data not available
CSC Health Fund	197,392 enrollees → 5.23%	No	Yes	% of coverage differs among hospitals Limit on n# days covered also differs among hospitals (from 7-10 days at one hospital to 3 months at others) Possibility for limits on patient's age	Yes	40,000 LBP per consultation Limit of 1 consultation per month 75% of drug costs	Therapy sessions	Data not available
Army Medical Brigade	225,250 enrollees → 5.97%	No	Yes	100% coverage through Army facilities and contracted hospitals (not bound by annual ceiling for contracted hospitals)	Yes	100% coverage for services provided by Army mental health specialists only 100% of drugs through Army facilities or other pharmacies based on predefined rates	–	Data not available
ISF Health Department	77,609 enrollees → 2.06%	No	Yes	100% coverage (bound by annual ceiling for contracted hospitals)	Yes	25,000 LBP per consultation 100% of psychotherapeutic drugs through ISF pharmacy, and 15% through other pharmacies	Therapy sessions Self-injury and suicide attempts	Data not available

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(*continued*)

Table 2. Thematic Analysis- MH Coverage by Financing Intermediary

Financing Intermediary	Enrollment % of the population	Specific Budget Allocation	Mental Health Coverage: Inpatient		Mental Health Coverage: Outpatient		Exclusions	Annual MH Expenditure
			Coverage	Limitations	Coverage	Limitations		
GSF Health Department	14,310 enrollees → 0.38%	No	Yes	100% coverage (not bound by annual ceiling for contracted hospitals)	Yes	25,000 LBP per consultation 35,000 LBP per therapy session 100% of psychotherapeutic drugs	–	124,906,005 LBP
SSF Health Department	5,645 enrollees → 0.15%	No	Yes	100% coverage (not bound by annual ceiling for contracted hospitals)	Yes	50,000 LBP per psychiatrist's consultation 45,000 LBP per psychiatrist's therapy session 37,500 LBP per psychologist's visit 100% of psychotherapeutic drugs (free choice of provider) Uncoded diagnostic tests are covered as a consultation at 50,000 LBP	–	Data not available
Mutual Funds	152,961 enrollees → 4.05%	No	No	–	No	–	–	0
Private Insurance	315,249 enrollees → 8.35%	No	No	–	No	–	–	0

Note: Currency exchange rate: 1 USD= 1500 LBP.

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Table 3. Annual MH Expenditure of MOPH and GSF

	Type of expenditure	Amount	Percentage out of Total MH expenditure
MOPH	Psychotropic drugs* distributed in PHCs in 2012	$138,321	22%
	Advanced drugs* in 2012	$2,161,430	
	Inpatient admissions (short & long term care) in 2011	$8,138,015	78%
	Total MH expenditure	$10,437,766	100%
GSF	Inpatient services	$61,898	74%
	Outpatient services	$21,372	26%
	Total MH expenditure	$83,270	100%

* List of all drugs can be found in Appendix A.
Note: Acronym definitions: MOPH= Ministry of Public Health; GSF= General Security Forces; MH= Mental Health.

Disparities between MH Coverage & Standard Coverage

There was no disparity between the MH and standard health coverage of the MOPH, Army, GSF and SSF (Appendix B). As for the rest of the intermediaries.

National Social Security Fund (NSSF)

The NSSF excludes the services of psychologists and psychoanalysts from coverage (**Table 4**), and the respondent explained this is because they are not among the professions that can contract with the NSSF since they are not currently regulated by an Order- a national body which ensures the legal recognition of the profession, outlines the rights and obligations of its members, sets the basic requirements for practicing the profession and seeks to promote the development of the profession. Effort is currently underway by the Lebanese Psychological Association to set the standards for practicing psychotherapy in Lebanon.

Civil Servants Cooperative (CSC)

There is a vast disparity in the coverage of inpatient services by the CSC. The CSC typically covers 90% of the hospital bill, however for MH-related admissions the percentage drops and varies across different hospitals. CSC also places limits on the length of stay and in some cases on the patient's age. These however do not appear to be following a specific policy but rather treated on case-by-case basis and at the discretion of the CSC officer. Regarding outpatient services, the CSC places a limit of 1 consultation per month and excludes therapy sessions from coverage (**Table 4**).

Internal Security Forces (ISF) Health Department

The ISF covers 100% of MH inpatient services and is bound by the annual ceiling for every contracted hospital, just like other medical conditions. However, it excludes self-injury and suicide attempts; the respondent stated that in such cases the ISF pays for the enrollee's hospitalization but later retrieves the amount to cover medical and psychiatric services through monthly deductions from the enrollee's salary. As for outpatient services, the ISF excludes therapy sessions from coverage (**Table 4**).

Mutual Funds

The respondent explained that the reason MH is not covered is because mutual funds are constrained by the Stop-Loss policy (a policy meant to protect the fund against catastrophic claims and which takes effect after a pre-specified monetary threshold that varies among plans has been paid in claims) of their reinsurer, which is usually a private insurance company. The respondent also explained that theoretically the fund can use its excess profit margin, if any, to cover such cases when needed. However, the coverage in such an exceptional case where the primary focus is on MH care would be subject to limits that are lower than the usual limits for medical illnesses.

Private Insurance

The respondent confirmed that private insurance companies in Lebanon exclude MH services from their coverage[18] although some of the same companies operating in neighboring Arab countries do cover MH. The respondent also explained that if the risk of mental illness can be estimated and priced insurance companies may consider covering MH. Moreover, the respondent stated that if mental comorbidity is discovered while an enrollee is medically insured, the company has the right to terminate or not renew the annual policy based on a medical report that determines whether the mental illness can interfere with or worsen the existing medical condition.

Emerging Themes from Key Informant Interviews

Several themes emerged from the interviews. The rationale for not covering services rendered by psychologists and psychoanalysts, who operate as independent clinicians, was as follows, ''Similar to nurses, psychologists just carry out the treatment ordered by the doctor, who is the psychiatrist and who is already reimbursed for his/her services''. Another theme was the lack of understanding of mental illnesses, relegated to casual interpersonal conflicts and assumed to be solely dependent on the individual's will to sail through them. Moreover, lack of awareness about the debilitating impact that mental illness can have on people's lives and the general public was revealed, ''car accidents can lead to disability, ruin people's lives'' and ''affect society as a whole'', and should be covered implying mental illness does not. The most alarming theme was the

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Table 4. Disparity between MH Coverage and Standard Health Coverage of NSSF, CSC and ISF

Financing intermediary	Services	Standard health coverage[21]	MH coverage	Parity
NSSF	Inpatient	90% direct payment to contracted hospitals	90% direct payment to contracted hospitals (40,000 LBP per day for psychiatrist's fees & procedures are reimbursed based on predefined rates)	=
	Outpatient	95% for cancer drugs and 85% for all other drugs and services (reimbursement to user) Specialist rate: upto 50,000 LBP per visit	50,000 LBP per psychiatrist's consultation (+15,000 for 1st visit), & 15,000 LBP for follow-up within 2 weeks 80% of psychotherapeutic drugs Services by psychologists and psychoanalysts are excluded	≠
CSC	Inpatient	90% direct payment to contracted hospitals	% covered differs among hospitals Limits on n# days covered also differs among hospitals (from 7-10 days at one hospital to 3 months at others) Limits on patient's age	≠
	Outpatient	75% reimbursement to user Specialist rate: 75% of 50,000 LBP= 37,500 LBP	40,000 LBP per consultation Limit of 1 consultation per month 75% coverage for drug costs Therapy sessions are excluded	≠
ISF	Inpatient	100% coverage	100% coverage (bound by annual ceiling for contracted hospitals) Self-injury and suicide attempts are excluded	≠
	Outpatient	100% coverage Specialist rate: upto 25,000 LBP	25,000 LBP per consultation Therapy sessions are excluded 100% coverage for psychotherapeutic drugs through ISF pharmacy and 15% through exernal pharmacies	≠

Notes:
Currency exchange rate: 1 USD= 1500 LBP.
Acronym definitions: NSSF= National Social Security Fund; CSC= Civil Servants Cooperative; ISF= Internal Security Forces; MH= Mental Health.

intentionality of self-harm whereby suicide attempts were considered ''under the person's control'' by several respondents. Such ideas are misconceptions which do likely impede MH from receiving equal coverage as other medical conditions.

Roundtable Discussion

The most prominent outcomes of the roundtable discussion were the following:

- The Lebanese Psychological Association is currently working on decreeing a law that regulates the profession and establishes a licensing mechanism and an Order for psychologists. Once in place, this law would make psychologists eligible to contract with the NSSF, and their services would no longer be excluded from coverage. The MOPH also expressed willingness to collaborate with the NSSF in figuring out payment rates specific to psychologists once the practice is regulated.
- Commitment was expressed by the MOPH representative to contact the ISF in order to tackle the suicide attempt exclusion:

> *'...the ISF issue is clearly unethical, there is a problem there, we can notify the ISF (...)This should be solved. We as a government cannot leave a person who has attempted suicide left without treatment. This is why if uncovered, we cover him. We are obliged to legally.'*

- Educating the labor force to pressure unions and syndicates to demand MH coverage from their insurers is an important

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option to pursue, and the Lebanese American University's case is a success story.

'...the labor force is incredibly ignorant about the facts and statistics and damage that is done due to mental illness (...) The first issue I think is educating the labor force, because the labor force will pressure the companies. Some unions are very very strong, and the cost is not high, and I think insurance companies will respond.'

This initiative should start with the Lebanese Order of Physicians (LOP), and it is fundamental especially due to the huge number of members in the LOP (around 13,000) who can exert significant pressure on their insurers and start a momentum of change.

'One person alone cannot do it, You need a group to ask for it.'

- Forming a multidisciplinary knowledge sharing mechanism/committee in order to bridge the knowledge gap between the scientific and business communities and collaborate effectively to change policy is needed. Private insurance representatives explained that their main reason behind excluding MH is that they lack the knowledge needed to study the feasibility of MH coverage, and they welcomed the idea of partnering with MH specialists in order to exchange the needed information.

'I think what we still have in Lebanon is lack of information about mental health. We don't have, as an insurance company, complete information about it. That's why I think it's still not introduced as a cover. It's not that we cannot do it.'

Therefore, a viable option for improving MH financing in Lebanon is the creation of a multidisciplinary knowledge sharing mechanism/committee. Much of the needed information is already available and the psychiatrists committed to transferring that knowledge to the insurers at the meeting (such as prevalence and incidence rates of mental disorders, costs of treatment and average length of stay in Lebanese hospitals). As for the unavailable information (such as cost utilization in cases of mental-physical comorbidities in Lebanon), research will have to be conducted by the scientific community to provide it.

'I think what we need in Lebanon is really a study of the savings and of the macroeconomic impact of having for example prevention and wellness programs, which we lack of greatly in Lebanon (...) If we have studies that really show the material impact of covering mental benefits and their impact on cancer, I think that we can convince a lot of companies to start covering mental health benefits.'

'...for example, if mental health could reduce length of stay and readmissions, we can calculate this and come up with a number based on different simulations, and we can say that if we have this coverage on the medium term or long term depending on the study, we could have this much in savings.'

'I think that the partnership between the specialists in psychiatry and the insurance companies would help to really better know the risk so that we can better quantify it and control it.'

However, there are obstacles including lack of funding for the research, and ambiguity to whether insurance companies will agree to a ''hybrid'' study using data from Lebanon paired with cost-utilization comprehensive studies from US and Europe to benchmark the local estimates.

- Setting an annual cap, or ceiling coverage, per enrollee was deemed to be a viable payment method in MH financing by stakeholders, because it simplifies the complexity that mental illness diagnosis poses on the pricing process. It is currently used by Saint George Hospital and the Lebanese American University which recently added MH coverage to their medical plans for students, employees and faculty.

'...The cap per person does not get used up quickly. The number of persons that end up being readmitted to the hospital within the same year is a minority, less than 10%. Ninety percent of people don't get admitted more than once a year to the hospital.'

'...Making a package with a maximum limit is better. And regarding alcoholism, many times you have a psychiatric comorbidity (...) meaning a patient would get admitted because he is depressed and is at the same time alcoholic, so you cannot constrain it. You can limit it better if you create a package with a cap.'

It is important to note, however, that capped coverage in and of itself does not satisfy the goal of parity, since annual limits on each individual's coverage are not imposed for non-mental health conditions. Capped coverage might be a necessary compromise on the road to full parity, during a transition period while insurers get comfortable with covering mental health.

Discussion

Providing proper access to MH care is essential. MH financing is a fundamental public health issue as good MH decreases costs of physical health care, increases productivity at the national level and reduces demands on the criminal justice system.[19,2,3] This paper aimed at providing a systematic review of the current situation of MH coverage in Lebanon and recommending strategies for improvement, as a first step in the efforts towards parity of mental health. The literature revealed that Lebanon lags behind peer countries in terms of targeted budget allocations for MH, dependency on OOP payments, and protection of the rights of MH patients. The heavy reliance on OOP expenditure, whether full or co-payments, comes at a grave cost and restricts individuals from obtaining the MH care they need;[19] severe mental illness exposes individuals to catastrophic health expenditures, which makes OOP spending a major barrier to access.[3] Reliance on OOP spending implies that the benefits of MH are distributed according to patients' ability to pay,[3] rendering mental illness a 'disease for the wealthy'. Mental illness is associated with unemployment and poverty,

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therefore OOP expenditure deprives those who are most at risk of having a mental illness from access to MH care. OOP spending is burdensome even for patients with higher than average incomes as treatment expenses are sometimes too high.[19,5,2,13,18]

On a more favorable note, the key informant interviews revealed that all public financing intermediaries in Lebanon cover MH inpatient, as well as outpatient services. However, it is the actual benefits covered and the terms of the coverage that, when closely examined, are problematic. It was revealed that for most intermediaries, access to MH services was more restrictive when compared to other medical conditions. Also worthy of acknowledgement is the MOPH's efforts of integrating MH into its primary healthcare (PHC) network. PHC centers dispense expensive MH drugs completely free of charge, and the MOPH has been working on training health practitioners in these centers on diagnosing, treating and referring MH patients to psychiatrists.

Equity, effectiveness and efficiency are three components of the health care system that are known as ''the triad for improving health outcomes''.[20] Studies have demonstrated that each component alone is insufficient and that the 3Es must operate as a triad to result in better health outcomes.[20] Consequently, these criteria are often used jointly to evaluate a health care system and draw policymakers' attention to important gaps or issues. In evaluating MH in Lebanon according to the 3Es criteria, equity, effectiveness and efficiency,[19] the following can be highlighted.

Equity refers to whether there are differences in access among different segments of the population and whether any segment is unduly favored.[19] The fragmented system in Lebanon leads to differences in MH coverage across different financing intermediaries, which is inequitable. For example, enrollees of the GSF and SSF are covered for psychotherapy visits but ISF enrollees are not. Moreover, enrollees of private insurance and mutual funds have to pay fully OOP for MH services and remain unprotected from catastrophic costs. When closely examining the disparities in the public coverage of MH by the CSC, ISF and NSSF as compared to medical illness, several inequities are exposed: limitations on length of stay, patient's age, percentage of hospital costs covered, number of consultations per month, exclusion of psychologist and psychoanalyst services and psychotherapy sessions, and exclusion of self-injury or suicide attempts. The exclusion of self-injury and suicide attempts, in particular, is discriminatory against people suffering from mental illness and denies access to those who need it the most.

The degree of *effectiveness* is a measure of how well desired outcomes are achieved. The fact that one out of four Lebanese suffer a mental disorder throughout their lives and very low percentages of those obtain treatment signals a problem in effectiveness. There are also long treatment delays, ranging between 6 to 28 years.[6] It is important to note that inadequate financing is only one determinant of the low MH service utilization rates, and issues related to stigma and the taboo of seeking MH care are also responsible and cannot be overlooked.[6,7]

As for *efficiency*, the inefficient fragmentation of MH financing among the seven public intermediaries is a problematic characteristic of the healthcare financing system as a whole. Moreover, the orientation of the general healthcare system towards curative rather than preventive care is reflected in MH financing as well. With over 70% of the mental health care spending of the MOPH and the GSF going to inpatient services, a problem of efficiency is signaled. This is in light of evidence indicating that outpatient services can be more cost effective than inpatient; for example in the case of alcohol dependence and substance abuse, treatment in outpatient settings cost $6,300 per abstinent case, compared to $15,600 in inpatient.[21]

To begin moving towards parity in MH, there are several easy wins that can be pursued in Lebanon. As a first step, the most basic and minimal improvement that can be made is the removal of the self-injury/suicide attempt exclusion from the ISF's MH coverage criteria; as of November 2013 this exclusion has been removed, as a result of the roundtable discussion and the diligent follow up that was made by key stakeholders. Modifying the limitations placed on MH coverage by public financing intermediaries to be at par with those of general medical conditions is another step. A further disparity can also be removed once the Lebanese Psychological Association establishes an Order and regulates its practice, making psychologists eligible to contract with the NSSF. In parallel, private insurance companies, which collectively cover a considerable 8% of the Lebanese population (around 315,000 individuals) but explicitly exclude MH services from their policies,[22,18] should become more inclusive with their policies. The roundtable discussion has shed the light on an opportunity to form a multidisciplinary knowledge-sharing mechanism between the scientific and the insurance communities in order to collaborate in bridging the knowledge gap. Private insurance representatives requested information such as prevalence and incidence rates of mental disorders in Lebanon, costs of treatment and average length of stay in Lebanese hospitals, much of which is already available to study the feasibility of MH coverage. They also welcomed the idea of partnering with MH specialists and academicians and informing future research to study cost utilization in cases of mental-physical comorbidities in Lebanon. In addition, some coverage limitations at Mutual Funds result from policies of the private insurance companies that provide reinsurance; this is another area that policymakers should address, by passing legislation or regulation that would prevent reinsurers from applying discriminatory rules.

The paper has several limitations that merit stating. Aside from the MOPH and GSF, none of the financing intermediaries was able to provide data about MH spending mainly due to the lack of an automated information system. It was therefore not possible to calculate a total annual MH expenditure on a country-level. However, the lack of proper information systems is in itself a risk of misallocation of limited resources to well identified health needs. Another limitation is the inability to map the sources of funding with the MH service provision sector, an exercise recommended by WHO when mapping the MH system in a country.[19]

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More extensive data about the MH services provided by each of the public, private, voluntary (NGO) and informal sectors is needed, along with data on the MH expenditure of every financing source.

Conclusions

Not only are they held back by their fear of stigma, individuals with mental disorders commonly suffer from unemployment and poverty as well. Therefore, OOP payments for MH services for these people can be more of a severe obstacle than it is for physically ill patients. It is imperative to find more equitable ways of financing MH that will decrease the OOP share.[19] Providing a clear description of the current MH financing system would allow policymakers to recognize the disparities present in the coverage of MH, guiding them into making informed decisions on allocation of funds and defining which services are covered or prioritized. This study therefore constitutes the first step towards achieving more equitable and socially just coverage, advances knowledge and provides locally relevant research, which is well-needed in light of the scarcity and ambiguity of such information in the literature.

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