Ministry of Health

- Health Sector Modernisation Programme -

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برنـــــامج تطويـــــر القطـــــاع الصحـــــي
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A possible roadmap towards a national health insurance system in Syria

Result six of the HSMP: sustainable health financing

Draft

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Damascus, January 2007

Consortium GTZ / EPOS / OPTIONS

gtz IS International Services

EPOS Health Consultants

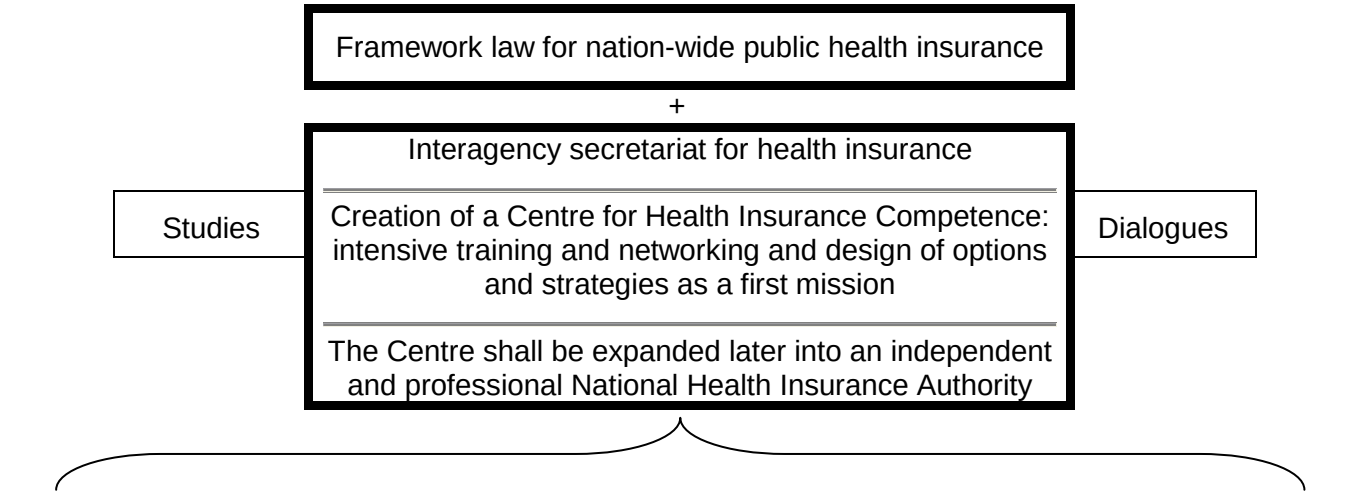
Options

A roadmap towards a national health insurance system in Syria

Draft

Content

A possible roadmap towards a national health insurance system in Syria An overview



Optional components of a national health insurance system in Syria

Health financing options by households' Main employment sector		Health financing options			
	Workforce (rough and rounded estimates)	Payroll contribution insurance	Insurance for self-employed	Community participation schemes	Tax-based health insurance
Government & public companies	1.000.000	60 %			
Formal private companies	2.000.000				
Better-off self-employed	500.000		10 %	↑↑↑↑↑↑	
Poor self-employed	500.000			10 %	30 %
Unemployed and poor	1.000.000			↓↓↓↓↓↓ Expansion strategy	
Households in Syria	5.000.000	60 %	10 %	(~10 %)	30 %
Population in Syria	18.000.000	60 %	10 %	(~10 %)	30 %

Sources: own estimates and calculations, 2005

Some recommendations for implementing health insurance in Syria

Background

About 30 billion SYP are spent yearly by Syrian families for buying health care. They spend it privately, when they are sick and need help. In case of catastrophic diseases families often can not afford to pay. They get impoverished or postpone needed health care. Health insurance tries to convert out-of-pocket spending for health care in case of illness into relatively small regular pre-payments by as many people as possible. Statutory health insurance schemes try to cover the whole population with appropriate contributions. The poor will be exempted, of course. Health insurances intend to give health care according to need and not according to the ability to pay.

In close accordance to the 10th Five-Years-Plan the Syrian Government is highly interested in improving social protection in health for the citizens and especially to cover the needs of the poor living in the country. A national health insurance system should be supported. This is the result of the various assessments, studies and analyses initiated and conducted under the umbrella of the EU-financed HSMP. Palpable actions and necessary allocations for building up health insurance should be undertaken now, e.g. for setting up a centre for health insurance competence.

Regarding the implementation of health insurance in Syria, a step by step approach is recommended starting with the best prepared and selected government sectors, e.g. with the educational sector or with pre-existing health benefits schemes run by public companies and workers unions all over the country, or with both a the same time taking in account that each single step has to be well prepared and made with good guidance.

For opening the opportunities for implementing social protection, the health insurance law proposal from 2003 should be approved with some minor modifications as a framework law regulating the general approach. It is not recommendable to go into details that might block further adaptations which are very likely to become necessary during the implementation process. Furthermore, the health insurance law has to be accompanied by a close revision of all legislation regarding health care financing and provision, namely the labour and social insurance laws. Furthermore, all decrees regulating public companies, workers unions and professional associations in order to overcome step by step structural constraints and vested interests. Special focus has to be put on opening additional options for innovative designs and models that offer opportunities for affordable good quality health care. This includes a palpable improvement of quality of care and an ongoing institutionalised accreditation process for providers in parallel to the implementation of health insurance.

Based on the policies proposed in the 10th five-years plan of the Syrian Government regarding health financing strategies to be applied, the forthcoming health insurance fund ought to be independent especially from the MoH (Government of Syria 2006, p. 752), but possibly also from other ministries. However, effectiveness of funds does not rely exclusively on the resources collected and used for the purposes they are created for; they also need well-trained and reliable human resources for being transparent and efficient. At the time being, Syria does not have sufficient personnel needed for administering and managing the health insurance fund on the national and/or regional level. Thus, professional training and capacity building are major imminent tasks to tackle with before a broader health insurance system is implemented.

All efforts on the technical, financial and administrative fields have to be accompanied by an intensive health education programme for the whole population and by public awareness campaigns in order to improve the understanding of social protection in health, the demand for health insurance and the willingness to prepay for health care in a regular and sustainable way. A nationwide campaign for health insurance should disseminate the basic ideas of health insurance and disseminate a shared understanding about health and education as essential drivers for macroeconomic and social development.

The Syrian government has expressed strong interest in tailoring health insurance in an equitable way and to allocate relevant resources to those who cannot afford to pay for the needed health care. Social safety nets for the poor will be an indispensable asset for achieving broad population coverage, and it is important the government transfers the subsidies required and takes over social responsibility for fairness and equal opportunities for all citizens. The funds released by the government for supporting health insurance for the poor and the needy should possibly be increased by adding some Zakat and Endowment funds designated for health in order to improve quality of care for the poorest population share.

Regarding equity and efficiency, a single payer system offers a series of advantages compared to multiple payer systems. Under the given conditions of a highly atomised social health protection system in Syria, however, a stepwise approach based on existing health benefit schemes offers strategic options that should be used as starting point for implementing health insurance. In this context, the policy towards the poor and the needy requires special attention in order to avoid discrimination or stigmatisation of vulnerable groups. The implementation of a nationwide health insurance system should be aware of the problem from the very beginning and try to link social safety nets as close as possible to the other sectors of health insurance.

Introducing a national health insurance system takes time. It is not an engineering task of technical nature, it is a social process. International experiences can help. Research and studies are needed. Good data and information is essential. HSMP and the Centre for Strategic Health Studies will support the drive towards a public health insurance, which contributes to a sustainable health financing for excellent health care.

Undoubtedly, the way towards comprehensive and hopefully universal coverage will be long and difficult. It will require political commitment as well as the willingness to continuously evaluate the process, to adapt it to upcoming necessities and to correct mistakes that use to be unavoidable in such a complex social policy programme as implementing health insurance.

Furthermore, it has to be pointed out that health insurance will create no revenue for the government. All revenues of health insurance by contributions of employers, employees, user fees or other funding options will be entirely used for purchasing health insurance benefits. Introduction of new financing sources for the health sector reduces government budget needs and frees money for other investments to stimulate economic growth. Pooling and purchasing policies of the Health Funds will increase productivity of providers. Better health is investment in human capital and avoidance of insolvencies of families due to catastrophic health care costs is investment in social capital.

Preconditions

In the Syrian society, the full meaning of health insurance and the idea behind are not widely understood yet. Since experience with health insurance is lacking, the implementation of broad pre-payment schemes for health requires intensive public campaigns in order to create awareness of the population. At the same time, a series of professional training activities and specific courses will be indispensable for preparing and performing a health insurance system. Qualified human resources will be a indispensable precondition and asset before starting with a national health insurance system in the field, and highly educated cadres for health insurance and health system management have to be available in the country.

1. Legal base: Framework law and institutional setting

Although a health insurance law is certainly not all, legislation is a crucial element of implementing a broad and hopefully universal health insurance system. A series of legislative measures will be required:

1. Develop a framework law for nationwide health insurance that defines only general aspects of social protection in health; details will have to be continuously revised and adapted according to ongoing experiences and requirements
2. Revise carefully all laws, decrees and rules that affect company-based health benefit schemes
3. Implement laws that allow company-based, professional, workers-union based and other schemes to select and contract directly with health care providers
4. Give health benefit schemes the legal right and autonomy to negotiate with health care providers on service delivery, tariffs and other aspects of health care for their employees/beneficiaries

The law has to specify where to institutionalise the emerging health insurance authority. There are various options that should be analysed ac cording to comparative advantages.

Institutions	Advantages	Disadvantages
Ministry of Health	▪ Medical expertise ▪ Great experience in the field of health care provision ▪ Certain influence on providers	▪ No experience on how to manage insurance funds ▪ Lobbyist of health care providers ▪ Doubtful willingness
Ministry of Social Affaires and Labour	▪ Long experience with managing social insurance ▪ Institutionalised administrative and managerial procedures ▪ Valuable data base ▪ Trained personnel ▪ Expressed willingness	▪ Lack of experience with health insurance and health care ▪ Overload of tasks by additional scheme
Prime Minister	▪ Potential to overcome rivalries between different ministries ▪ Chance to make HI sufficiently independent from provider interests and influences ▪ Corroborate the relevance of HI for both the country and the government ▪ Leadership and political power	▪ Might provoke “jealousy” of other potentially responsible ministries ▪ Lack of technical and managerial experience
Independent HI Fund	▪ Avoidance of rivalries and jealousies among ministries and other stakeholders ▪ Independency from lobbyists and powerful stakeholders	▪ Requires to build up a completely new infrastructure and organisation

2. Knowledge base: Creation of a Health Insurance Competence Centre and intensive training and networking

The Syrian government has expressed the desire to initiate the implementation of health insurance as soon as possible. However, to start under the current conditions has a relatively high risk of inducing a series of major problems. Due to the lack of reliable and valid data and knowledge on the demand and supply and according to the first study findings available, the options to create a nationwide, well performing health insurance system is an ambitious and complex social policy goal and requires in any case a knowledge based and dedicated preparation. Otherwise the risk of another failure (1979!) and generalised disappointment among stakeholders and citizens could be very high. Further conceptual preparation, planning and decision-making seems to be unavoidable before starting the implementation process. It has to be clear that health insurance needs a multi-sector and interdisciplinary approach that goes far beyond drawing and passing a health insurance law or any ministerial or even presidential decree. This is especially true in a socio-cultural surrounding where legal dispositions are often not met or not applied accordingly. Undoubtedly, health insurance needs an adequate legal framework, but financial, administrative, managerial and other tasks as well as concrete experiences in place seem to be even more crucial for implementation and performance.

Steps

1. Initiate an intensive period of capacity building and training of human resources that will be needed for implementing and running health insurance in Syria. The Centre for Strategic Health Studies (CSHS) could play an important role.
2. A comprehensive study on status and options of a public health insurance system in Syria that encompasses all population should be conducted by an internationally recognized consortium specialized in this area, e.g. GTZ, WHO and ILO.
3. At the beginning, a smaller scale secretariat for health insurance should be set up by the Prime Minister, bringing together professional and experienced teams from Ministry of Health, Ministry of Social Affairs and Labour, Ministry of Finance as well as from Teachers Association, Workers Union and other important stakeholders.
4. Thereafter and supported by the secretariat, implementation of a CHIC has to be started with strong financial input by Government; the CHIC might start in close co-operation with the health financing department of the CSHS that is currently built up.
5. Training of a sufficient number of adequately prepared staffs for tackling with the diverse tasks of health insurance (recruitment, enrolment, contribution collection, provider contracting and payment, accounting, controlling, etc.). Trainees could be recruited from the ranks of those who manage health benefit schemes.
6. Improve and co-ordinate research related to health and health financing in Syria in order to get a better knowledge of the situation and the most relevant challenges. All four institutes of the CSHS could be involved intensively.
7. Establishment of a network of existing health benefit schemes and health insurance schemes to consult the process of national health insurance development.

It is neither necessary nor desirable to develop within each health insurance scheme the technical and managerial capacities to run each single health insurance scheme autonomously. A national Centre for Health Insurance Competence (CHIC) can play a crucial role within the network of health insurance organisations and provide consistent and long term support and back-up to its associated members. Health insurance schemes or micro-insurances may obtain this expertise from a higher level institution and concentrate their efforts instead on other issues where they have comparative advantages.

A national Centre for Health Insurance Competence (CHIC) has the following objectives:

1. Provide organisational and managerial competencies essential for setting up, implementing and monitoring a health insurance scheme (e.g. outsourced services).

2. Negotiate with insurance companies for good group insurance terms or develop standardised products and procedures suitable for local adoption
3. Exchange ideas and concepts with the government, service providers and civil society

At the beginning this centre will concentrate dealing with the following tasks:

- strengthening all health insurance endeavours in Syria
- pursuing the process of discovering, analysing and supporting existing health insurance schemes in the private and public sectors
- contracting studies on the situation of health and health care, accreditation of providers, and other relevant topics for supporting the introduction of health insurance, and especially
- designing and conducting training on health financing, health economics, health management and health insurance management together with other partners (e.g. universities, Centre for Strategic Health Studies, etc.).

Therefore an independent and autonomous centre for health insurance competence should be build up with sufficient budgetary resources and autonomy, possibly with additional support from international donors. It shall be in the hands of a highly professional manager with considerable international experiences and supervised by a relatively small multi-sectoral board of directors, headed by the Prime Minister.

Health insurance offers a powerful tool for improving the performance and quality of health care provision. The larger a health insurance fund is, the better are its opportunities to negotiate in favour of the beneficiaries. Health insurance schemes can select and contract the best private and public providers according to a strict and transparent accreditation programme. One of the crucial international experiences regarding health insurance is that it can be successful only, if good and cost-effective accredited health care is provided. And the second lesson is that health care providers tend to benefit from the creation of health insurance since it guarantees stable and assured income even though fees might perhaps be lower than what they charge from individual patients.

Basic strategy: Social protection of the poor

For the poor, who can not afford to pay health insurance contributions, special programmes have to be developed and implemented. This might apply for about one out of every three Syrians. The poor should be entitled first to the benefits available at public hospitals and primary health care facilities. Programmes for the protection of the poor are of utmost importance for a national health insurance system. Therefore, mechanisms for means-tested identification of the poor should be applied that allow for giving them preferential treatment as a mandate for public health care.

The 10th Five Year Plan gives health insurance and the protection of the poor quite some importance. The Cabinet decided already, that health insurances shall be pilot-tested in Al Raqqa, as well as in Dara'a and Lattakia under the guidance and support of the HSMP. These tests were started and they will give the selected Governorates the chance to participate in the design and the decision making process on health insurances in Syria.

Social protection systems or "safety nets" for the poor have the potential to improve the situation of the poor and to reduce the gap between different population groups. However, it is not easy to enhance equity and efficiency, especially if a separate subsystem for the neediest is implemented. The creation of a special body or welfare system covering the health needs of the poor might even run contrary to the goals of a pro-poor policy aimed at supporting the vulnerable groups and at reducing poverty. Special attention has to be paid on

avoiding any kind of stigmatisation or discrimination of poor people. Health care free of charge for those living below a defined poverty line might induce different or worse treatment by providers compared to those who pay for insurance or out of pocket. Discrimination of the poor is often increased by applying different basic benefit packages for the various groups of insurance and welfare beneficiaries.

Decision-makers and drivers of a nationwide health insurance system should be aware of this problem from the very beginning and try to link social safety nets as close as possible to the other sectors of health insurance. Many countries all over the world are currently struggling to overcome the segmentation of health care and health financing systems consisting of minister-born welfare coverage for the poor, social health insurance for the formal and parts of the informal sector, and private financing and delivery of health benefits.

A recommendable solution is to lay the responsibility for social health protection of the poor and social health insurance for the better-off under the umbrella of a single national health insurance fund. The national health insurance fund would have two sources: (a) Contributions from people who are able to pay contributions according to their salary, and (b) an earmarked subsidy from the government for those who cannot afford to buy health insurance by themselves. At the moment of need, providers should not be able to distinguish between the different groups of beneficiaries.

Key issues:

1. Identification and targeting of the poor, i.e. not only those below a certain income ceiling but also those members of middle classes who endanger the financial sustainability of the entire family due to catastrophic diseases or health spending.
2. Define a reasonable benefit package to be provided free of charge (and without cost sharing!) to all citizens in Syria in order to prevent impoverishment due to catastrophic health expenditures
3. Prevent any kind of discrimination or stigmatisation of the poor as expressed the Proposed Policies for the Health Financing Development Strategies related to Strategy 9 of the 10th Five Years
4. Implement the social welfare net for the poor in the same organisation in which the emerging national health insurance body will be hosted.
5. Establishment of a capital stock to be used in the future as re-insurance fund for catastrophic illness episodes and for the health protection of the poor.

<table>
<tr><th colspan="3">Stepwise plan towards the protection of the health of the poor</th></tr>
<tr><th>2007</th><th>2008</th><th>2009</th></tr>
<tr><td>Search and discuss adequate instruments for identifying and targeting of the poor</td><td>Test targeting methods</td><td>Apply targeting methods</td></tr>
<tr><td>Define a reasonable benefit or exclusion package</td><td colspan="2">Assure availability of quality health care according to the benefit package defined</td></tr>
<tr><td>Investigate capacities of health care delivery in Syria</td><td colspan="2">Invest in public health care providers for achieving requirements of benefit package</td></tr>
<tr><td>Orient the Centre for Strategic Health Studies towards poverty alleviation and safety nets for health care</td><td colspan="2">Start studies and scientific research on poverty-related aspects of health</td></tr>
<tr><td>Plan countrywide PR-campaigns for health insurance</td><td colspan="2">Apply systematic strategy for disseminating understanding of safety nets and poverty alleviation</td></tr>
<tr><td colspan="3">Start building up a re-insurance fund as early as possible</td></tr>
</table>

Strategy A:	Stepwise networking, harmonisation and expansion of existing public sector schemes

One option for implementing a national health insurance system could start with some employee groups in the formal public and possibly also in the private sectors. The total number of formally employed workforce in both sectors is about 3 million Syrian citizens. If health insurance would cover not only the employee but also their families, then more than 10 million Syrians could benefit from a total coverage of this employment sector.

Public company and also some ministry benefit schemes have already been contacted and assessed by the HSMP/MoH teams and contracted companies. They offer a broad range of interesting experiences in the field of health financing and management that is very likely to be useful for creating and implementing a more comprehensive and wider system in Syria.

Steps

1. Identify the best performing and most successfully operating company, professional and workers union health benefit schemes
2. Revise legislation regarding public sector benefit and insurance schemes carefully for detecting all legal obstacles that might limit future co-operation and expansion of those schemes beyond the individual company or membership level
3. Study the benefits covered and the needs for health care in order to define a benefit package that meets the needs and expectations of the target group and pays special attention to impoverishment due to catastrophic health expenditures
4. Gradual transfer of existing health benefit schemes of public companies and ministries into a national health insurance scheme of the public sector

According to the latest draft of a national health insurance law the contribution shares of the employers shall be 6% of the salary and 3% for the employees. More than 20 billion Syrian Pounds could be generated by a payroll tax according to the following simplified calculation.

Insured	Average salary per month (SYP)	Employer share (6%) per month (SYP)	Employee's share (3%) per month (SYP)	Total contribution per month (SYP)	Total contribution per year (SYP)	Total contribution per year (US$)
1	7.000	420	210	630	7.560	150
3 million	21 billion	1,260 million	630 million	1,890 million	22.68 billion	450 million

A second step would be to expand health insurance into the informal sectors of society. Starting social health insurance with the formal sector offers a series of technical advantages, but it avoids tackling the challenge to cover also the relevant population share employed informally and, thus, more difficult to register and to charge regular contributions from. The relative size of the formal and informal sectors is relevant for implementing a nationwide health insurance system. The larger the informal sector, the greater the administrative difficulties in assessing incomes, setting the health insurance contributions of informal sector workers, and collecting contributions. As in many other countries, the major challenge will be how to further include the rural and urban informal sector population in a potentially universal coverage plan. Income for this population fluctuates and spontaneous willingness to declare true income and pay regular contributions is low. The barriers for implementing a national health insurance scheme are high, and the necessary steps ought to be analysed and studied accordingly. This would be one of the tasks of a Centre for Health Insurance Competence.

Strategy B:	Improve and expand sector-wide schemes

Start with selected sectors or branches of the public and possibly private sectors and with the poor who cannot afford health care and need protection against the financial risks of ill health. For instance, the staffs employed by the Ministry of Education offers some comparative advantages and have to be taken in account when the implementation of health insurance starts. Teachers live and work all over the country, represent an important population group, and they are relatively well organised and used to prepay regular contributions for health care. The teachers' professional association has acquired long-term experience with running and administering a proper health benefit scheme, and a broad range of provider contracts and payment mechanisms is in place. Furthermore, the ministry has established financial subsidies to the teachers' benefit scheme, and they might have the potential to foster and to back-up emerging schemes.

Steps:

1. Further assessment of health insurance scheme of the Teachers Association, especially regarding contribution collection, coverage and benefit package, organisational and managerial performance, provider contracting and payment, claim processing and controlling
2. Opinion survey and survey on ability/willingness to pay among teachers
3. Investigate position of ministries and institutions involved, i.e. eventually the Ministry of Higher Education, too.
4. Study the available supply of health care by revising distribution, accessibility and quality of health care providers as well as their managerial and financial status
5. Design of an affordable benefit package fulfilling the objective and as far as possible the felt needs of educational staffs, eventually starting with catastrophic diseases, only
6. Intensive training of administration and management personnel of the Teachers Association, possibly in co-operation with CSHS
7. Repeated short-term consultancies of the CHIC, regional and international experts to the staff of the Teachers Associations' insurance scheme covering all relevant tasks of health insurance
8. Equip the administration of the existing and expanding benefit scheme with adequate technical devices and software for handling more effectively the various health insurance task and be prepared for expanding the target group to other sectors

Annexes

Annex 1

Draft of a profile for health insurance as policy direction

(June 2005)

Proposal for 10th 5 Year Plan

<table>
<tr><td>Name</td><td>Affordable social health insurances for all, especially for catastrophic cases and illnesses of the working population, the vulnerable, and the poor</td></tr>
<tr><td>Goal</td><td>Social protection and a safety net shall be given to all Syrian population in the transition from socialism to a social market economy</td></tr>
<tr><td>Result</td><td>Families are protected against high costs of illnesses</td></tr>
<tr><td>Proponent</td><td>Ministry of Health</td></tr>
<tr><td>Partners</td><td>Ministry of Health (MoH) together with State Planning Commission, Ministry of Social Affairs and Labour, existing health benefit and health insurance schemes for the public and the private sector. The private sector will be involved gradually, since health insurance will negotiate and buy private services. International cooperation will be invited to cooperate.</td></tr>
<tr><td rowspan="8">Lead Activities</td><td>Study of various options for a fair health insurance financing and appropriate benefit packages, especially for the poorer majority of the population</td></tr>
<tr><td>National debate and discussion on health care financing options and development and gradual implementation of pilot projects</td></tr>
<tr><td>Establishment of a health insurance competence centre as initial step towards a National Health Insurance Corporation</td></tr>
<tr><td>Establishment of a network of existing health benefit schemes and health insurance schemes to consult the process of national health insurance development</td></tr>
<tr><td>Gradual transfer of existing health benefit schemes of public companies and ministries into a national health insurance scheme of the public sector</td></tr>
<tr><td>Exemplary introduction (in selected areas) of pro-poor policies in primary health care and in hospitals with a preferential treatment and provision of drugs to the poor, people with chronic diseases and diseases of childhood and old age</td></tr>
<tr><td>Development and pilot-testing of ways to provide the poor (about 20 % of the population) with comprehensive health services and free drugs</td></tr>
<tr><td>Establishment of a capital stock to be used in the future as re-insurance or trust fund for catastrophic illness episodes</td></tr>
<tr><td>Procedure</td><td>National or social health insurance will be started with these activities. MoH and Health Insurance Competence Centre will develop meaningful projects as soon as possible and reasonable to be integrated into the Five Year Plan later. The following cost estimates are a financial framework to be filled with good projects and programmes, step by step</td></tr>
<tr><td>Government expenditure</td><td>
<table>
<tr><td>In SP</td><td>Investments</td><td>Recurrent</td><td>Total</td></tr>
<tr><td>2006</td><td>100.000.000</td><td>900.000.000</td><td>1.000.000.000</td></tr>
<tr><td>2007</td><td>500.000.000</td><td>1.500.000.000</td><td>2.000.000.000</td></tr>
<tr><td>2008</td><td>500.000.000</td><td>2.500.000.000</td><td>3.000.000.000</td></tr>
<tr><td>2009</td><td>500.000.000</td><td>3.500.000.000</td><td>4.000.000.000</td></tr>
<tr><td>2010</td><td>500.000.000</td><td>3.500.000.000</td><td>4.000.000.000</td></tr>
</table>
</td></tr>
<tr><td>Revenues</td><td>There will be no revenues for the government. All revenues of health insurance by contributions of employers, employees, user fees or other funding options will be entirely used for purchasing health insurance benefits.</td></tr>
<tr><td>Economic impacts</td><td>Introduction of new financing sources for the health sector reduces government budget needs and frees money for other investments to stimulate economic growth. Pooling and purchasing policies of the Health Funds will increase productivity of providers. Better health is investment in human capital and avoidance of insolvencies of families due to catastrophic health care costs is investment in social capital.</td></tr>
</table>

Annex 2

Project proposal: Health insurance options study

(June 2005)

Proposal for 10th 5 Year Plan

1. Name	Study of various options for a fair health insurance financing and appropriate benefit packages, especially for the poorer majority of the population
2. Location	Nationwide
3. Description	1. Collect, summarize, and synthesize all relevant documents and data bases prepared for Syria and provide an overview for a comparative analysis of the situation in Syria with selected countries in the region and the World. 2. Identify important existing solidarity schemes in Syria and analyse their structure, impact, and performance. 3. Review existing health insurance schemes in Syria, including public sector programmes, private health insurance, community-based health insurance and company-based health insurance schemes. 4. Conduct and analyse a health financing opinion survey of politicians, Islamic leaders, citizens, development partners, local governments, ministerial officials, insurance companies, public and private health care providers, NGOs, workers' syndicates and the medical association. 5. Visit and interview the ministries and other central institutions, public and private health care providers, district local councils and health offices on Governorate and district levels. 6. Compare the present situation in Syria experiences in similar countries in the region and worldwide in order to determine which preconditions are required to start a National Health Insurance System. 7. Analyse and discuss in a workshop(s) all findings and suggested alternative health care financing options with major stakeholders and draw conclusions against background of the realities in Syria 8. Develop at least 3 alternative health financing proposals which assure the equity of health care provision. Each proposal should cover issues related to revenue collection, provider payment, choice and unit of enrolment, benefit package, pooling arrangements, contribution schedule & method and purchasing. 9. Propose an implementation plan with stages of regional, social and organizational expansion according to priorities, management capabilities, quality of existing health services, and preparedness of population groups 10. Prepare the National Health Insurance financing framework for each proposal as well as preliminary macro-financial projections for the first 10 years. 11. Identify areas of demand for future technical assistance for the establishment of a National Health Insurance system in Syria
4. Time frame	90 days starting 15. March 2006
5. Main purpose	Data collection and analysis as basis of evidence for decision making about social health insurance in Syria
6. Outputs	Report
7. Activities	Hiring an international team, e.g. GTZ with Options, in collaboration with WHO and ILO
8. Inputs	200 days of international experts, 200 days of Syrian counterparts, travelling in Syria, conduction of workshops
9. Total costs	300.000 Euro or approximately 20.000.000 Syrian Pounds
10. Beneficiaries	Especially the vulnerable and poor population of Syria

11. Staff	There should be a twinning of the international team, i.e. each international expert will have an English speaking Syrian counterpart during altogether 200 days
12. Classification	Service
13. Project type	New
14. Investments	None
15. Staff costs	200 days of local professionals; support staff will be taken from MoH. For MoH there are no incremental costs to be expected
16. Revenues	None
17. Inter-Sector effects	Coordination of public sector(Ministry of Health and all Ministries with health benefit schemes, Teachers Organization, etc.) with large organised private sector as well as with non-governmental organizations
18. Employment effects	None (because it is a small project)
19. Environment effects	None
20. Civil society effects	Private sector health care provision will be dealt with as well as improved health seeking behaviour of families
Note: This proposal is essentially a replication of a study to be conducted from July to October 2005 in Yemen under the leadership of the consultant and awarded by the Yemenite Government to GTZ in cooperation with WHO and ILO	

Annex 3

Project proposal: Centre for Health Insurance Competence

(June 2005)

Proposal for 10th 5 Year Plan

1. Name	Establishment of a health insurance competence centre as initial step towards a National Health Insurance Corporation
2. Location	Damascus
3. Description	A Centre for Health Insurance Competence (CHIC) will be set up in Damascus to support all activities towards designing and implementing a national social health insurance. At the same time it will consult all existing health benefit schemes of the ministries and public companies in their transformation processes from benefit schemes to health insurances. At the same time it will advise the existing social health insurances of the Workers Union, the Teachers Association and other to strengthen and expand their activities and to coordinate it with national health insurance. This CHIC can be franchised from the German Agency for Technical Cooperation (GTZ). Main tasks are: • Information, analysis, studies, etc. • Business planning, training, support, etc. • Networking with government, peers, partners, etc. • Semi-governmental structure It will be a joint venture of the Institute for Health Economics of the Centre for Strategic Health Studies and of the Department of Planning and Statistics of the Ministry of Health
4. Time frame	Design period starting 1.1.2006, implementation starts half a year later
5. Main purpose	To back up and strengthen public health benefit schemes for employees and health insurance schemes and to attune it to a national health insurances network.
6. Outputs	Advise, coordination, training, documentation, management support
7. Activities	1. Finding and upgrading office space in the Ministry of Health 2. Recruitment of international experts 3. Recruitment of Syrian professionals with experience in this field 4. Recruitment of support staff 5. Buying and installing equipment, furniture, etc.
8. Inputs	16 staff members, office space, equipment and furniture and running costs
9. Total costs	Approximately 25.000.000 Syrian Pounds per year
10. Beneficiaries	Members of social health insurances
11. Staff	Two international long-term experts on social health insurance for approximately two years, 6 national professionals, 8 persons as assistants (two translators, two communication specialists, 4 miscellaneous staff)
12. Classification	Service
13. Project type	New
14. Investments	Rehabilitation of office spaces, approximately 100.000 SP
15. Staff costs	Local staff: 1.500.000 SP per year. International staff: 15.000.000 SP per year
16. Revenues	Increasingly, CHIC will sell its services to clients. During the first years considerable revenues are not expected
17. Inter-Sector effects	Linking all sectors interested in social health insurance, also the private sector when it will be mandatory to join a social health insurance
18. Employment effects	High-quality and high-productive employment generation. Syrian professionals will take over the duties of the international experts after a certain period
19. Environment effects	None
20. Civil society effects	Non-governmental and community-based health benefit schemes and health insurances will be advised and will join the national health insurance drive.

Annex 4

Project proposal: Re-insurance fund for social health insurance

(June 2005)

Proposal for 10th 5 Year Plan

1. Name	Establishment of a capital stock to be used in the future as re-insurance fund for catastrophic illness episodes
2. Location	Damascus
3. Description	A trust fund will be built up to back up a future health insurance. Small health insurances can access this fund as well as uninsured poor people and those who by virtue of their poverty will be exempted from paying health insurance contributions.
4. Time frame	Starting with first transfer of funds.
5. Main purpose	Social health insurances in Europe suffer from being paid by the monthly revenue from contributions and are not backed up by an accumulated capital stock, as private pension funds are financed usually in USA. Therefore a re-insurance fund should be build up for supporting future social health insurance activities. This fund aims at making affordable the health insurance
6. Outputs	Operation of funds. Pilot-testing of using the fund.
7. Activities	Trust fund regulation design and preparation as law. Set up of high-ranking committee and supervisory body, eventually with international backing. Accreditation of high-quality health care providers.
8. Inputs	Fund manager and staff. Bureau will be attached to the President or Prime Minister. Eventually managed by the State Bank.
9. Total costs	6.5 Billion Syrian Pounds during the Five Year Period
10. Beneficiaries	Poor people with catastrophic illness episodes, chronic conditions and/or repeated episodes of illness
11. Staff	One fund manager, one assistant, two staff
12. Classification	Service
13. Project type	New
14. Investments	2006 500.000.000 SP 2007 1.000.000.000 SP 2008 1.500.000.000 SP 2009 2.000.000.000 SP 2010 2.000.000.000 SP
15. Staff costs	Approximately 360.000 Syrian Pound per year
16. Revenues	The fund will generate highest possible revenues which will be used only for reimbursing the cost of catastrophic diseases and considerable expenses for chronic diseases and repeated illness episodes.
17. Inter-Sector effects	Partnership between office of Prime Minister, State Bank, Ministry of Health and health insurances
18. Employment effects	None.
19. Environment effects	None.
20. Civil society effects	This fund will strongly increase the social reputation of the government since families with catastrophic health care costs will benefit from the fund as well as especially accredited high-quality providers of health care.

Annex 5

Elements of the feasibility of health insurance in Syria

(December 2005)

Discussion paper for national and
regional awareness generation meetings
for pilot-testing in Dara'a, Lattakia and Al Raqqa

1. Situation analysis

Population	Data missing on household/family size, census data to be deeper analysed
Employment	Data missing on employment sectors (public, private, self-employed, unempl.)
Income, salaries	Data not disaggregated for governorates Household survey to be analysed deeper Data on income generally missing
Poverty	UNDP survey data analysis available Scarce individualized data on poverty
Economics	Mainly national data
Health	Data on morbidity & diagnoses missing Health survey data missing
Health care	Data on supply not fully accurate Data on utilization and quality missing
Government health budgets	MoLA budget known, but inflexible Budgets of others not yet known
Family health care financing	Old and roughly estimated survey data Data con catastrophic cases missing
Health benefit / insurance schemes	Quantity and quality mostly unknown InfoSure analysis missing
Other social protection	To be assessed still

2. Strengths

Political willingness to boldly support health insurance (10thFYP)
Ministry of Health interested in health insurance (prepared law proposal)
Existing health benefit and health insurance schemes
International donors supporting health insurance

3. Weaknesses

Failed health insurance initiative in 1979
Expectation of free public services for health care
Lack of understanding on health insurance (patients, providers, politicians)
Private/public sector mix-up of many publicly employed professionals
Rationing of available public health care hits all, especially the poor
High and irrational out-of-pocket expenditure in case of illness
Essential data and information wrong or not available
Competitive provider market not available in Governorates
Health insurance options for applications in Governorates are limited
Pilot-testing would be better with a national focus in mind
Division of labour between provision and purchasing of health not given yet
Weak representation of patients rights and interest within the health sector

4. Difficulties for health insurance

Preconditions for health insurance		
Money	Sufficient public financial resources?	?
	Ability to pay for health insurance?	?
	Willingness to pay for HI?	?
	Decentralised public health funds?	-

Mastermind	Leadership & willingness nationally?	?
	Leadership & willingness locally?	?
	Best practices in HI known & active?	-
	Clear concepts and ideas?	-
Mechanisms	Appropriate scheme management?	?
	Appropriate national management?	-
	Clear purchasing-provision split?	-
	Government back-up for reform?	?
	Donors back-up?	?
	Sufficient anti-misuse control?	?
Markets	Sufficient urban quality providers?	?
	Sufficient rural quality providers	-
	Private health insurances	-
Manuals	Laws and regulations available?	-
	Enforcement of laws and regulations?	?
Manpower	Sufficient qualified cadre?	-
	Sufficient health financing experts?	-
	Sufficient HI management experts?	-
	Sufficient training capabilities?	?
Motivation	Knowledge, awareness, excitement?	-
	Consensus of stakeholders?	-
	Solidarity support for the poor?	?
	Trust in central fund management?	?
Measurement	Sufficient data and information?	-
Summary assessment		-/?

5. Available choices

Sectoral approach
i.e. starting with selected employment sectors or professions, step-wise

Optional components of a national health insurance system in Syria

Health financing options by households' main employment sector	Workforce (rough and rounded estimates)	Health financing options: Payroll tax contribution insurance	Self-employed insurance	Community participation schemes	Tax-based public services
Government & public companies	1.000.000	60 %			
Formal private companies	2.000.000				
Better-off self-employed	500.000		10 %	↑↑↑↑↑↑	
Poor self-employed	500.000			10 % ↓↓↓↓↓↓ Expansion strategy	30 %
Unemployed and poor	1.000.000				
Households in Syria	5.000.000	60 %	10 %	(~10 %)	30 %
Population in Syria	18.000.000	60 %	10 %	(~10 %)	30 %

Sources: own estimates and calculations, 2005

Regional approach
- Governorates' health funds (Egypt's or Canada's model)
- Starting with free health care for the poor and vulnerable (especially drugs)

6. Proposals, solutions	A note of caution: - do not rush with health insurance pilot-tests – it will take time, ca. 2-5 years - keep existing benefit and insurance schemes in mind – opt for pluralistic approach Essential data collection and studies supported by HSMP - situation analysis (confer point 1) - discovery, description and analysis of existing health benefit/insurance schemes - surveys on ability and willingness to pay for health insurances - case studies on demand, availability and quality of providers to be contracted Political dialogues and technical training on social and national health insurance - trips to Egypt and Jordan for key strategic and technical professionals - conferences and policy debates with decision makers - training sessions and consultancies by Centre for Strategic Health Studies Pilot-testing in selected Governorates and with selected groups nationally - health protection schemes for the poor and vulnerable (especially regarding drugs) - networking/expansion of some existing health benefit/insurance schemes - introduction of health insurance for selected population group Policy papers and studies towards a national health insurance system
7. Costs for health insurance	Costs to be covered by government and donors, at the beginning Raqqa Governorate needs national or HSMP funds for studies (2006: 1 Mio SYP) All pilot-tests to be monitored in view of national cost implications
8. Laws and regulations	If necessary, framework law for allowing pilot-testing and budgetary innovations
9. Coverage & target group	Always in view of a national and social health insurance system for all, including analysis of impact of private health insurances
10. Results within one year	Key cadre prepared for health insurance start-up Consensus growing on a sensible strategy towards national health insurance system Strategic plan for a national and social health insurance system formulated

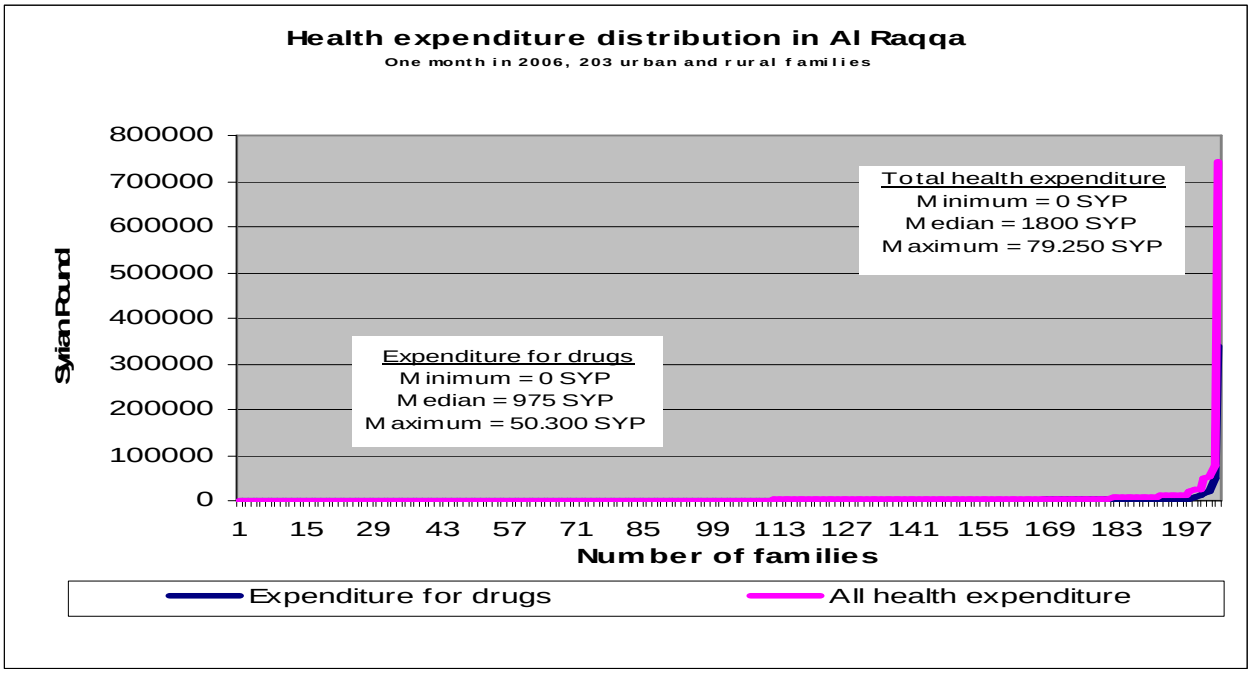
Annex 6

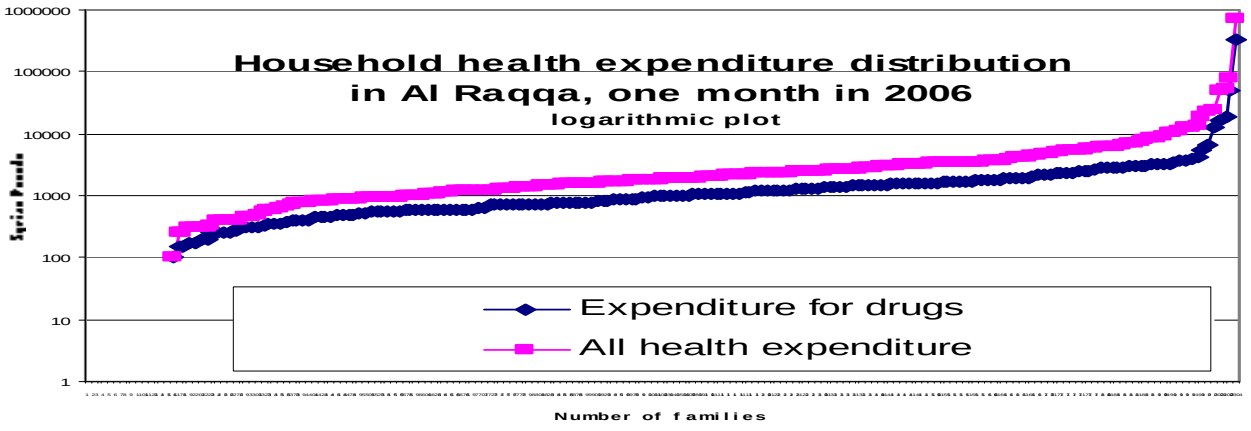
Health expenditure distribution and poverty

(December 2006)

Household health expenditure surveys reveal that normally quite a number of families do not spend large amounts of money for health in a typical year. This might be caused by (relatively) good health or by avoiding health expenditure. Catastrophic illness episodes or expenditures hit just a very small fraction of society, as can be seen in the following graphs.

Health expenditure distribution in Al Raqqa case study 2006



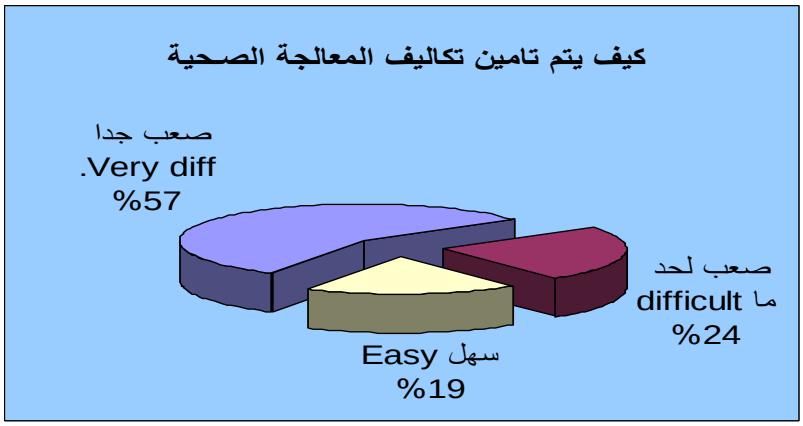


Protection of the poor in the health systems does not refer only to those living below a certain 'means-tested' income ceiling. In view of the sometimes exorbitant high costs of care for catastrophic cases of illness or for chronic diseases even middle-class families can fall into poverty if there is no health-safety net for them. If there are no savings in the families, a spending of more than 40% of the regular income for health can be considered catastrophic. Other expenses would have to be downgraded, including spending for education and nutrition, for example. Health insurance has to deal with catastrophic diseases or spending for health care wherever they occur. The formula is: small mandatory prepayments by all for high payments of a few in need.

Al Raqqa case study 2006: catastrophic health spending

Percentage of families	Percentage of spending
1.5	24.6
8.9	49.7
36.5	79.9

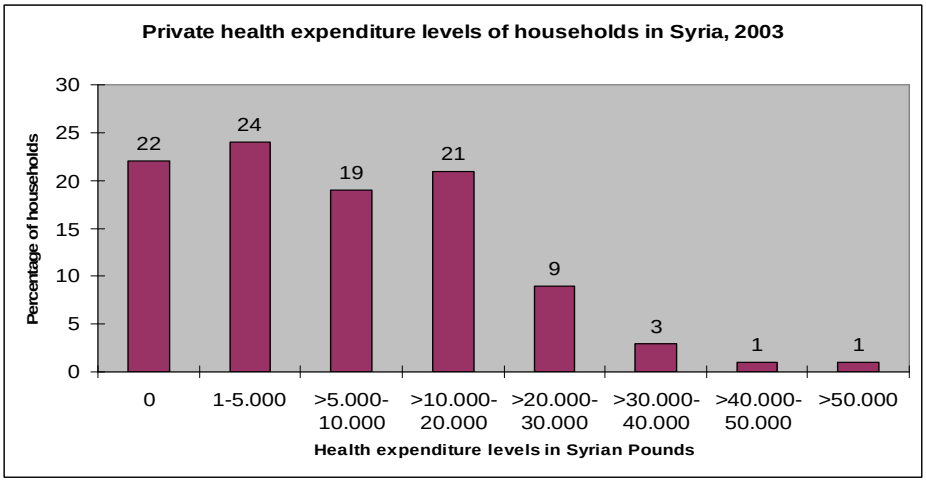
Al Raqqa case study 2006: difficulties for paying for care among 203 families



Al Raqqa case study 2006: financial burden of chronic diseases

Family members with chronic conditions	Number	Percent %	Total monthly health care expenditure SYP	Percent %
0	110	54.19	299.099	40.29
1	66	32.51	204.575	27.56
more	27	13.30	238.723	32.16
Totals	203	100	742.397	100

Central Bureau of Statistics: National household health expenditure survey 2002



Poverty in Syria

Indicator	Year	Syria	Dara'a	Lattakia	Raqqa	Source
Population below poverty line (%)	2003	20				CIA
Population in extreme poverty, i.e. with less than 1 US$ per day in percent	2003-4	0.3				CBS
Population with less than 2 US $ per day, %	2003-4	10.4				CBS
Upper poverty incidence (%)	2003-4	30.13	32.93	31.78	35.27	UNDP
Upper poverty depth (%)	2003-4	7.39	9.08	8.80	9.89	UNDP
Upper poverty severity (%)	2003-4	2.60	3.48	3.41	3.90	UNDP
Upper poverty incidence (%) - urban	2003-4	28.48	33.34	30.51	38.84	UNDP
Upper poverty depth (%) - urban	2003-4	6.97	9.94	8.85	9.89	UNDP
Upper poverty severity (%) - urban	2003-4	2.44	3.99	3.48	3.65	UNDP
Upper poverty incidence (%) - rural	2003-4	31.82	32.70	33.04	33.20	UNDP
Upper poverty depth (%) - rural	2003-4	7.82	8.59	8.76	9.90	UNDP
Upper poverty severity (%) - rural	2003-4	2.76	3.19	3.34	4.05	UNDP
Lower poverty incidence (%)	2003-4	11.39	15.43	11.55	17.59	UNDP
Lower poverty depth (%)	2003-4	2.13	3.22	2.28	3.91	UNDP
Lower poverty severity (%)	2003-4	0.62	1.06	0.67	1.30	UNDP
Lower poverty incidence (%) - urban	2003-4	8.70	13.99	11.04	14.92	UNDP
Lower poverty depth (%) - urban	2003-4	1.57	2.91	2.32	2.70	UNDP
Lower poverty severity (%) - urban	2003-4	0.46	0.95	0.71	0.72	UNDP
Lower poverty incidence (%) - rural	2003-4	14.18	16.26	12.06	19.13	UNDP
Lower poverty depth (%) - rural	2003-4	2.70	3.40	2.24	4.60	UNDP
Lower poverty severity (%) - rural	2003-4	0.79	1.12	0.63	1.64	UNDP
HH owning agricultural land (%)	2003-4	n.a.	8.15	23.81	39.35	UNDP
HH owning sheep and goat (%)	2003-4	n.a.	3.25	0.26	28.63	UNDP
HH owning trucks (%)	2003-4	n.a.	3.76	2.98	3.66	UNDP

United Nations Development Programme (2005): Poverty in Syria: 1996-2004. Diagnosis and pro-poor policy considerations. Damascus (UNDP)

Explanation 1: The 'lower household-specific poverty line', calculating essential food and non-food requirements, is used as a basis for the analysis of the report, although two other distinct poverty lines were also calculated using the household-specific methodology. The analysis constructed a food poverty line – the cost in SL of a minimum food basket – often considered to be the 'ultra' poverty line. In addition, an 'upper' poverty line reflects the actual consumption expenditure of the poor – not just expenditures on essential needs – and thus reflects the standard for satisfying a *reasonable* level of basic needs. Finally, the 'lower' poverty line falls between these two extremes, and reflects a basket of basic food and non-food needs. Households' consumption at this line would satisfy the *essential* food and non-food requirements.

Explanation 2: The head count index (P0) is a measure of the prevalence of poverty. It denotes the percentage of households that are poor – as defined by the poverty line – as a proportion of total population. This measure; however, is insensitive to the distribution of the poor below the poverty line. This is captured by the following two indices, P1 and P2. The ***poverty gap index*** (P1) is a measure of the depth of poverty and denotes the gap between the observed expenditure levels of poor households and the poverty line. Assuming perfect targeting, the poverty gap index indicates the amount of resources (transfers) needed to bring all poor households up to the poverty line. The ***poverty severity index*** (P2) measures the degree of inequality in distribution below the poverty line and gives greater weight to households at the bottom of the income (or expenditure) distribution.

Annex 7

Costs of a national health insurance system

(December 2005)

The STE revised his mapping of health financing options according to the households main employment sector by including now the security sector – military and polices – in his calculations, even if it is just a speculation, that half a million persons are employed by this sector.

Optional components of a national health insurance system in Syria

Health financing options / by households' main employment sector	Workforce (rough and rounded estimates)	Health financing options: Payroll tax contribution insurance	Self-employed insurance	Community participation schemes	Tax-based public services
Government & public companies	1.000.000	64 %			
Public security sector (?)	500.000				
Formal private companies	2.000.000				
Better-off self-employed	500.000		9 %	↑↑↑↑↑↑	
Poor self-employed	500.000			9 % ↓↓↓↓↓↓ Expansion strategy	27 %
Unemployed and poor	1.000.000				
Workforce in Syria	5.500.000	64 %	9 %	(~9 %)	27 %
Population in Syria	18.000.000	64 %	9 %	(~9 %)	27 %

Sources: own estimates and calculations, 2006 – with security sector added.

Based on this mapping of affairs the STE drafted a first scenario on potential revenues of a national health insurance system in Syria. Calculations took as a guideline the contribution shares proposed in the most recent draft of a national health insurance law, recommended by the Ministry of Health. A 6% share of the salaries should be paid by the employer and 3% by the employee. It can be debated if it is wise to have not the same shares of employers and employees. Considering the meagre salaries in the public sector it has to be recommended that children up to an age of approximately 15 years should not be covered by health insurance but by free health care for the poor and the vulnerable. In view of the high prevalence of additional jobs in the afternoons it has to be discussed, if salaries should be taken as the yardstick to calculate premiums or rather income or flat rates. The following calculation therefore is only one of many possible scenarios.

Expected health insurance contributions per employee

Insured	Average salary per month (SYP)	Employer share (6%) per month (SYP)	Employee's share (3%) per month (SYP)	Total contribution per month (SYP)	Total contribution per year (SYP)	Total contribution per year (US$)
1 only	7.000	420	210	630	7.560	150
1 Million	7 Billion	420 Million	210 Million	630 Million	7.6 Billion	150 Million

Assuming a total coverage of the national health insurance system we estimate a total revenue of about 27 billion Syrian Pounds per year as can be depicted from the following table.

Expected health insurance contributions
of a national health insurance system in Syria

Employment category	Insured In Mio	Revenue assumption	Million US$	Billion SYP
Public civilian sector	1	100 %	150	7.6
Public security sector	0.5	100 %	75	3.8
Private larger formal sector	1	100 %	150	7.6
Private smaller formal sector	1	50 %	75	3.8
Better-off self-employed	0.5	100 %	75	3.8
Poor self-employed	0.5	0 %	0	0
Unemployed and poor	1	0 %	0	0
Totals	5.5	-	525	26.6

We assume that the private smaller formal sector will need a subsidy of 50% by the government. Anyway, these calculations are very optimistic. It will be not an easy task to insure all the private sector and all self-employed. In a more detailed cost calculation given in Annex 31 we assume a slow phasing in of various employment groups, especially of the private sectors between soon and 2020. The following table presents some selected data of the aforementioned annex.

Cost Estimates for National Health Insurance System in Syria
(in 1.000s of US$)

Issue	Details	2006	2010	2020
HI institution building	HI support institutions (Centre for HI competence + HI Authority)	250	3,000	5,000
Government subsidies for HI	30% of public and private contributions	0	67,500	157,500
Government fund for the poor	Pro-poor health development fund	10,000	50,000	100,000
Health budgets of all ministries	Less provision, more prevention, regulation, etc.	500,000	400,000	200,000
Public budgets for health	MoH + pro-poor-fund + HI subsidies + Institution	510,250	520,500	462,500
All government HI contributions	Total government as employer contributions	0	100,000	150,000
All government health budgets	For health care and for salary contributions	510,250	620,500	612,500
All public employees contributions	Public employees salary contributions	0	50,000	75,000
All private HI contributions	Contributions from all employers & employees	0	75,000	300,000
All health budgets + HI contributions	Public and private, employers and employees	510,250	745,500	987,500

These calculations are very first and preliminary ways of stimulating criticism for enriching discussions on the introduction of a health insurance system in Syria.

Some Tentative Cost Estimates for National Health Insurance System in Syria (in 1000s of US$)

(First, simplified and very preliminary draft, just an exercise in thinking about possible futures)

Contributions

Insured	Average salary per month (SYP)	Employer share (6%) per month (SYP)	Employee's share (3%) per month (SYP)	Total contribution per month (SYP)	Total contribution per year (SYP)	Employer share (6%) per year (US$)	Employee's share (3%) per year (US$)	Total contribution per year (US$)
1 only	7.000	420	210	630	7.560	100	50	150

No	Issue	Details	Comments / calculations	2006	2008	2010	2015	2020
1	**HI institution building**	HI support institutions (Centre + Authority)	Additional funds from donors	**250**	2,000	3,000	3,000	**5,000**
2	Public sector HI contributions	Salary contributions of government	For up to 300.000 teachers	0	30,000	30,000	30,000	30,000
3	=	Salary contributions of government	For additional 700.000 employees	0	0	70,000	70,000	70,000
4	=	Salary contributions of government	For remaining 500.000 employees	0	0	0	0	50,000
5	=	Total government as employer contributions	6% salary rate	0	30,000	100,000	100,000	150,000
6	=	Public employees salary contributions	3% salary rate	0	15,000	50,000	50,000	75,000
7	=	Total public sector HI contributions	For up to 1 million employees	0	45,000	150,000	150,000	225,000
8	Private sector HI contributions	Employers contributions for HI	For up to 500.000 employees	0	0	50,000	50,000	50,000
9	=	Employers contributions for HI	For second batch of 500.000	0	0	0	50,000	50,000
10	=	Employers contributions for HI	For smaller companies, 1 million	0	0	0	0	50,000
11	=	Employees and workers contributions for HI	For up to 500.000 employees	0	0	25,000	25,000	25,000
12	=	Employees and workers contributions for HI	For second batch of 500.000	0	0	0	25,000	25,000
13	=	Employees and workers contributions for HI	For smaller companies, 1 million	0	0	0	0	25,000
14	=	Better-off self employed contributions for HI	For up to 500.000 self-employed	0	0	0	0	75,000
15	=	Poorer self-employed contributions for HI	Same for unemployed and poor	0	0	0	0	0
16	=	All private sector HI contributions	For up to 3 million workforce	0	0	75,000	150,000	300,000
17	All HI contributions, public&private	Revenues from p&p employers & employees	For up to 4.5 Mio contributors	0	45,000	225,000	300,000	525,000
18	**Government subsidies for HI**	30% of public and private contributions	All population	**0**	13,500	67,500	90,000	**157,500**
19	**Government fund for the poor**	Pro-poor health development fund	About 1 million households	**10,000**	30,000	50,000	100,000	**100,000**
20	**Other ministries health budgets**	Less provision, more prevention, regulation, etc.	All population	**500,000**	500,000	400,000	300,000	**200,000**
21	**Public budgets for health**	MoH + pro-poor-fund + HI subsidies + CHIC	Line 1+18+19+20	**510,250**	545,500	520,500	493,000	**462,500**
22	**All government HI contributions**	Total government as employer contributions	Line 5	**0**	30,000	100,000	100,000	**150,000**
23	**All government health budgets**	For salary contributions and for health care	Line 21+22	**510,250**	575,500	620,500	593,000	**612,500**
24	All public employees contributions	Public employees salary contributions	Line 6	0	15,000	50,000	50,000	75,000
25	All private HI contributions	Contributions from all employers & employees	Line 16	0	0	75,000	150,000	300,000
26	All health budgets + HI contributions	Public and private, employers and employees	Line 23+24+25	510,250	590,500	745,500	793,000	987,500

Annex 8

Assessment of existing health benefit and insurance schemes

(January 2007)

Year	Schemes	Contents and comments
2000	Ministries	Coverage and costs of all ministries
2002	Social insurance of MoSAL	Narrative report of Dr. Guiliana Bensa, estimating 2.4 billion SYP for 490.000 employees covered with approximately 2.5 million beneficiaries at an annual cost of 4924 SYP per employee
	Syrian Insurance Comp. - MoEc	
	Teachers Union	
	Trade Union	
	Damascus Electricity Company	
	Syrian Medical Association	
2004	Teachers Association	Detailed training and self-assessment on the basis of 185 multiple-choice questions of the InfoSure methodology by HSMP
	Workers Union	
	Dental Association	
	Ministry of Health	
	Ministry of Transport	
2005	Public health benefit schemes in Al Raqqa	Report of Directorates of Health on coverage and costs requested by MoH for Prime Minister
	Public health benefit schemes in Dara'a	
	Public health benefit schemes in Lattakia	
2006	156 public institutions with and without heath benefit schemes in Dara'a, Lattakia and Al Raqqa Governorates	Assessment of employment, coverage and cost of health benefit schemes. Institutional coverage is 52%, population coverage is 13%. Study contracted to private consulting company.
	Dara'a: ➢ Commercial Bank of Syria ➢ General Electricity Company ➢ Teachers Syndicate ➢ Drinking Water and Drainage Est. ➢ Al Qsour Petrol Station	More detailed assessment of public and private schemes: 1. Membership 2. Financing 3. Benefits 4. Legal issues 5. Administrative issues 6. Healthcare conditions 7. Risk management Studies were contracted to private Syrian consulting companies. Main result training, management advice and mutual exchange of experiences with other schemes are advisable
	Lattakia: ➢ 11 public companies	
	Al Raqqa: ➢ Agricultural Cooperative Bank ➢ Popular Credit Bank ➢ Postal Establishment ➢ Telecommunications Establishment ➢ Direct. of Agriculture/Agrarian Reform	
	Syrian insurance Company - Death disability pension ins Professional group schemes - Teachers Association Ministries - Ministry of Telecommunication (Transport) Public corporations - Commercial Bank - Public Electricity Company - PEC Co-operation fund - PEC Al Raqqa - Central Bank Al Raqqa - Reconstruction C. Al Raqqa - Euphrates Dam Corporation Third Party Administrators - Bankers Best Assistance - IMPA Ltd. Private health insurance - United Insurance Co. Private Companies - Syriatel / Ramak-Group Health care providers - Al Shami Hospital - Damascus Hospital	Short-term consultancy report of Jens Holst, July 2006: Many more in-detail studies are needed, since reported data and information does not tally with STE's assessments. Estimation that about 20% of the population is covered by health benefit or insurance schemes, since most of available assessments do not take into account properly all the many details of health benefit and insurance schemes, e.g. compared with a full application of InfoSure methodology.
	Health benefit & insurance schemes Assessments of - Ministry of Finance Cooperation Fund - Lattakia Port Corporation - Syrian Tobacco Corporation	Review of studies done and recommendations for peer review and improvement Assessment of three public schemes

Some data on selected health benefit and insurances schemes

Five health benefit and insurance schemes – a few indicators

Questions		Multiple-choice answers		Ministry Transport	Teachers Association	Workers Union	Dental Association	Ministry of Health
1 Setting up the scheme								
1.1	Set-up period	Year of decision		1970	1965	1975	1975	2000
		Year of first contributions		1970	1965	1980	1975	2000
		Year of first benefits		1970	1965	1980	1975	2000
2 Membership								
2.7	How is membership constituted	Voluntarily			■	■		
		Compulsory by law		■				
		Compulsory by group membership			■		■	
		Opting out of social insurance scheme						
		Varies according to the group of members						
		Other: decision of ministry						■
2.11	Definition of family members	Max. number of household members covered		all	all	all	0	all
		Maximal number of spouses covered		1	1	1	0	all
		Maximal number of children covered		all	all	all	0	6
		Male spouses covered		0	0	0	0	0
		Parents covered dependant parents		Dep	0	Dep	0	Dep
		No clear definition						
		Other						
3 Financing								
3.1	Sources of finance	Contributions			■	■	■	
		Co-payments and user charges						
		Subsidies		■	■	■		■
		Donations				■	■	
		Loans			■	■		
		Revenue from sales			■		■	
		Fines (e.g. for late payment)					■	
		Interest			■		■	
		Other: investment revenue				■		
3.2.3	Level of contributions	Average contribution	in SP per year					
		Member			2000	360	300	
		Dependants						
		Households						
		Other: no contribution		0				0
		Income estimates	in SP per month					
		Low income level		4500	6000	3900	10000	4500
		Middle-income level		9000	8000	6000	25000	9000
		High income level		14000	16000	12000	60000	14000
11	**Financial profile**	Expenditure during last year		14 Mio SP	316.292.655 SP	200 ass. à 5 Mio SP	2 Mio SP	N/A
12	**Statistical profile**	Number of target population		1.100	290.240	1 Mio	11.164	60.000
		Number of members		1.100	288.204	1000 pas	11.268	60.000
		Number of beneficiaries		6.000	1.15 Mio	4000 pas per assoc	11.268	258.000

Application of InfoSure multiple-choice questionnaire with about 185 detailed questions. The answers were given during a six days training and assessment seminar conducted by the Health Sector Modernisation Programme of the Ministry of Health, between 21st of November and 2nd December 2004. All questions were given in a questionnaire in Arabic language, in company with two other questionnaires – one with the same questions asking for open answers and another one on financial and statistical issues of the participating schemes.

Private insurance

Agent	Benefit coverage	Yearly € premium	Comments
Sadoui	Inpatient Syria and Lebanon	360	Premia are for young adults up to about 36 years
	Inpatient care in Syria	130	
	Outpatient care in Syria	64	
	Drugs Syria	32	
Bankers Company	IPC 100%, OPC 90%	160-200	
Private schemes	Exclusion of expensive care	100-200	
International Re-insurers	Premium-coverage rate: 80 € per 120.000 € applicable also for health insurances		
IPC = inpatient care; =PC = outpatient care			
Source: Holst [15]			

Coverage and cost of public health benefit schemes in three Governorates

Indicators / Areas	All public inst.	Inst. with health benefit schemes	Institu-tional coverage %	Popu-lation	Bene-ficiaries	Coverage of popu-lation %	Cost per beneficiary per year SYP
Dara'a	49	27	55	858.000	126.095	14.70	1.062
Lattakia	42	20	48	891.000	107.327	12.05	754
Al Raqqa	66	34	52	811.000	91.523	11.29	1.383
Totals	157	81	52	2.560.000	324.945	12.69	1.051

Public companies studied according to coverage of health benefit schemes in three Governorates

Dara'a	Lattakia	Al Raqqa
With benefit scheme	**With benefit scheme**	**With benefit scheme**
Agricultural Bank	Social Security Directorate	Central Bank of Syria
Central Bank of Syria	Railway	Commercial Bank of Syria
Commercial Bank	Electricity Co.	Communication Directorate
Credit Bank (limited incomes)	Lattakia Port	Cooperative Agricultural Bank & its Branches
Dara'a Building Co	Post Service	Credit Bank
Dara'a Cereal	Central Bank	Directorate of Agriculture
Dara'a Communication	Real-estate Bank	Directorate of Transport
Dara'a Consumptive Est.	Duty Free	General Construction Co.
Dara'a Electricity	Credit Bank	General Co of Potable Water
Dara'a Finance	Productive Credit Bank	General Co. of Advertisement
Dara'a Post	Water Est.	General Co. of Bakeries
Dara'a Religious Endowments	Internal Transport Co.	General Co. of Euphrates Dam
Directorate of Irrigation	Marble Co.	General Co. of Poultry
Directorate of Transport	Directorate of Industry	General Co. of Social Security
Education Directorates	Pharmix	General Co. of Water Projects
Fuel Company Dara'a Branch	Directorate of Tourism	General Co. of Road Transport
Industrial Bank	Hmeisho Cars	General Electricity Co
Pharamix	Abu Musa Co	General Est for Development of Furat Basin
Productive Credit Bank	Directorate of Culture	General Est. of Cereal
Real-estate Bank	**Without benefit scheme**	General Est. of Consumptive Materials
Social Insurance	Directorate of Agriculture	General Est. of Metals & construction Materials
Syrian Air	Insurance & Pensions	General Est. of Railway
Syrian Insurance	Directorate of Finance	General Ways& Bridges Co.
Technical Services Directorate	Courts	Industrial Bank
Yarmuk Mills	Labour & Social Affairs	Land Reclamation
Without benefit scheme	Real-estate Directorate	Military Housing Est.
Central Corpus	Directorate of Supply	Radio & Television Center
Civil Affairs Directorate	Education (Technical)	Raqqa Mail Directorate
Dara'a Advertisement Branch	Radio &Television	Raqqa Sugar Co.
Dara'a City Council	Aviation Agencies	Real-estate Bank
Dara'a Directorate of Economy	Cereal Est.	Sundus Center
Dara'a Directorate of Environment	Electric Motors Co.	Syrian Co. for Storing & Distribution of Materials
Dara'a Directorate of industry	Economy & Trade Directorate	Syronics
Dara'a Directorate of Justice	Education Directorates	Technical Services Directorate
Dara'a Health Directorate	Assad University	**Without benefit scheme**
Dara'a Planning Directorate	Sport Premises	Administration of State Affairs
Dara'a Railway	Environmental	Central Corpus of Financial Monitoring
Dara'a Real-estate0	Religious Endowments	Central Corpus of Monitoring& Inspection
Dara'a Religious Endowments	Syriatel	Civil Affairs
Dara'a State Affairs	Areeba	Directorate of Civil Affairs
Dara'aa Purchase centre	University	Directorate of Culture
Directorate of Affairs		Directorate of Education
Directorate of Agriculture		Directorate of Finance
Directorate of Culture		Directorate of Social Affairs &Labor
Directorate of Tourism		Directorate of Tourism
Farmers Union		Eradication of Unemployment Office
Labourer's Union		General Est. of Seeds
Potable Water Est.		General Co. of storing and marketing
Saving Bank		General Est of Mills
Secretariat of Dara'a Governorate		General Est. of Geology and Minerals
		General Est. of Pension & Insurance
		General Est. of School Books
		Governorate Secretariat
		Local Councils of towns & village Municipalities
		Military Housing Est
		Public Institution
		Raqqa Directorate of Economy
		Raqqa Directorate of Health
		Raqqa Directorate of Industry
		Raqqa Directorate of Internal Trade
		Raqqa Directorate of Justice
		Raqqa Directorate of Planning
		Raqqa Directorate of Religious Endowments
		Raqqa Directorate of Statistics
		Real-estate Directorate
		Saving Bank
		Silage Est.
		Transport of Goods Office
The numbers of the above mentioned establishments do not tally exactly with the numbers mentioned in the executive summaries of the contracted company.		

Annex 9

HSMP advice on health insurance in Syria

A historical sketch until end of 2006

STE	Dates			Lead activities
	N.	Dates	Days	(for details: see knowledge data bank in Ministry of Health)
Detlef Schwefel	1	2003 05-06	18	Review of Italian report on Syrian health benefit and insurance schemes (HBaIS) Estimation of financial share of HBaIS (~4.5% of all health exp.)
	2	2003 09	21	First assessment of status and context of HBaIS in Syria. Comparison with South Korea, Philippines and Thailand. Hint at indigency programmes.
	3	2003 11-12	31	Review of drafted law on health insurance. Introduction of InfoSure methodology for assessing HBaIS
	4	2004 01-03	61	Training on health insurance. Planning on future steps of HSMP. Translation of InfoSure questionnaire into Arabic.
	5	2004 07-08	27	Pilot-test of InfoSure questionnaires Plan for interagency involvement Training on fair financing
	6	2004 10-12	56	Interagency consultation, training and assessment of five schemes Health economics training
	7	2005 06	22	Health insurance inclusion in 10th Five Year Plan Draft of a profile for health insurance as policy direction Proposal of 8 lead activities towards social health insurance Proposals for reforming allocations for health
	8	2005 11-12	37	Sednaya conference as response to cabinet request Draft of 10 elements for discussing health insurance Proposal on studies on health benefit and insurance schemes Statistical data compilation and analysis
	9	2006 01-02	43	Compilation of documents and excerpts for Prime Ministers Office Proposal on modifications of 10th Five Year Plan strategy Health insurance workshops in three Governorates The importance of protecting the poor Cost of a national health insurance system The issue of privatisations A framework law for health insurance
	10	2006 04	7	Health financing and insurance in Egypt Family health funds in Egypt
	11	2006 04	5	Review for monitoring
	12	2006 06-07	34	National health insurance committee participation Willingness to pay for health insurance – first results
	13	2006 11-12	36	Household health expenditure data requesting health insurance Support for monitoring mission First review of four studies on provincial health benefit schemes
	Total		398	Health insurance was only one of six tasks for the short term consultant, i.e. approximately 66 calendar days were spent for advice in this area between 2003 and 2006
Jens Holst	1	2006 07	21	Comparison with Lebanon, Jordan, Chile Private and public health insurances and benefit schemes InfoSure assessment of some existing schemes
	2	2006 12	14	Private and public health insurances and benefit schemes InfoSure assessment of some existing schemes
	Total		35	Consultancy given on health insurance, only.

Annex 10

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