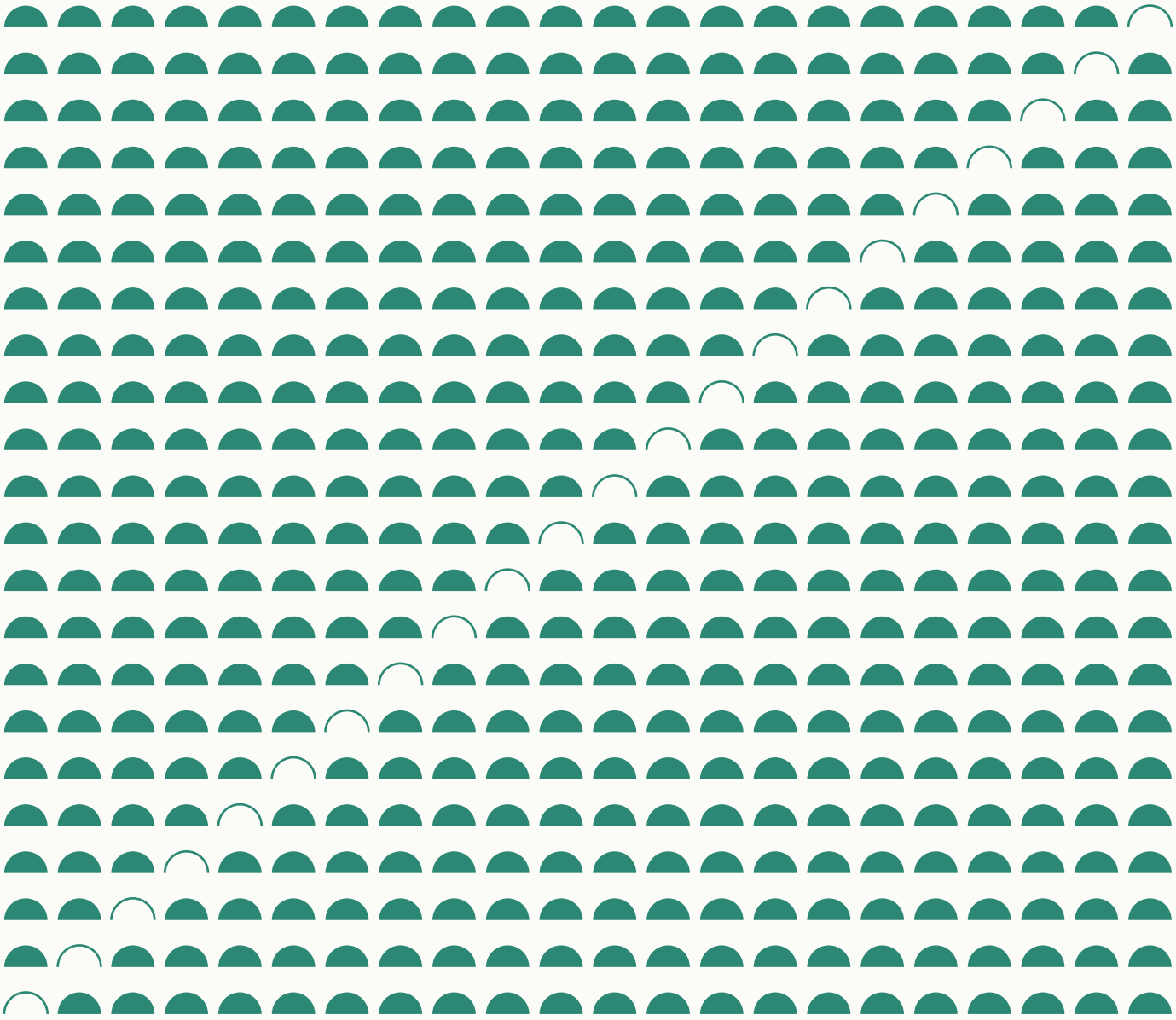

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Survey Report on The Challenges of The Current Social Protection System in Lebanon Amidst The Crisis.

The Centre For Social Sciences Research & Action

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Survey Report on The Challenges of The Current Social Protection System in Lebanon Amidst The Crisis.

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Executive Summary

This report analyzes the impact of the multilayered Lebanese economic crisis and its major macroeconomic shocks on the social protection landscape in Lebanon. It aims to examine the social protection mechanisms and effective health care systems and coverages in Lebanon, amid an ongoing social and economic crisis hitting the country since the financial collapse of late 2019. The study is based on a survey conducted between July and August 2022, with a nationally representative sample of 1,327 respondents of Lebanese nationality. The sample was gender-balanced, and it covered 26 districts (*Cazas*) scattered in all eight governorates. The survey provides social and economic indicators that are instrumental to understand the real impact of the crisis on the Lebanese social protection framework, especially on the predominant contributory schemes (public and private), and to inform evidence-based policies.

First set of results:
The impact of the multi-layered crisis on the Lebanese population

62.2%

of the respondents currently have a **monthly income below 8 Million Lebanese pounds** (LBP, hereinafter referred as Lira), equaling less than $200[1].

9%

of this lowest-income group have declared having currently a **monthly income below 2 Million Lira** ($50).

13.1%

of the respondents **lost their jobs after the 2019 crisis**, and the job losses reached their peak in the first quarter of 2020.

As a result, the extreme majority of the respondents declared that their socio-economic status has decreased since the beginning of the Lebanese crisis.

79.2%

of the respondents are **concerned with this decrease in the subjective perceived socio-economic status.**

1- According to the exchange rate in the parallel market (at the time of writing, 22/11/2022) of LBP 40,000 for one US dollar.

Second set of results:

Levels and rates of coverage for the Lebanese population

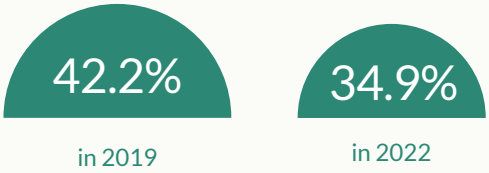
60.4%

of the respondents **are currently benefiting from at least one insurance plan**, either through private insurance companies or various publicly mandated programmes.

39.6%

of the respondent **do not have any coverage at all** and are left completely unprotected.

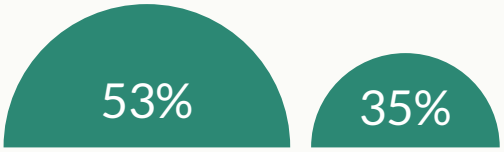
The level of public coverage of the unemployed has **significantly deteriorated** following the 2019 crisis.



in 2019

in 2022

More than half of the homemakers (almost exclusively women) and a third of the retired persons are currently **not covered by any public insurance scheme.**



Homemakers (almost exclusively women)

Retired persons

Third set of results:
Private vs. public health coverage

32.1%

of the whole sample represent the **privately insured persons**, and private insurance companies remain the major provider of health coverage in the country.

16.9%

of the sample **are enrolled in the NSSF,** 2nd major provider of health coverage in the country.

The majority of the respondents have been able to maintain the same health plans in times of crisis. Yet the rates of coverage have decreased significantly, due to the fact that publicly mandated programmes are still funded by contributions collected in Lebanese Lira, unlike private insurance companies. Half of privately insured persons have shifted to health plans covered in Lira or in "Lollars", thus accepting higher participation percentages (out-of-pocket expenses) and lower effective coverages. Regarding the effective coverage offered by the NSSF and the state-run Cooperatives, one out of two respondents did not use their services at all, in the last 12 months, and less than 20% of the respondents declared to be satisfied with the services received.

Forth set of results:

Family-based solidarity and gender gaps in social protection

31.7%

declared having **high reliance on their family support.**

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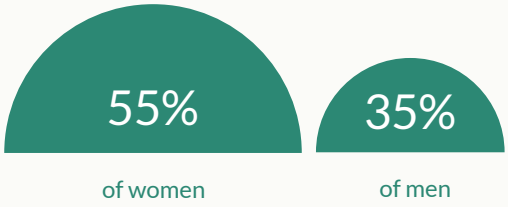
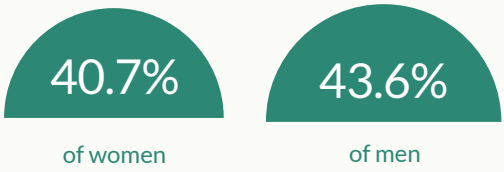
In this regard, the gender differences are salient. **Women are significantly more dependent than men on family support,** and they receive more in-kind assistance than men.



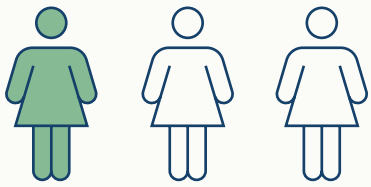
13.8%

declared that **the family is somehow needed to provide financial and in-kind support.**

The **cash transfer** seems to be more benefitting men (43.6%) than women (40.7%).



Finally, women are living in higher precarious conditions than men, despite the similar levels of coverage. They have significantly lower levels of savings than men, and less assets to use in case of medical emergency or to face uncertainties.



More than one woman out of three **declare not having any savings at all,** compared to 28.7% of men.

In conclusion, more Lebanese citizens are currently being excluded from what was already considered an elitist and exclusive social protection system. Our survey showed that a substantial proportion of the Lebanese population is currently left totally without any private or public coverage (around 39.6%). On one hand, the survey showed that only 27.3% of respondents are benefitting from at least one social protection coverage, a percentage that might be higher than the 13.9% reported in last available data from 2021, yet it remains below the regional and global averages, respectively 46.9% of the global population, and 40% of the population in Arab States (ILO 2021a). On the other hand, the rate of effective coverage has significantly dropped for the majority of the insured persons, even though the level of coverage may seem theoretically unchanged.

Moreover, the redistributive impact of the Lebanese social protection system tends to be clearly regressive, benefitting the richer more than the poorer, and this historical tendency seem to be accentuated today in time of crisis, since only the privileged minority subscribing to a private insurance in fresh dollar (16% in our sample) can still benefit from an almost full-medical coverage. Historically skewed towards civil servants, public-sector workers, and military and security forces (Institut des Finances 2021), the Lebanese social protection system is currently leaving these former privileged groups with almost no effective coverage, due to the dollarization of the medical bill when the official price grid is still denominated in Lira.

Even for the privately insured population, the rate of coverage has significantly declined while the premium has increased. Since 38.9% of the insured persons had to pay their premium in Lira, and 17.4% paid their subscription in “Lollars”, one can conclude that more than the half of the privately insured population shifted from an almost full medical coverage to various partial coverage schemes, thus signaling that private insurance companies are currently increasing their profit margins.

Introduction

This report aims to examine the social protection mechanisms and effective health care systems and coverages in Lebanon amid an ongoing social, political, and economic crisis hitting the country since the financial collapse of 2019. Based on the survey conducted between July and August 2022, the report provides a rapid and reliable assessment of the changes in the social protection landscape in Lebanon in light of the severe economic and social crisis.

Even before the beginning of the Lebanese economic depression, the social security landscape was characterized by fragmented and inadequate coverage plans, predominated by contributory-based schemes (UNICEF & MoSA 2019) that usually exclude the low-income households and the most vulnerable populations. The latter are targeted by multiple ad hoc social assistance programmes that are limited in scope and whose impact is deemed low or negligible by available impact assessments (ILO 2021b, ILO & Unicef 2021). Overall, the Lebanese social protection landscape is highly scattered, and its fragmentation contributes to widespread social insecurity in the country (Scala 2022).

In Lebanon, there are a multitude of social security systems. The private sector employees are supposed to be covered by the National Social Security Fund (NSSF), yet a substantial proportion of the labor force working in the private sector is practically excluded from the NSSF(ILO 2021b). In the public sector, the "Cooperative of civil servants" covers teachers in public schools and civil servants in public administrations, while military and security personnel have their own schemes and funds. Contractual personnel in public administrations are covered by the NSSF, and contractual teachers are not covered by any scheme. Yet, citizens who are not covered by any formal social security scheme can benefit from the support of the Ministry of Health which can reach up to 85% of the hospitalization cost for the treatment of certain serious conditions (MoPH 2016).

Estimates from the pre-crisis period show that 44% of households did not have any kind of insurance and 45% of them were linked to publicly mandated social security schemes, namely, NSSF, civil servants' cooperative or army and security forces (BlomInvest Bank 2015). Moreover, in the last decades, the successive governments did not guarantee social protection floors or minimum resources for the poorest within a comprehensive system of non-contributory social assistance, thus failing to protect the most vulnerable Lebanese and non-national residents against economic hardship and severe poverty. Lebanon's social assistance programmes, such as the National Poverty Targeting Program[2] (NPTP) or Social Safety Net, were significantly below the MENA region's average as a percentage of GDP (less than 1% in Lebanon compared to 1.7% in the MENA region) and they remain limited in their scope and their coverage targets (Karam et al., 2015). Finally, many studies have measured the regressive nature of the pre-crisis social protection system (Boustani et al. 2021, Institut des Finances 2021,

2-The NPTP was initially launched in October 2011 in response to the refugee crisis, but as the Syrian crisis persisted, it was extended as an Emergency programme targeting the poorest and the most vulnerable Lebanese population in 2014 (Kukrety, 2016)

ILO 2021b). Indeed, before the crisis, social insurance affiliation was higher for the highest income population (over 65% for the highest decile, compared to 20% for the bottom decile), while in the bottom decile more than 60% of the Lebanese individuals were not covered by any form of social protection (ILO 2021b).

Since the beginning of the Lebanese crisis, access to health care has become a luxury that even insured persons might not be able to afford. With skyrocketing unemployment and vulnerability rates, more people are currently excluded from what was once considered an already elitist and exclusive health care system (ILO & Unicef 2021).

In this regard, how far is the Lebanese national system of social protection from providing effective and universal coverage to its resident population? To which extent the ongoing Lebanese crisis has impacted the social protection framework? And how is the current social protection landscape architecture impacting the Lebanese households' coping capacities, especially those who are already threatened in their livelihoods and struggling with dire economic conditions?

The study is based on a survey conducted between July and August 2022, with a nationally representative sample of 1,327 Lebanese respondents. It aims to understand the current social protection mechanisms in Lebanon, especially the predominant contributory schemes amid the severe and prolonged economic depression, as well as the practical and current challenges faced by those enrolled in the system. Thus, the survey provides social and economic indicators that are instrumental to understand the real impact of the crisis on the Lebanese social protection system, and to inform evidence-based policies.

1 - The questionnaire:

The questionnaire consisted of 56 questions divided into 5 sections: employment status, socio-economic status, social protection coverage, family- and solidarity-based assistance, and socio-demographic data.

2 - Sampling methodology:

The effective sample size was 1,327 respondents from Lebanese nationality. Non-Lebanese residents were excluded from the sample. The survey presents estimates at the national and sub-national levels. The geographical distribution of the sample covered 26 districts (Caza) scattered across the 8 governorates (Beirut, Mount Lebanon, North Lebanon, Akkar, Bekaa, Baalbek-Hermel, South Lebanon, and Nabatieh). All the collected data is disaggregated by gender and by governorate.

GEOGRAPHICAL DISTRIBUTION OF THE SAMPLE

	Caza	Weight in the sample (%)
1	Baabda	10,8
2	Maten	10,2
3	Beirut	7,2
4	Akkar	6,9
5	Aley	6,0
6	Chouf	5,8
7	Keserwan	5,8
8	Saida	5,8
9	Tyr	5,2
10	Tripoli	5,0
11	Baalbeck	4,7
12	Zahle	3,6
13	Nabatieh	3,3
14	Minieh-Danniyeh	3,1
15	Jbeil	2,8
16	Bint Jbeil	2,1
17	West Bekaa	1,9
18	Marjeyoun	1,8
19	Zgharta	1,8
20	Koura	1,6
21	Batroun	1,5
22	Jezzine	0,7
23	Rashaya	0,7
24	Hermel	0,6
25	Becharri	0,5
26	Hasbaya	0,5

***Table 1**- Geographical distribution of the respondents by Caza*

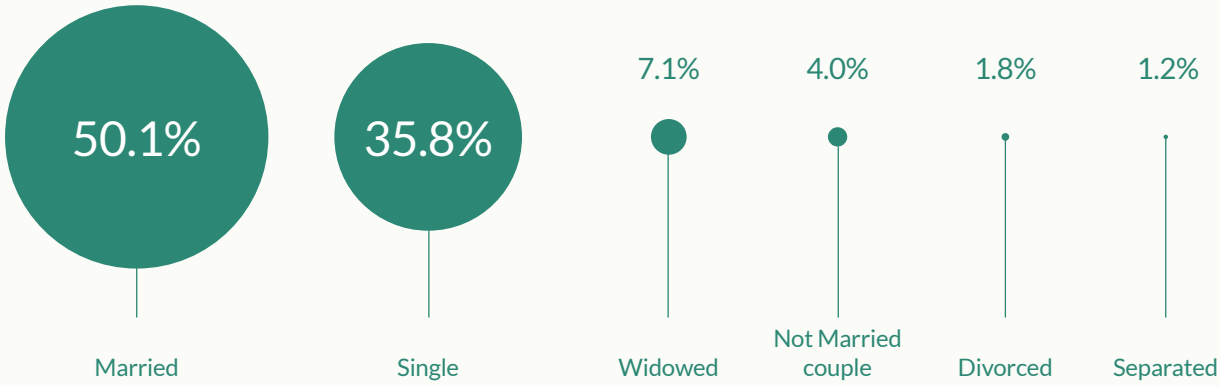
3 - Data collection method:

Data was collected in July and August 2022. The data collection method used Computer-Assisted Personal Interviews, with the interviewer combining face-to-face data collection method with the use of tablets and mobile phones to record answers given during the interview. This method ensures better quality data by facilitating the recording of the data as well as the enumerator monitoring (the interviews starting time and end time, GPS location, etc.).

4 - General description of the sample:

The data collection achieved a gender-balanced sample, with 656 female respondents out of the 1327 (49.4%).

Figure 1- Civil Status of the respondents



All respondents were above 18 years old. The age group [18-34] represented 38.3% of the total, while the age group [35-54] represented 30.2%, and the [55-64] age bracket weighted 13.5% of the total. Moreover, some 17.9% of the respondents were above the retirement age of 64 years old. Regarding their civil status, some 50.1% of the respondents declared being in a married couple, some 35.8% were single, and 4% declared being in an unmarried couple.

5 - Structure of the report:

The first section of this report draws a contextual overview of the weakening national social protection system in Lebanon, as well as its major trends before and after the financial collapse of 2019. Section 2 shows the major results of the survey regarding the deteriorating social and economic conditions of the Lebanese population and analyzes the impact of the crisis on the social protection system. Section 3 draws the major indicators related to the deteriorating labor market outcomes. Section 4 focuses on the levels and rates of health coverages for the various public and private schemes, depicting the major challenges faced by the insured population. Finally, section 5 draws particular attention to the impact of non-institutional forms of solidarity against the shortcomings of the institutionalized mechanisms of social protection, as well as the gender gaps in social protection.

6 - Survey's limitations:

Scattered among 26 Cazas in 8 governorates, the sample of 1,327 respondents is regionally and nationally representative. Nevertheless, some limitations to our sampling methodology are worth noting. Firstly, the respondents were sampled among the population living in formal housing. Population living in camps or quasi-camps, as well as population living in irregular neighborhoods were excluded from the sample. On one hand, our survey follows the sampling methodology usually applied by the Central Administration of Statistics (CAS), as well as by the ILO or other major international data providers in order to reach comparable indicators and measures. On the other hand, the data collected through this sampling methodology tend to underestimate levels of poverty and overestimate the levels of social protection coverage since it excludes de facto some groups among the most vulnerable population.

Secondly, the survey is mainly targeting the social protection schemes and the level of coverage of the Lebanese population. As such, it excludes non-national populations, especially refugees, asylum seekers, stateless persons and labor migrants. Therefore, similarly to other surveys and estimates drawn from other studies and reports based on a similar sampling methodology, the figures and the indicators given here do not fully represent, nor faithfully reflect, the reality of the exclusion of a wide proportion of the national and non-national residents from the social protection system. Despite these limitations (common to the main available studies on the Lebanese social protection framework), the data gathered through this survey provide reliable measures of the levels and rates of coverage of the sampled population, bringing additional evidence regarding the social distress that is inflicted on the Lebanese population due to the deterioration of the national social protection system.

Thirdly, our report mainly focuses on the predominant contributory schemes of the Lebanese social protection system, while non-contributory schemes were difficult to capture in our survey. Generally speaking, the Lebanese social protection system combines three integrated micro-economical pillars:

Insurance-based programmes (such as the health insurance or the end-of-services schemes provided through the NSSF, or other contributory schemes providing compensatory support for the insured person);

Social assistance programmes (usually linked to fiscal policies and resulting from the redistributive effects of social policies, such as the National Poverty Targeting Program or other non-contributory targeted programs); and,

Various charity-based forms of social assistance founded on voluntary actions and informal protective systems, arising within social networks and civil society organizations (such as networks of mutual aids, family-based support or NGO's aid/livelihood interventions). In the Lebanese context these voluntary logics of assistance usually combine family-based, sectarian-based and politically-based forms of solidarities (Abdo 2019, Cammett et al. 2014, Cammett et al. 2010).

Nevertheless, data collected in our survey on social assistance programmes proved to be unreliable, due to low response rate among this category (between 90 and 120 responses, representing less than 10% of the sample). Thus, some components of the questionnaire, notably those related to non-contributory social assistance, had to be excluded from the analysis.

Finally, even though labor market outcomes and labor policies are major components of any social protection system, our survey does not claim to draw a complete image of the Lebanese labor market. Therefore, two major divergences with the most recent labor force surveys (ILO & CAS 2018-2019, 2022) are to be signaled here. Firstly, the population under 18 was excluded from our sample for ethical consideration related to the incapacity of conducting data collection with children and minors without IRB and ethical committee's supervision. As a consequence, a non-negligible part of the Lebanese labor force is excluded from the sample. Secondly, data regarding the so-called informal employment and informal sector was impossible to collect or to measure without a proper labor force survey. Yet the easily measurable so-called "formal employment" (employees in the formal sector with registered contracts and related social benefits) stand at 25.3% of the labor force in our survey, significantly lower, when compared to ILO and CAS figures. Therefore, data collected through the current survey suggest an underestimation of the rate of informal employment projected by other available studies specifically gauging informal employment.

Contextual overview of the Lebanese social protection system before and during the ongoing economic collapse

The principle of universality of social protection is based on the right for every human being to be protected against social risks throughout the life cycle (ILO 2012). Social risks are not merely a consequence of individual choices since they are usually generated or aggravated by collective behaviors and social interactions, as in the cases of public health issues or unemployment. Moreover, social risks are not the mere responsibility of individual agents since they are usually driven by negative externalities and could be brought about as results of economic fluctuations or flawed policies, thus calling for collective responsibilities and social coverage.

The universality of social protection not only refers to human rights, but also asserts that the society as a whole should be considered as collectively responsible for the uncertainties it creates. On one hand, social protection as a human right emphasizes the moral obligation for governmental bodies and non-governmental organizations to guarantee basic levels of social coverage for the whole population (WB & ILO 2016, ILO & UNICEF 2021). On the other hand, recent developments in public economics theory show that social protection schemes could be approached as an instrumentalist means to achieve better macroeconomic outputs. Indeed, higher economic insecurities at the individual level usually translate into higher macroeconomic instabilities, thus calling for coverage schemes that are legally binding and enforceable (Stiglitz & Kaldor 2013). Moreover, the weakening of national social protection systems in the last decades has generated higher volatilities on the global scale, a thesis that is nowadays supported by considerable scientific evidence, and perfectly illustrated by the last global financial crisis in 2007-2009 (Stiglitz 2013). Indeed, according to Joseph Stiglitz, weak national social protection systems proved to have lower resilience and less capacities to absorb external shocks, while national economies with strong social protection systems usually benefit from positive automatic stabilizers that are instrumental to cushion the impact of the crisis (Stiglitz 2013, Stiglitz & Kaldor 2013). Thus, enhanced social protection is nowadays considered to be not only correlated with better well-being for individuals, communities and societies, but also with higher economic efficiency on the national and global scales (Stiglitz 2013, WB & ILO 2016). More recently, the Covid-19 pandemic showed that strong and well-structured social protection schemes played a crucial role in ensuring that people have access to their basic needs, and the global health crisis helped raise awareness on the importance of universal health coverage (ILO 2021a).

Therefore, social protection could be approached as a "procedural claim for social justice" (as shown by the ILO social protection floors for instance) as well as an "instrumental claim" stating that better social protection instruments are correlated with better economic outputs (Sen 1992, Stiglitz & al. 2009).

As shown by ongoing research and as enshrined in international standards and current Sustainable Development Goals (SDGs,) the human-rights-based approach to social protection, as well as social justice values are considered to be an important economic lever to foster human development and economic stability in a world of rising uncertainties (UNDP, 2022).

Indeed, universal coverage and access to social protection are considered as an essential part of the development agenda, especially after the adoption of the SDGs and more specifically the targets and indicators referenced under Goal 1, calling for eradicating poverty in all its forms and manifestation for all people, as well as target 1.3, 3.8 and 8.b[3]. Finally, the convergence between the instrumentalist and the human-rights approaches was one of the achievements of the Global Partnership for Universal Social Protection that was launched by the

3- In particular target 1.3, assert that adequate financing of social protection is fundamental in order to end poverty and enhance well-being, especially for the most vulnerable populations. Target 1.3: Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable. Indicator 1.3.1: Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable. - 3.8: Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all. - 8.b: By 2020 develop and operationalize a global strategy for youth employment and implement the ILO Global Jobs Pact.

ILO and the World Bank in 2016. This initiative was guided by ILO social security standards including the Social Protection Floors Recommendation, No. 202, adopted by 185 states in 2012. The World Bank and ILO universal social protection initiative highlights that social protection is not only a powerful means to reduce poverty and income inequalities but also a foundation for sustained social and economic development (WB & ILO 2016).

Social protection usually relies on contributory schemes (contributions are matched with entitlements and compensatory benefits) and non-contributory programmes (social assistance and targeted programmes to protect vulnerable populations against economic hardship) (ILO 2021). Yet the Lebanese social protection system is predominantly dependent on contributory schemes and insurance systems that proved to be both unequal and regressive in the past, mainly skewed towards civil servants, public sector employees, and middle to high income households (Institute des Finances, 2021).

Indeed, even before the beginning of the financial crisis, a majority of the resident population was excluded from social security schemes (ILO & UNICEF 2021). Thus, almost half of the Lebanese population had no health coverage whatsoever (Marquis 2021), mainly the inactive population, as well as the unemployed[4], self-employed or freelancers. Moreover, Lebanon has never established an unemployment insurance or assistance schemes for job seekers. Also, pension schemes are limited to specific socio-professional categories (mainly liberal professions, public servants and security forces), while the population covered by NSSF does not benefit from retirement pension but receives only an end-of-service indemnity. Regarding the non-contributory assistance, the successive governments have shyly implemented insufficient and inadequate social assistance measures in the last decade[5] targeting households living in extreme poverty. Nevertheless, these initiatives leave an important proportion of the population without any access to social benefits or non-contributory social assistance (Scala 2022). Social assistance benefits (cash or in kind) were usually limited by the insufficient public social expenditures (European Commission 2020) and sectarian "capture" of the funds (Abdo 2019). More generally, public spending on social protection (mainly on retirement salaries and end-of-services indemnities) has never exceeded 25% on average of the total budget between 2017 and 2020, i.e. around 6% of the GDP, below the average spending of other lower middle-income countries, as shown in a recent benchmarking. In addition to that, public spending on social protection has been drastically declining since 2020 (Institute des Finances 2021).

In the last quarter of 2019, the depreciation of the Lebanese Lira and the removal of subsidies on some medicines led to a rapid increase in the price of medications. On September 30, 2019, the Banque Du Liban (BDL) issued the intermediate circular 530 to regulate access to foreign currencies for the importers of wheat, fuel, and medications, thus initiating a cycle of supply shortages of pharmaceutical products, rationing of subsidized medications, and dollarization of the medical bills. The increase in prices intervened in a context of supply shortages and rationing due to the limited capacities of local medicine and pharmaceutical importers facing the uncontrolled banking restrictions and the non-regulated capital control. As a result, access to basic medications or hospitalization became a luxury that could not be afforded by a great proportion of the Lebanese population, in a context of an increasingly expensive and fragmented health system. Even before the crisis, the Lebanese health care system was dominated by private hospitals and private insurance

4- The inactive population refers to the set of people who are outside the labor force, while the unemployed population is defined as the group of jobless persons who are actively looking for a job, thus the active population include both unemployed and employed persons.

5- Such as the National Programme Targeting Poverty (NPTP), and the Emergency Response Social Safety Net Project (ESSN). The "ration-card" programme did not start yet due to lack of funding.

companies. Following the depreciation of the Lira, private pharmaceutical importers and syndicates became in charge of distributing medications and equipment subsidized by the central bank (i.e. the monetary policy).

In addition, the country had to simultaneously face the outburst of the Covid-19 pandemic in February 2020, and the Lebanese Government default on its sovereign debt in March 2020. Paradoxically, the health crisis was culminating when the economic contraction and the shrinking fiscal spaces were forcing the government to accumulate unpaid 'silent dues' to a number of public institutions, among which the National Social Security Fund (NSSF) or the Civil Servants Cooperative (Boustani & al. 2021). After the Beirut Blast of August, 4, 2020, and the massive destruction of large parts of the capital, the Lebanese multifaceted crisis was considered among the top 10 most severe crises in modern history and it could probably be ranked among the top 3 according to the World Bank (WB 2021). In this context, Lebanese citizens suffered from the weakening of publicly mandated social protection systems, and state-run schemes of medical coverage, while simultaneously experiencing an unprecedented increase of poverty rates and unemployment rates. Indeed, unemployment rates skyrocketed from 11% in 2018 (ILO & CAS 2018-2019) to 29% in 2021 (ILO & CAS 2022). Regarding monetary poverty, nearly three quarters of the population were living on less than LBP 706,050 per adult-equivalent per month in 2021, while the share of the population living on very low incomes (below LBP 470,700 per adult-equivalent per month) represented more than a third (34.1%) in 2018 (ILO & UNICEF 2021). Moreover, when taking into account the various manifestations of poverty (and not only its monetary measure), some 82% of the households fall under the multidimensional poverty line measurement (ESCWA 2021).

Undoubtedly, those two compounded macroeconomic effects (rising unemployment and poverty rates) inflicted extreme stress on the already stretched and weakened Lebanese social protection system. Consequently, the decrease of the fiscal space for social protection and the worsening labor market outcomes are dampening the levels and the rates of coverage of both contributory and non-contributory schemes of social protection.

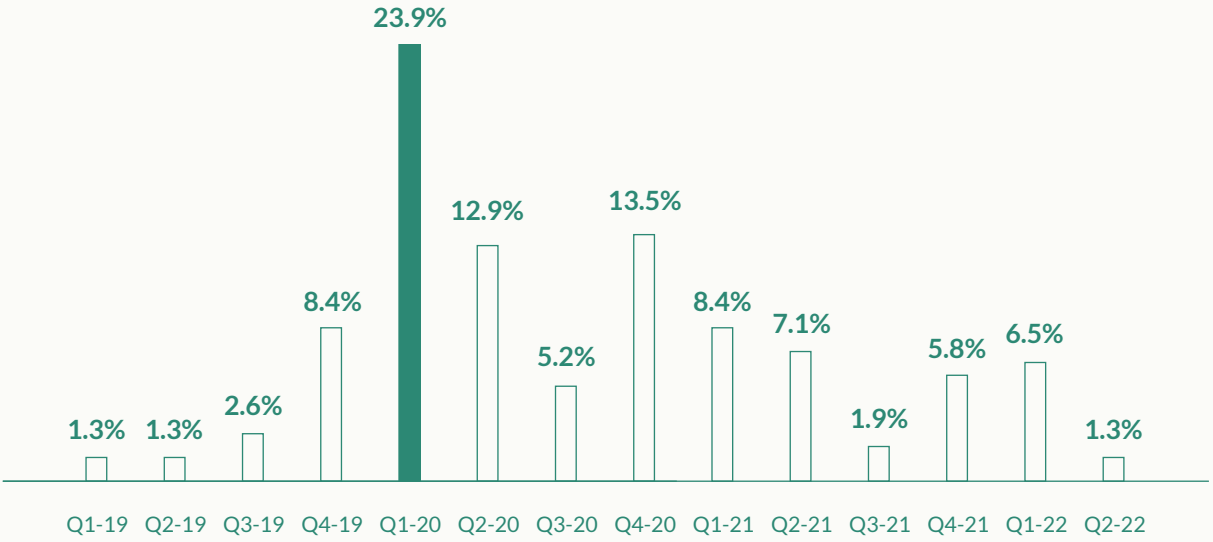
Access to basic medications or hospitalization became a luxury that could not be afforded by a great proportion of the Lebanese population, in a context of an increasingly expensive and fragmented health system.

General overview of the impact of the crisis on Lebanese households

This section depicts the general composition of the sample, and the subjectively perceived socioeconomic status of the respondents, especially focusing on their revenues and their employment status before and following the crisis. It thus describes the impact of the Lebanese multilayered economic and social crisis on their livelihoods and their jobs.

Before 2019, some 55.2% of the respondents had a declared monthly income above 2 Million pounds (LBP, hereinafter referred as Lira, around $1,320, according to the pre-crisis exchange rate of 1,507 Lira for $1). In our survey, some 62.2% of the respondents could be considered as poor, since they currently declare a monthly income below 8 Million Lira, representing less than $200 per month according to the current exchange rate[6]. Among this lowest-income group, some 9% have declared having currently a monthly income below 2 Million Lira ($50), while 31.4% have declared a monthly income between 2 and 5 Million Lira ($50 and $125), and 21.8% a monthly income between 5 and 8 Millions Lira ($125 and $200).

***Figure 2**- Quarterly evolution of job losses after 2019*



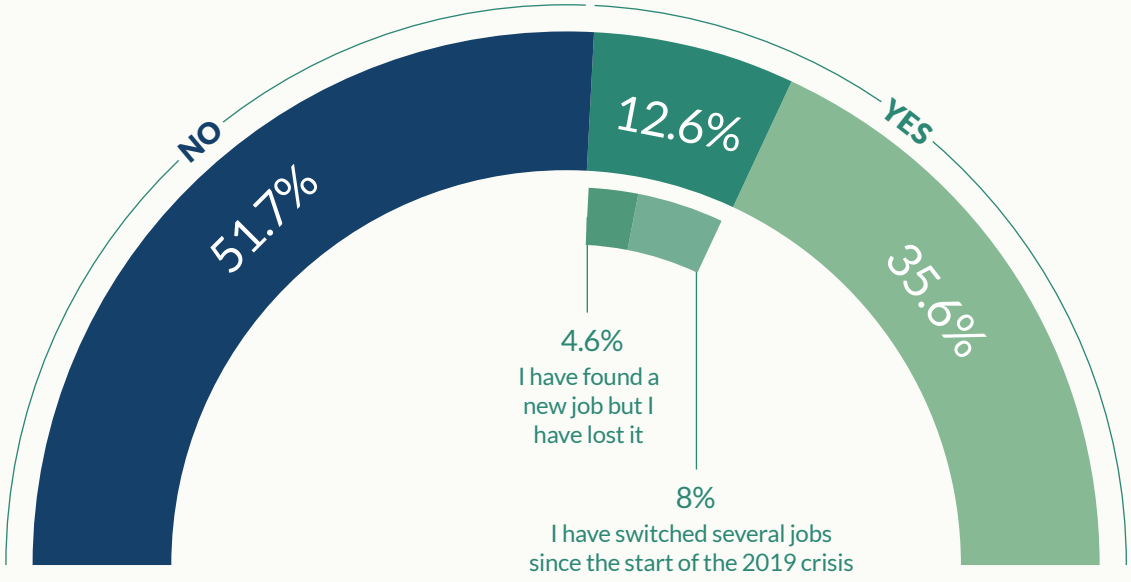
Around 13.1% of the respondents lost their jobs after the 2019 crisis, and the job losses reached their peak in the first quarter of 2020. A second wave of layoffs started in the third quarter of 2020 and peaked during the 4th quarter of the same year, following the Beirut port's explosions.

The main reason for these job losses was layoffs, for almost 44.8% of the cases, followed by the personal decision to quit the job, for 35% of the cases. The majority of the persons who lost their jobs were unable to find a new one, representing 51.7% of the cases. An additional 4.6% of them have found a second job but they ended up losing it again, and around 8% were forced to switch between several jobs after 2019.

6- According to the current exchange rate (at the time of writing, 16/10/2022) of 40,000 LBP for one US dollar. Due to the high volatility of the exchange rates, and to the meaningless reference to an average exchange rate on a specific period, we will refer to this fixed exchange rate of 40,000 LBP = 1 USD to reflect the real purchasing power. Thus, this rate will be used in the remaining of this study. At the time this report was submitted, the exchange rate had reached 39,600 LBP for 1 USD (10/11/2022). Cf. https://Lirarate.org/

IF YOU LOST YOUR JOB AFTER 2019, HAVE YOU FOUND A NEW JOB?

Figure 3- Professional reintegration of those who lost their jobs after 2019



Among the group of persons who have been able to keep their pre-crisis jobs, 22.8% had to decrease their working hours.

Finally, 12.8% of the respondents declared that they had to work multiple jobs following the 2019 crisis, while 10.3% of the respondents had to change their professional activity, the majority of them working today in a different economic sector.

As a result, the majority of respondents declared that their socio-economic status has decreased since the beginning of the Lebanese crisis. This decrease in the subjective perceived socio-economic status concerns 79.2% of the respondents, while 13.8% felt that they maintained the same, and only 7% claimed to feel that it has increased. It is worth noticing that women are more likely to feel that their socio-economic status has decreased than men.

Finally, as perceived by the respondents, the financial crisis had more negative impact than the Covid-19 pandemic, on both the individual professional activity and the economic sector. Indeed, some 59.2% of the respondents either agree or totally agree that the pandemic has negatively impacted their personal economic activity, while 67.5% of them either agree or totally agree that it was negatively impacted by the financial crisis. Similarly, some 61% of the respondents either agree or totally agree that the pandemic has negatively impacted their economic sector, while 68.8% of them either agree or totally agree that it was negatively impacted by the financial crisis. Most importantly, the difference in perception is most likely to be found among the group of persons who totally agree that the financial crisis had a more severe impact on jobs and economic sectors. Therefore, one can conclude that the financial collapse of 2019 is perceived by the Lebanese citizens as having a worse impact on jobs and professions than the health crisis related to the Covid-19 pandemic.

***Figure 4**- The perceived socio-economic status by sex, before and following the crisis*

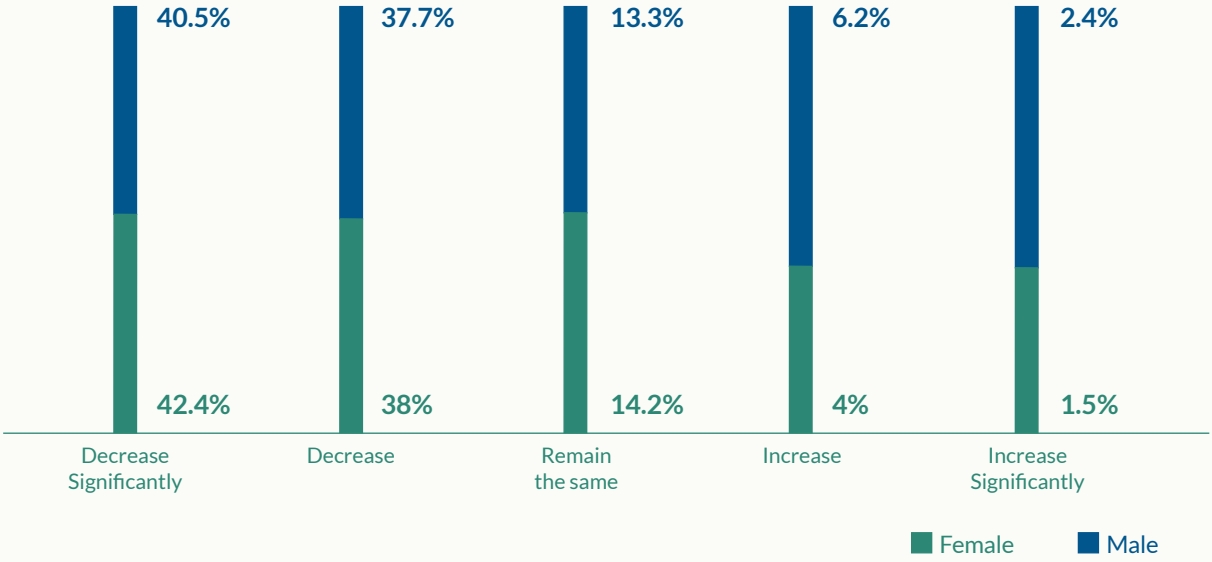
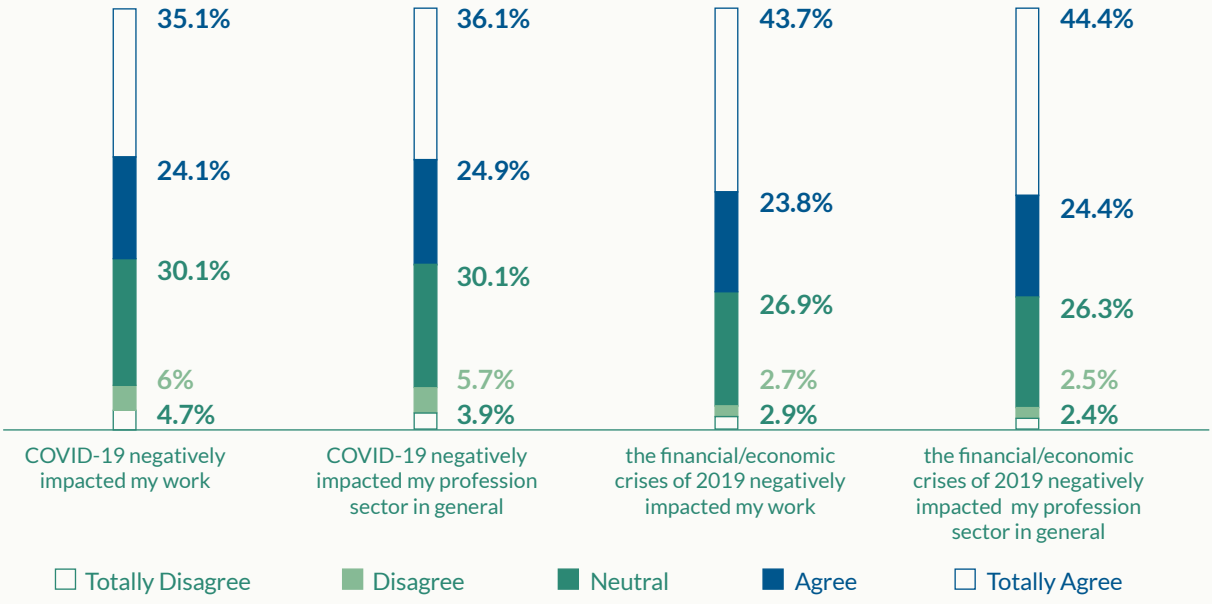


***Figure 5**- The perceived impact of the Covid-19 pandemic and the financial crisis on the personal job and the economic sector*



Indicators regarding the levels of coverage of the Lebanese population

On the global scale, only 66% of the world population is effectively affiliated to a publicly mandated programme guaranteeing affordable access to health care. Moreover, only 47% of the world population is effectively covered by at least one social protection benefit (excluding healthcare and sickness benefits), and less than 34% of persons with severe disabilities are covered by cash benefit (ILO 2022).

Comparatively, our survey shows that an important proportion of Lebanese citizens is excluded from the formal system of social protection, thus not benefiting from any kind of social coverage, and the levels of coverage of unemployed and persons with disability are below the international averages. Moreover, since social security is a central element in labor rights, it is important to understand how the level of coverage is varying among different socio-professional categories, and disaggregated data by region and gender is instrumental to measure the regional disparities and the gender gaps in social protection. Thus, four main indicators are particularly important to measure the level of coverage in the current social protection landscape, and to understand how it is evolving since the beginning of the crisis:

1. "Proportion of population who are not covered by any health insurance";
2. "Proportion of unemployed benefiting from health insurance";
3. "Proportion of population affiliated to a publicly mandated programme guaranteeing affordable access to health care"; and,
4. "Proportion of persons with disabilities receiving benefits".

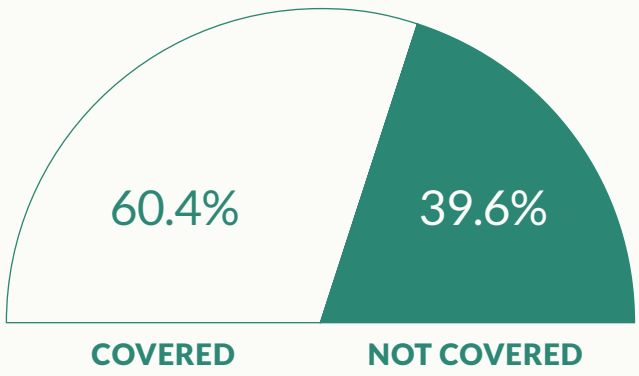
1. The insurance plans and their level of coverage among the Lebanese population

Even before the Lebanese economic crisis, the social protection system showed very low levels of coverage, since a non-negligible proportion of the Lebanese workers are legally or de facto denied access to basic coverage schemes and instruments (Institute des Finances 2021). Indeed, a majority of the Lebanese population does not have the right to retirement pensions schemes, and those affiliated with the NSSF only benefit from an end-of-service indemnity. Moreover, 42.1% of the Lebanese population were not directly covered by any type of health insurance plan (ILO & CAS 2018-2019).

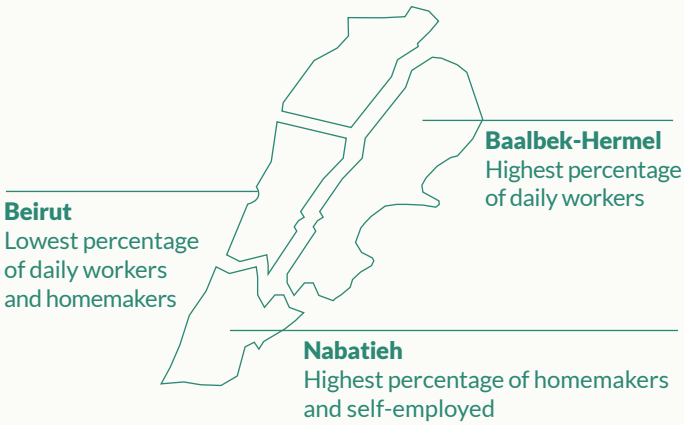
Our survey shows that only 60.4% of the respondents are currently benefiting from at least one insurance plan (either private or public), while 39.6% do not have any coverage at all, and remain completely unprotected. The gender difference does not seem to be significant, although slightly more women (62%) are covered than men (58.9%).

Yet, the survey shows important regional disparities. Indeed, the percentage of Lebanese individuals totally unprotected reaches its lowest in Beirut (25%), and Mont-Lebanon (28.9%), while it is more than the double in the South (57.7%) or in Baalbek-Hermel (58.6%) and reaches its peak in Nabatieh (65.7%).

***Figure 6**- The privately or publicly covered vs. the totally not covered Lebanese population*



These regional disparities are linked to the regional segmentation of the labor market. For instance, the percentages of homemakers and self-employed are also the highest in Nabatieh (16.3% and 24.7% respectively), while the percentages of daily workers (*mouyawimin*) are the highest in Baalbek-Hermel (78%) followed by Nabatieh (53.8%). Comparatively, Beirut accounts for the lowest percentages of daily workers (9.3%) and homemakers (5.3%).

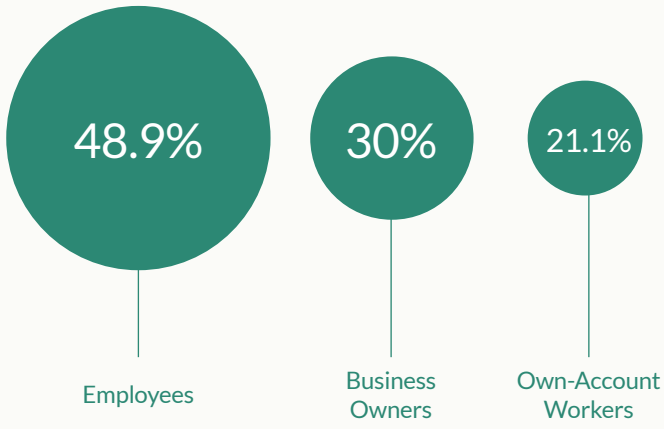


2. Social protection according to labor force status

Social protection schemes enclose various measures linked to social insurance, social assistance, and labor market policies. Yet, in Lebanon they remain dominated by contributory schemes. Thus, the level of coverage of the Lebanese population varies according to the labor force status.

In our sample, 25% of the respondents were outside the labor force, with 8.8% being retired and 16.3% being homemakers. The unemployment rate was 21.2%. Regarding the "employment by status in employment at main job", 30% of the respondents stated that they are entrepreneurs or business owners (either in formal or informal sectors), 21.1% are own-account workers, and 48.9% are employees[7].

Figure 7- Employment by Status in employment at main job



Business owners and entrepreneurs are the largest group covered by private insurance (69.8% of them stated that they have subscribed for a private insurance), while the proportion of employees with formal employment and registered work contract are the largest group covered by the NSSF (around 40.5%).

42.2%

Unemployed persons benefiting from a publicly mandated coverage before the 2019 crisis

34.9%

Unemployed persons benefiting from a publicly mandated coverage following the 2019 crisis

Most importantly, the level of public coverage of the unemployed persons has significantly deteriorated following the 2019 crisis, since 42.2% of them were covered before the crisis (as they are registered by a family member), while only 34.9% of them are still currently benefiting from a publicly mandated coverage. The majority of them is covered through the NSSF (20.8% compared to 29.7% before the crisis), followed by the military and security forces, offering coverage through a relative to 10.4% of the unemployed, and finally by the Civil Servants Cooperative covering 3.8% of the unemployed. Overall, around 65% of the unemployed persons have no access to any form of public insurance.

7- It is worth noting that the high rate of business owners in our sample is due to some of the highlighted limitations of the sampling, as explained in the introduction (i.e. the exclusion of informal dwellings, as well as the non-Lebanese population, and the population under 18 years old).

Similarly, among the inactive population, the survey shows that more than half (53%) of the homemakers (almost exclusively women) and a third of the retired persons (35%) are currently not covered by any public insurance scheme. Following the 2019 crisis, the proportion of homemakers covered by the NSSF has decreased from 26.1% to 19.8%, while the NSSF coverage for the retired person has decreased from 16.3% to 14.8%.

Finally, the survey could not measure the levels of coverage of informal employees, since informal employment encompasses various labor situations that are only captured through a labor force survey. According to ILO's guidelines[8] informal employment comprises the total number of informal jobs. Employees are considered to have informal jobs if their employment relationship is, in law or in practice, not subject to national labor legislation, income taxation, social protection or entitlement to certain employment benefits (advance notice of dismissal, severance pay, paid annual or sick leave, etc.), comprising own-account workers or employers employed in their own informal sector enterprises, as well as contributing family workers. According to this definition, an important proportion of the respondents who declare being a business owner or self-entrepreneur could be falling under various levels of informality (either working in informal sector or business, either working informally in a formal business or sector).

Therefore, data collected through the current survey might suggest an underestimation of the rate of informal employment projected by other available studies specifically gauging informal employment. The latest update of the national labor force survey showed that 62.4% of the Lebanese labor force fall under the so-called category of informal employment, while the employment in the informal sector was estimated at 48.3% of total employment (ILO & CAS, 2022). Even though our survey was not intended to estimate informality, it shows that the level of public coverage decreases drastically when the employee is not formally registered in a formal job. Indeed, self-employed persons constituted the group of workers who are the most excluded from NSSF coverage (only 24.8% compared to 40.5% of formally employed persons with official work contract).

62.4%

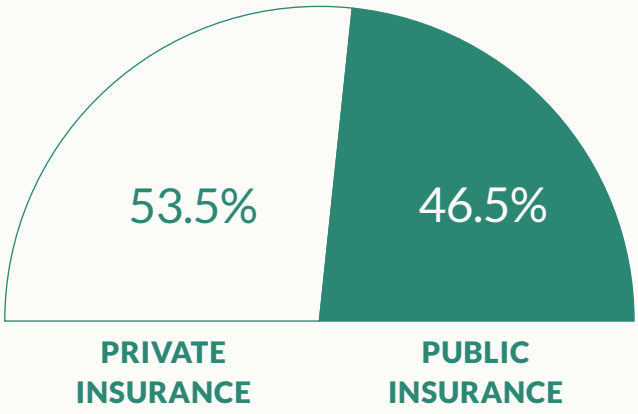
of the Lebanese labor force fall under the so-called category of informal employment

8- ILO's Guidelines concerning a statistical definition of informal employment Informal, The Seventeenth International Conference of Labor Statisticians (ICLS). https://www.ilo.org/wcmsp5/groups/public/---dgreports/---stat/documents/normativeinstrument/wcms_087622.pdf

3. The insured population: publicly mandated insurance programme vs. the private insurance plans and coverage

In Lebanon, private sector formal workers are covered by the National Social Security Fund (NSSF). The NSSF is funded by contributions amounting to 23.5% of the workers' salary, with 21.5% covered by the employer while the worker is mandated to contribute with 2% of the salary. The NSSF covers for various social risks, namely the insurance for sickness and maternity care, the family and education allowance, and the "end-of-service" indemnity. Regarding the latter, the NSSF does not provide a retirement pension, but rather a lump-sum that depends on the number of years of services, thus leaving many retirees without retirement pay or medical coverage[9].

Figure 8- The insured population: public vs. private insurance



The public-sector employees could fall under various employment-based social insurance funds, namely the Civil Servants' Cooperative on the one hand, and the Military, Internal Security, State Security Forces and General Security forces schemes on the other. Unlike the population covered by the NSSF, the public-sector workers usually have the option, upon retirement, between choosing to receive an end-of-service indemnity or a permanent pension[10].

According to the Ministry of Public Health, the NSSF was the most important contributor to health expenditures in the country before the crisis, representing around 20% of the total health expenditures in 2017, followed by private insurance (13.6%), while the military and security forces funds contribute to less than 5% of the total (MOPH, 2017b)[11].

Among the persons benefiting from medical coverage, our survey shows that only 46.5% have access to public insurance (civil servants' cooperative, NSSF or Military and security forces), while a majority of the covered persons rely on private insurance (53.5%), with no significant gender differences.

Yet, among the persons covered by public insurance, women are more likely to be covered by the NSSF, while men are more likely to be covered by the Civil Servants' Cooperative.

Women are more likely to be covered by the NSSF

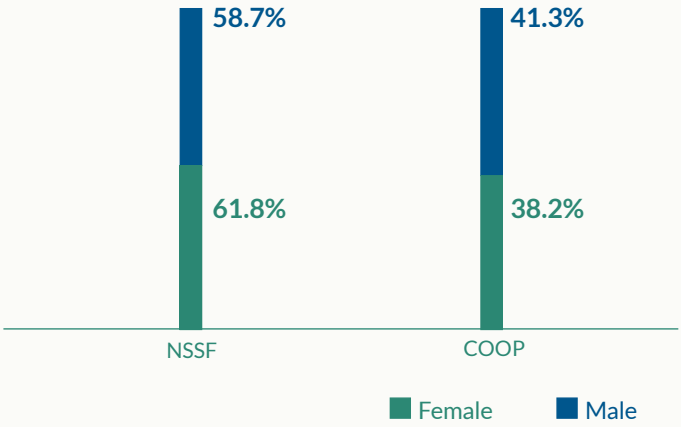
Men are more likely to be covered by the Civil Servants' Cooperative

9- Moreover, if one loses the job before having completed at least 20 years of service, the employee is subject to a scale of reduced rights (Jarmuzek & Nakhle, 2018). In 2017, the NSSF coverage for health care was expanded to the retired since (Law No. 27/2017). Yet, in order to be eligible for medical care, retired workers should have 20 years of contribution (ILO 2020).

10- As public-sector employees may access a retirement pension, they have been traditionally considered as a "privileged group", at least until the outbreak of the current multilayered crisis and the currency depreciation of the national currency that has produced a class downgrading of public sector employees (Scala 2022).

11- Nevertheless, as we will show in the next section, the current landscape of the public coverage has drastically changed after the 2019 financial collapse, since publicly mandated programmes are still following reimbursement grids in Lebanese Lira, while medical bills are almost completely dollarized, thus leaving the publicly insured persons without any effective coverage.

Figure 9- The publicly insured population by sex: NSSF vs. Civil Servants' Cooperative



Beirut accounts for the highest reliance on private insurance (63.4%), while the South has the highest dependence on public insurance (65.2%).

Finally, relatively to the whole sample, some 28% of the respondents are effectively affiliated to a publicly mandated programme guaranteeing access to health care, below the world average of 66% (ILO 2022).

4. Coverage of persons with disabilities (by gender and region)

The term "disability" used in the survey refers to the UN definition, stating that "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others[12]". Persons with disabilities (PWDs) account for 15% of the world population, and international statistics regularly show that the prevalence of disabilities is higher in lower income countries (WHO & WB, 2011). According to the World Health Organization (WHO), the prevalence of disabilities in Lebanon was very low in 2002, the year of the last available official data for Lebanon, accounting for 1.5% of the total population[13]. Yet the years of healthy life lost due to disability (YLD) or ill-health are around 9.1 years, among the highest in the region (WHO & WB, 2011, p. 273).

Our survey shows that 10.1% of the respondents declare having at least one family member with disabilities, a percentage that is significantly higher than the last available official figures (presumably 1.5%), who surely underestimate the prevalence of disabilities in order to justify the insufficient allocated public funds. The prevalence is the highest in Baalbek-Hermel (20%), followed by Beirut (17.9%) and Bekaa (13.4%), while the lowest is in the South (3.3%).

Moreover, in Baalbek-Hermel and Bekaa, the majority of the persons with disabilities do not have the disability card[14], while this percentage is the lowest in Mount-Lebanon and Beirut, showing that more efforts are still needed from the Ministry of Social Affairs to include persons with disabilities in remote regions.

12- Convention on the Rights of Persons with Disabilities (CRPD) - Article 1. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-1-purpose.html

13- The percentage of persons holding the Personal Disability Card was estimated at 2.6% in 2019 (UNICEF & MOSA 2019). In a recent report, the proportion of PWDs was estimated at 4% ILO (2020, p. 9)

14- The Personal Disability Card (PDC) grants access to care through specialized institutions providing a package of care, as well as, therapy services, and specialized equipment. Nevertheless, major gaps in the legislation and the services of the PDC should be addressed in order to increase its effective coverage. As indicated in a recent report, "there are number of reasons for the low rates of reported disability which are discussed further below, and they include the definition and classification of disabilities used14, stigma associated with reporting disability, and low take-up of the PDC" (UNICEF & MOSA 2019, p. 46)

Effective coverage of health insurance plans

Effective coverage of social protection is usually measured by the number of people who are either actively contributing to a social insurance scheme or receiving benefits (contributory or non-contributory). This section focuses on the level of coverage of health insurance programmes (either private or public), and more specifically on the rates of coverage of the various insurance plans. In the Lebanese case, various public and private insurance schemes are currently ineffective, due to both adverse demand and supply-side effects. Indeed, a privileged minority is currently subscribing to private insurance in fresh Dollars[15], while an important proportion of the insured population is currently either partially covered or almost not covered, due to uncertainties regarding the currency used by the contributor to cover the subscription (if paid in lollar[16] or Lira).

Moreover, the covered population has to navigate a highly segmented insurance market, with major institutional failures from the suppliers-side (whether private insurance companies, NSSF, Cooperative, or mutual funds, etc.) who retain huge asymmetrical power), and are capable of unilaterally changing the terms of the contracts (not covering expensive medications or treatments, or specific hospitals and medical centers, etc.).

Coverage plan	Level of coverage
Totally not covered	39.6%
NSSF (Private sector)	16.9%
Military and security Forces	6%
Civil Servant/Teachers/Public sector employee	5.4%
Private insurance	32,1%
Subscription in Lira	11%
Subscription in Lollar	5.1%
Subscription in fresh USD	16%
Total	100%

***Table 2**- The levels of coverage by type of insurance plan*

15- The "Fresh Dollars" refer to cash transactions in US dollar (banknotes) and/or to cash deposits or transfers denominated in US dollar, that were accomplished (either transferred or received) after 17 October 2019. The same distinction applies to other foreign currencies (especially for bank accounts in fresh euro). Reversely, bank deposits in USD that date back to before 17 October 2019 are labeled as "Lollars", meaning that they are only theoretically denominated in US dollar, but are subject to transfer and withdrawal restrictions, and their exchange rate is totally regulated by the Lebanese central bank (cf. next note).

16- "Lollars" is a sarcastic denomination coined by the analyst Dan Azzi to designate pre-crisis bank deposits in foreign currencies, meaning simultaneously that those deposits are ironically "Lebanese Dollars" that fall under the jurisdiction of the Lebanese financial system (referring to the internet slang LOL, initialism of laughing-out-loud). In practice, lollar became a currency that set a lower exchange rate for all bank deposits in foreign currencies dating back to before 17 October 2019, leading to a de facto haircut on these deposits due to the increasing spread with the market rate.

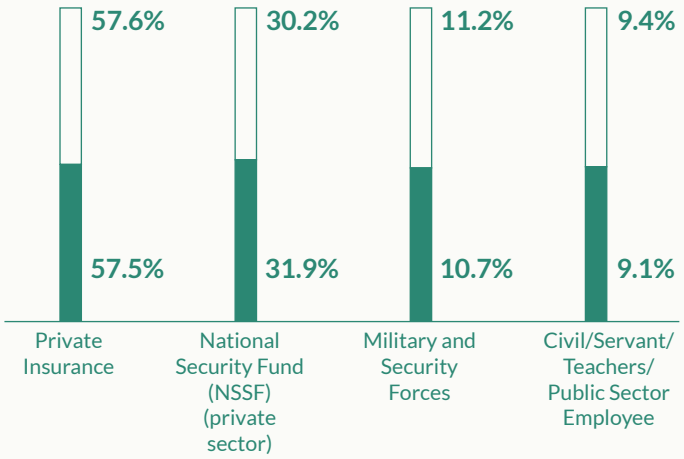
1. Private insurance coverage and challenges

Even before the Lebanese economic crisis, the social protection system showed very low levels of coverage, since a non-negligible proportion of the Lebanese workers are legally or de facto denied access to basic coverage schemes and instruments (Institute des Finances 2021). Indeed, a majority of the Lebanese population does not have the right to retirement pensions schemes, and those affiliated with the NSSF only benefit from an end-of-service indemnity. Moreover, 42.1% of the Lebanese population were not directly covered by any type of health insurance plan (ILO & CAS 2018-2019).

Our survey shows that only 60.4% of the respondents are currently benefiting from at least one insurance plan (either private or public), while 39.6% do not have any coverage at all, and remain completely unprotected. The gender difference does not seem to be significant, although slightly more women (62%) are covered than men (58.9%).

After the 2019 crisis and following the depreciation of the Lebanese Lira, the private health insurance premium could be paid in Lira, in lollar or in fresh USD, and the level of coverage depends on the subscription's currency. Generally speaking, in addition to the premium, one should usually have to pay other costs for health care, including non-covered services, as well as copayment and/or a fixed out-of-pocket amount paid by the insured in order to receive the covered services. Thus, even if one has purchased the premium in USD, the out-of-pocket amount has become extremely expensive for the insured, comparatively to the average monthly income. For those who subscribe their insurance plan in "Lollars" or Lira, the percentage participation that should be covered by the insured has increased significantly (Laughlin & Saad 2022).

*,**Figure 10**- The structure of the coverage levels before and following the crisis*



Therefore, even if the structure of the insurance plans has almost remained the same, before and after the 2019 crisis, the effective coverage of the insured persons has decreased dramatically. Indeed, it seems that the majority of the respondents have been able to maintain the same health plans in times of crisis.

60.4%

are currently benefiting from at least one insurance plan (either private or public)

39.6%

do not have any coverage at all, and remain completely unprotected

Nevertheless, half of the persons subscribing to private insurance have shifted to health plans covered in Lira or in "Lollars", thus accepting higher participation percentages and lower effective coverages. Indeed, among the group of people covered by private insurance plans, one out of two persons has paid the premium in Dollars, and the other half had to pay partially in Lira or in "Lollars". According to our calculation, 38.9% of the insured persons had to pay their premium in Lira, meaning that their effective coverage has decreased significantly, divided by 25 if compared to the pre-crisis percentage participation.

Moreover, 17.4% of the respondents paid their subscription in "Lollars", meaning that their effective coverage has been divided by 5. For example, if an insured person was covered at 85% before the crisis for the reimbursement of medication, today the insurance company will cover only 17% of the bill if the subscription is in "Lollars", and some 3.5% if it was purchased in Lira. Practically, those who purchased their premium in Lira, representing around the third of the insured persons, are almost not covered at all, and one out of 5 persons became partially covered.

Those who purchased their premium in Lira, representing around the third of the insured persons, are almost not covered at all.

2. Public social security coverage and challenges (by employment status, gender and region)

According to NSSF administrative records, there were 620,656 people registered in the fund and 787,429 people benefiting from its coverage in 2014 (Abdo, 2019), while the last available data showed that in 2018 there were 696,992 enrollees in the health care scheme covering for 848,761 additional dependent family members (ILO, 2020).

In our sample, the percentage of respondents covered by NSSF represented 16.9% of the total sample, and they represented 30.2% of the group benefiting from health coverage. Therefore, NSSF is the second most important health insurance plan, after the private insurance companies. There is no significant gender difference in the level of coverage by the NSSF, yet regional disparities are worth noticing. Indeed, before the crisis, the level of coverage of the NSSF was the highest in the Bekaa (39.7% of the residents of Bekaa who were benefitting from a health insurance plan were covered by the NSSF), followed by the South (38.5%), and Baalbek-Hermel (32.3%), followed by Beirut and Mount-Lebanon (at 29%), and the NSSF coverage was at its lowest in the North and Akkar (21.6%). Following the crisis, these levels remained almost unchanged in all the regions, except for Baalbek-Hermel, with a decrease in the NSSF coverage (from 32.3% to 29%). With an increase from 38.5% to 43.9%, the South became the region with the highest NSSF coverage after the crisis.

Finally, the regional distribution of the Military and security forces coverage remained practically unchanged. In 2022, it was the highest in Baalbek-Hermel (22.6%), in the South (15.2%), and in the North (10.5%), followed by Mount-Lebanon (10%), Bekaa (9.1%), Nabatieh (8.1%), and the lowest in Beirut (5.5%).

Unlike private insurance companies, publicly mandated programmes are still totally funded by contributions collected in Lebanese Lira, and through the deteriorating public budget. Since private medical centers and hospitals[17] are shifting towards total dollarization of the medical bill, state-run schemes can no longer afford to cover for the overpriced hospital bills, especially in class-A hospitals[18].

Consequently, the public-sector workers, civil servants or military/security staff who used to be considered among the most privileged in their pre-crisis coverage rates (Abdo 2019) are currently suffering from great uncertainties regarding their health coverage, since they have to pay large out-of-pocket sums for their hospitalization (Scala 2022). Similarly, the large discrepancies between the dollarized effective bill and the outdated official price grid of medications is dissuading a large proportion of the publicly insured population from seeking the reimbursement of their pharmaceutical bill through public social security institutions[19]. In this regard, one out of two respondents ensured through the NSSF and the state-run cooperatives did not use their services at all in the last 12 months, and less than 20% of the respondents declared to be satisfied with the services received. It is worth noting that women are more inclined to be dissatisfied with the services of the state-run cooperatives and NSSF than men, and the degree of dissatisfaction is the highest in Bekaa and Baalbek-Hermel, while the lowest levels of dissatisfaction are registered in Mount-Lebanon.

17- 80% of hospitals and 67% of the PHCC network are private (Jardali & al. 2017), adding up to almost 90% when including those run by non-governmental organizations (ILO, 2020b).

18- A recent study has also concluded that reimbursements from state-run schemes – still in accordance with the official pre-crisis exchange rate – only account for about 4% of the total hospital bills (Laughlin & Saad, 2022).

19- It is worth noting that similar situations could be found in some professional mutual funds available for various professional groups or orders, usually contracted with private insurance companies. Indeed, some of the mutual funds have also decided to break their contracts with what they consider as overpriced dollarized hospitals, limiting their coverage to specific hospitals, medical centers, or laboratories (for in-patients and out-patients as well). Officially, there were 46 mutual funds covering 9% of the population (about 350,000 beneficiaries) before the crisis, with varied pool sizes and benefit packages (Union Technique des Mutuelles Santé du Liban, 2019). A recent study counted 64 mutual societies covering around 340,000 individuals (Laughlin & Saad, 2022).

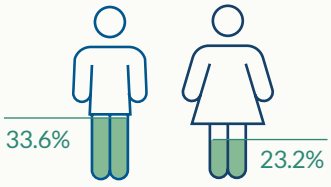
Finally, women are less likely to use the services of the NSSF than men, since 38.5% of the women did not use the NSSF services at all in the last 12 months, compared to 35.5% for men. Especially men are more inclined than women to use the NSSF services in order to cover the fees of physicians' consultations (14.7% for men compared to 10.7% for women) and to reimburse the medication (18.2% for men compared to 16.6% for women), while women showed a higher level of use for medical tests (16.6% for women compared to 14.8% for men), and the survey showed no gender differences for hospitalization. Gender differences are more likely to be observed among the population covered by the state-run Cooperatives. Indeed, the percentage of persons who did not use the services of the Cooperatives in the last 12 months is significantly higher among men (33.6%) than women (23.2%). Moreover, women have higher dependency on the Cooperatives for hospitalization (20.5% for women compared to 15.8% for men), medical tests (21.4% for women compared to 17.8% for men), and reimbursement of medications (19.6% for women compared to 16.4% for men.

Unlike private insurance companies, publicly mandated programmes are still totally funded by contributions collected in Lebanese Lira, and through the deteriorating public budget. Since private medical centers and hospitals are shifting towards total dollarization of the medical bill, state-run schemes can no longer afford to cover for the overpriced hospital bills, especially in class-A hospitals.

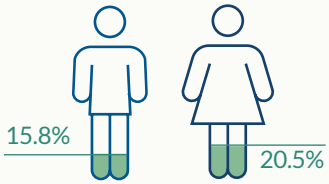
NSSF is the second most important health insurance plan, after the private insurance companies

1 in 2

respondents ensured through the NSSF and the state-run cooperatives did not use their services at all in the last 12 months, and less than 20% of the respondents declared to be satisfied with the services received



The percentage of persons who did not use the services of the Cooperatives in the last 12 months is significantly higher among men than women



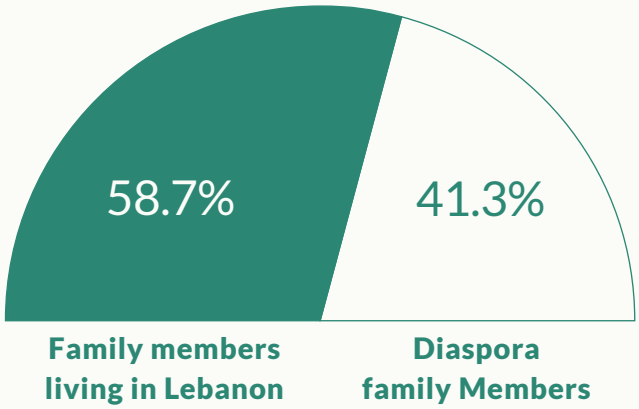
Women have higher dependency on the Cooperatives for hospitalization

Family and solidarity: The gender gap in social protection

In the context of the weak publicly mandated social protection, Lebanese citizens rely on family assistance and solidarity-based social networks in order to protect themselves and others from various social risks.

Even though one out of two persons declared not receiving any kind of assistance from their families, some 31.7% declared having high reliance on their family support, while 13.8% declared that the family is somehow needed to provide financial and in-kind support.
The family-based support seems to be highly dependent on family members living in Lebanon, even though 41% of the respondents declared receiving support from family abroad.

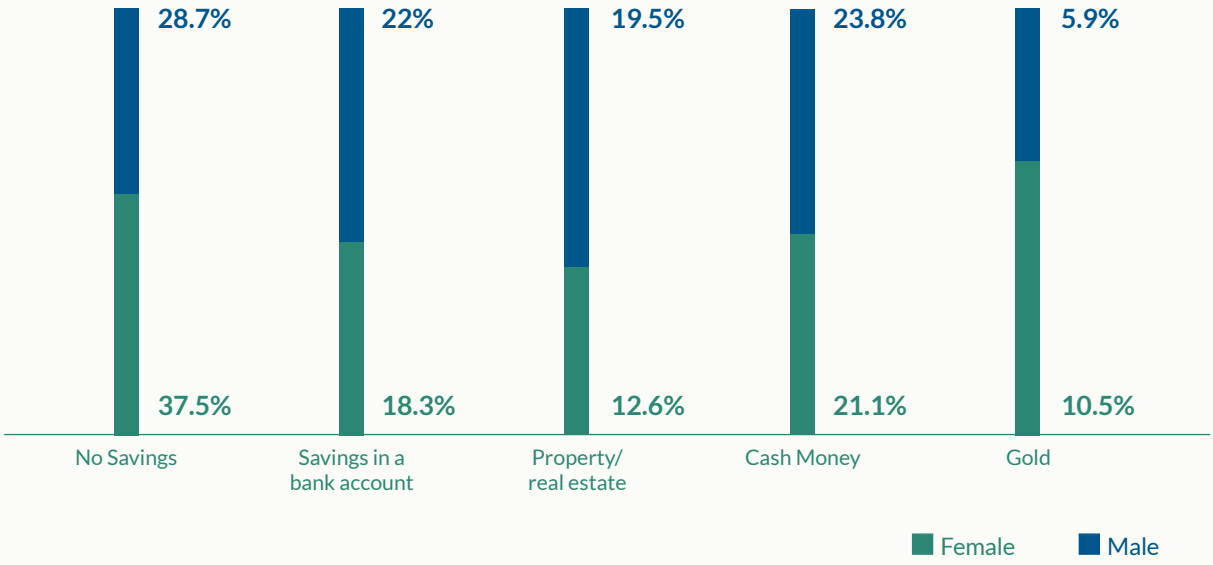
***Figure 11**- Support from family members in Lebanon and abroad*



Remarkably, the survey did not show significant geographical differences. Yet, the gender differences are salient. Women are significantly more dependent than men on family support (55% of women compared to 35% for men). This support is considered to be crucial to meet the subsistence need for more than 56.6% of the respondents, and women are more likely to consider that this support is crucial to meet their basic needs than men (61.5% and 49.2% respectively). Similarly, women seem to be more dependent on the support given by family members living in Lebanon (60.7% of women compared to 56.4% of men), while men seem to be more benefitting from the support of their family members living abroad (43.6% of men compared to 39.3% for women). This may also explain why women receive more in-kind assistance than men, while the cash transfer seems to be more benefitting men (43.6%) than women (40.7%). Assistance given through cash transfers seems to be the highest in Beirut, while the in-kind assistance seems to be the highest in the South.

Overall, the survey shows that women are living in higher precarious conditions than men, despite the similar levels of coverage, since they seem to detain less assets and savings to help them confront and manage social risk and economic uncertainties. Firstly, women have significantly lower levels of savings than men. More than one woman out of three declare not having any savings at all, compared to 28.7% of men. Secondly, women have lower access to real estate properties than men (respectively, 12.6% vs. 19.5%). Finally, men are more likely to have cash-savings than women (23.8% for men compared to 21.1% for women), as well as savings in a bank account (22% for men compared to 18.3% for women).

***Figure 12**- Savings and properties by sex*



Nevertheless, women are more likely to have gold-based savings (mostly in the form of jewelry) than men, but their relative weight is negligible (10% of the total sample), when compared to other saving plans groups.

Conclusion

Our survey showed that 2 out of 3 Lebanese individuals are currently earning less than 200$ per month, and more than 79% of the respondents feel that their (subjectively perceived) socio-economic status has decreased in the past 3 years. Surely, these figures underestimate the reality of the economic hardship that erupted following the financial collapse of 2019. Indeed, when considering the multiple manifestations of poverty, studies have shown that almost 4 out of 5 Lebanese individuals are currently living in multidimensional poverty (ESCWA 2021). The economic collapse in Lebanon had a crippling effect on the Lebanese social protection framework and has further revealed its structural shortcomings.

This report showed that the historically regressive distributive nature of the national social protection system was exacerbated by the multilayered Lebanese crisis. Indeed, 39.6% of the population have no access to any social protection benefits and are left totally unprotected, and more Lebanese citizens are currently being excluded from what was already considered an elitist and exclusive social protection system. On the one hand, the percentage of the Lebanese population who are not benefitting from any social protection coverage remain below the regional and global averages, respectively 53.1% of the global population, and 60% of the population in Arab States (ILO 2021a). On the other hand, our survey showed that the rate of coverage has significantly dropped for the majority of the insured persons (privately or publicly), even though the level of coverage may seem theoretically unchanged. Indeed, in our sample, 39.6% of respondents did not have any coverage at all, 28.3% were covered by a publicly mandated scheme in Lira, and 32.1% of respondents have subscribed to a private insurance, yet only 16% paid the subscription in fresh dollars.

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2 in 3

Lebanese individuals are currently earning less than 200$ per month

79%

of the respondents feel that their (subjectively perceived) socio-economic status has decreased in the past 3 years

The fragmented health care sector is scattered between various public social security schemes, mutual funds, and private insurances. The economic crisis and the outbreak of the Covid19 pandemic have emphasized this over-fragmentation.

Privately insured persons represented around 32.1% of the total population, yet only the privileged high-income group is capable of subscribing in fresh dollars to the insurance plan, while more than the half covered their subscriptions in so-called “Lollars” or in Lira, and could be considered respectively as partially covered, or almost totally not covered.

Thus, private insurance companies remain the main providers of health care coverage, covering 32.1% of the whole sample, followed by the NSSF (16.9%) and state-run cooperatives (11.4%). Even though the level of coverage remained relatively unchanged after the crisis, the rate of coverage has decreased significantly. Indeed, half of the privately insured population is currently subscribing to an insurance plan in Lira or in “Lollars”, meaning that they are only partially covered, while the percentage of Lebanese population who might be benefiting from an almost-full medical coverage does not exceed 16% of the overall population.

Moreover, the level of coverage varies a lot according to the employment status, and some inactive persons might still be covered through an active family member. Around 65% of unemployed persons have no access to any public insurance, as well as 53% of homemakers (almost all of them are women), and 35% of retired persons. Following the 2019 crisis, the proportion of homemakers covered by the NSSF has decreased from 26.1% to 19.8%, while the NSSF coverage for the retired person has decreased from 16.3% to 14.8%.

The volatility of the exchange rate between the Lebanese Lira and the US Dollar on the so-called “black market” resulted in a dramatic rise in the actual cost of medications and healthcare services, with a drastic increase of the out-of-pocket expenses, even for the insured persons. Moreover, for both the publicly and privately insured population, the levels of coverage might have remained unchanged, yet the effective rate of coverage has substantially decreased, since out-of-the pocket expenses in fresh US Dollars are significantly higher, especially when compared to the decreasing real revenues.

In this context, public social security institutions are incapable of supporting the cost hike because of the general deterioration of their budgets and their outdated reimbursement grids, still pegged on the official pre-crisis exchange rate. For instance, before the crisis, the NSSF covered 90% of the cost of the medical bill, while the enrolled person only had to pay 10% of the amount. Nowadays, the situation has practically reversed as the enrolled person has to cover around 90% of the medical bill. Thus, publicly-insured individuals are almost solely bearing the burden of the medical bill by mobilizing their own savings and assets – if any – and one out of two of them has stopped seeking the services of the public insurance institutions. For civil servants and public-sector employees, the out-of-pocket expenses became unreasonably inflated compared to their salaries, thus signaling a class downgrading (Scala 2020) of public sector workers and employees, who used to be considered in the past among the most protected social groups.

Moreover, the insured population (both privately and publicly) suffer from the increased asymmetrical distribution of powers in a context of rising institutional failures. Consequently, insurance providers (private companies, public insurance institutions, and mutual funds, etc.) are free to redefine the terms of the contract, in accordance with their interests, without any opposition from the public authorities (e.g. the insurance control commission) nor significant social contestation. Insurance companies can thus renegotiate the rates of their coverage arbitrarily. They could also refuse to cover and/or reimburse medication or health services.

Finally, insured persons suffer from supply shortages in medication and in hospitalization, due to the counter-productive monetary subsidies on pharmaceutical products (that subsidize the importer and not the patient or the end-user), and the inadequate social budgeting. Indeed, both fiscal and monetary subsidies have proved to be counterproductive and regressive. The former was already suffering from insufficient public funds, and from a decrease of the fiscal space for social protection. After 2019, public subsidies were mainly achieved through the monetary policy of the Banque du Liban (BDL), thus undermining what was left from the solidarity-based public spending on social protection. The BDL subsidies benefited the importers of medications and pharmaceutical products, and not the end-users (i.e. the patients), thus imposing drastic supply-shortages. Thus, since September 2019, the BDL has made provision to financially support pharmaceutical importers and primary medical materials used by the local pharmaceutical industries[20]. Consequently, the local market has witnessed a shortage of medicines culminating in scandals of rationing, over-pricing, and black-market's opaque transactions. Various groups of patients had to resort to the black-market competition in order to have access to vital medicines, or to instore privatized alternatives to import the needed medications by their own means.

This shift towards monetary subsidies translated in a drastic decrease in hospital admission for patients without "fresh Dollars" insurance plans, namely the publicly-insured population, and to a lesser extent the privately-insured persons paying their insurance plan in Lira or "Lollar". Even before the crisis, the Ministry of Public Health and the National Social Security Fund used to owe the hospitals late bills and payments of overdue contributions. Since those late invoices are in Lebanese Lira, and therefore subject to all the effects of the national currency depreciation, hospitals are currently reluctant to admit publicly-insured patients, and to a lesser extent privately-insured patients not covered in fresh Dollars. Otherwise hospitals and medical centers will usually be exposed to exchange risks, and to uncovered fees, until the date the accounts are settled by the insurers. These delays will surely have further negative impacts on the financial capabilities of these hospitals, thus showing a vicious circle in the quasi-privatized Lebanese health care system. Indeed, as a consequence of the skyrocketing medical bills in private hospitals, and in the absence of sufficient and adequate public health infrastructures, the low levels and rates of medical coverage has currently led to a decrease in the number of hospitalized patients, while private insurance companies are regularly increasing their overpriced premium.

20- The intermediate Circular 535 (26/11/2019) organized the monetary subsidies for the importers of medical and pharmaceutical products, by providing 85% of the foreign currency needed to import medicines at the previously established official exchange rate, and 50% for the medical supplies.

In this context, if private insurance plans were sold at their actual price, then one should expect a drastic decrease in the premium, since insurers are practically facing lower levels of claims and lower levels of recovery.

Nevertheless, the relatively unchanged levels of coverage and the increased premiums of private insurance companies indicate that private insurers are currently increasing their profit margins, thus signaling a transfer of welfare from the insured patients to the private insurance companies, and a transfer of well-being from the Lira-insured persons to the Dollar-insured persons. As a result, various social groups are currently suffering from lower level of coverage, especially homemakers (the proportion of homemakers covered by the NSSF has decreased from 26.1% to 19.8%), retired persons (the proportion of retired persons covered by the NSSF has decreased from 16.3% to 14.8%) and unemployed persons (the proportion of unemployed persons covered by a publicly mandated program has decreased from 42.2% to 34.9%).

Moreover, some of those who maintained the same levels of coverage are suffering from lower reimbursement rates and higher out-of-pocket expenses, such as publicly insured persons (28.3%), persons with disabilities (10.1%), and privately insured persons who settled their subscriptions in Lira or in “Lollars” (16.1%). Thus, while undermining the universality of the Lebanese social protection system, the over-fragmentation of the social protection landscape is currently amplifying the regressive distribution (from the poorer to the richer) of social policies and public subsidies.

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