Ministry of Health





- Health Sector Modernisation Programme -

SYR/AIDCO/2001/0215 Funded by the European Union

برنامج تطويسر القطساع الصحسي بتمويل من الاتحساد الأوروبي Result six of the HSMP: Sustainable health financing

Nine case-studies
on health benefit and insurance schemes,
private health care providers and
household health expenditure
in Syria

initiated and compiled by

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Consortium GTZ / EPOS / OPTIONS







Nine case-studies on health benefit and insurance schemes, private health care providers and household health expenditure in Syria

Introduction

The Health Sector Modernisation Programme of the Syrian Arab Republic is funded by the European Union. It aims at increasing equity, efficiency, effectiveness and quality of health services. At the same time it intends to achieve a maximum of transparency and accountability in public and private spending for health. This is to be supported by one of its six intended results, i.e. "framework for sustainable financing of health sector in place".

The annual workplans for these issues aim at achieving national health accounting and include in political debates options for a fair generation and allocation of resources. Among others, the following three products are to be produced:

- Product 1: Studies on household expenditure, willingness and ability to pay for health and health insurance are executed Private households in Syria spend out-of-pocket more than 50 % of the total health expenditure in Syria. Foregoing studies and surveys produced contradictory results on the level and targets of this expenditure. They did not go into the question of the ability of families to pay for health care and how they solve the problems of getting it financed or if they have to postpone treatments, instead.
- Product 2: Provider studies are executed More than 70% of Syrian families consult private outpatient clinics and private pharmacies during a year and they spend a lot of money on this. Nearly nothing is known on what they demand and what they get. Provider studies try to shed light on these issues.
- Product 3: Existing insurance schemes evaluated and approaches for integration into a unified or coordinated system proposed Syria has already quite a number of existing health benefit and insurance schemes in the public sector and among professional groups, like the teachers. Within a national health financing system for Syria such schemes play an important role. They account for about 9% of governmental health expenditure. Until now, we do not know these schemes sufficiently and they have not yet been evaluated in detail. This is needed because one priority of the 10th Five Year Plan of Syria is health financing and health insurance.

In the year 2006 the Health Sector Modernisation Programme of the Ministry of Health contracted out nine small scale studies in these three areas. Private consulting companies in Syria were invited to send proposals and the best of at least three proposals was chosen to get contracted. Two more studies were planned but could not be realized, yet, one on health benefit and insurance schemes of all ministries and one for pilottesting another questionnaire on household health expenditure.

Four notes of caution have to be given:

- All contracted companies did not have prior experience with studies on health financing, health benefit and insurance schemes. One purpose of contracting was to test the market and to eventually select one or two companies to cooperate with the Health Sector Modernisation Programme (HSMP) in the future.
- Guidance was given either by a team from the Ministry of Health or by members of HSMP only to those contracted companies that requested advice.
- The translation of the study reports into English was entrusted to the best available translator; it was not reviewed nor corrected by team members.
- The case studies were done at a very small scale. They do not pretend to produce representative results. The main aim was, to test the feasibility of doing studies with private Syrian consulting companies. The reader has to answer the question, if this was successful.

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Study 2: Health benefit schemes in three Governorates

Nasco

Health Sector Modernization Program Funded by European Union

(HSMP)

STUDY No. (2) Contract No. (7)

Benefit Schemes of the Ministries in three Governorates

Final Report 16 November 2006

Profile

The NASCO Group was started in 1988 with a set aim of achieving excellence and setting a standard of professionalism for others to follow. Having worked for more than 17 years in many diversified fields of business, the Group has acquired considerable knowledge and expertise in practicing business in many industries in Syria including Services & Contracting, Consultancies, Agencies, and Exhibitions' Organization. The Group's experience range covers the local, governmental, regional and international markets.

The Consultancies division of The Nasco Group has executed projects in the fields of consulting, management, planning and advise....etc., for the private industry. Its independent financial status safeguards the interest of the center clients in a very suitable and sound way.

A flexible organization structure that prefers to engage its cooperating consultants and experts in the projects preparation, and in laying down the general structure and ways and means of approach. We carry out Ad-hock management for the projects in consultation with the selected consultant one or more and in many cases we share in the field work required if it falls within the scope of our personal experience. This, we belief insures flexibility and efficiency.

The qualified cooperating consultants guarantee the efficient execution of its projects in a sound professional manner which is very beneficial for its clients. The consultants and the firm management are characterized for their personnel and professional reputation with deep and thorough understanding of the economical, administrative and the legal situation of the Syrian market, industry and the work environment from the top to the base of the pyramid (Management – Simple workers) independently and in relation to the regional and international market and its modern tendencies and global view. Our success is shared with our cooperating consultants and their high standards of professional and personal integrity and dignity.

The Nasco Group has presented consulting services in the following areas

- market research and survey.
- Feasibility studies.
- Financial advise and procedures.
- Legal advice.
- Auditing and taxation.
- Companies evaluation, technical and financial.

4

- Work relations, laws and procedures.
- Contracts.

Areas of Expertise & Specialization:

1.General Management

- Articles of Association.
- Company By-Laws.
- Organizational Structure and Reporting Lines.
- Financial and Administrative Responsibilities & Authorities.
- Management Information Systems.
- Operating, Monitoring, Control and Audit Systems.

2. Human Resources

- Personnel Policies and Procedures.
- Personnel Selection and Recruitment Methodology.
- Job Descriptions, Analysis & Evaluation.
- Salaries & Benefits Administration Systems.
- Staff Productivity and Incentives Schemes.
- Staff Performance Appraisal Schemes.

3. Administration & Services Systems

- General Office Services Policies & Procedures.
- Communications Routing and Archiving Policies & Procedures.
- Transport & Travel Policies and Procedures.

4. Accounting & Finance

- Financial and Management Accounting Systems.
- Budgeting, Financial Control and Internal Audit Systems.
- Cash Forecasts and Cash Flow Systems.
- Financial Analysis.
- Economic Feasibility Studies.
- Mergers and Acquisitions Studies.

5. Support Operations, Sales & Marketing

- Plant and Warehouse Systems, Policies & Procedures
- Plant and Warehouse Layout.
- Purchasing Policies and Procedures.
- Storage and Distribution Systems.
- Marketing & Sales Policies and Procedures.

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1-Executive Summary:

This study has been launched in accordance with MoH-HSMP- financed by the European Union and NASCO to make a study the purpose of which is to estimate the bulk of Health Services and number of benefits the Ministries and the Governmental Institutions provide to their staff. Three charts for three Pilot Governorates were produced to implement the study on (Namely: Daraa, Lattakia, and Raqqa). The purpose of this study is to obtain ToRs or a basis to modernize the Schemes with view to having this pioneering study to disseminate its results to other Governorates in Syria.

The study focused on collecting, auditing and analyzing the information available from Partial Health Services Schemes in the three Governorates them comparing it with the data provided by DoHs in these three Governorates (Daraa, Lattakia, and Ragga).

The information which were to be collected, audited and analyzed in this study included:

- 1. Calculus of the number of employees in those three Governorates.
- 2. Gross number of the employees families in those three Governorates .
- 3. Total number of the members of the employees families in those three Governorates.
- 4. Employees family members average in those three Governorates.
- 5. Calculus of the basic salaries paid to the employees in those three Governorates.
- 6. Annual cost of medical treatment to the employees in those three Governorates.
- 7. Coverage rates for employees in those three Governorates.
- 8. Coverage rates for employees families in those three Governorates.

We can sum up the results of this study as follows:

1-Daraa Directorate:

- -There are 49 parties in Daraa, among which 22 are not included in Insurance while the other 27 are included in.
- The number of employees and their family members included in Insurance tolls up to:/126.095/. While the toll of inhabitants residing in Daraa in mid 2005 was /858.000/ which is to mean that the number and the percentage of those included compared to total of inhabitants in the Governorate are:

126.095	14.70 %
858.000	

Annual Cost of Medical treatment: /133.922.412/

133.922. 412	/1062/ SYP is the annual cost of those in-	
126.095	cluded in Medical Treatment	

If, in case, the total number of are to be included in Health Insurance, the Annual Cost will be

858.000 X 1062 = /91.119.6000/ SYP.

2-Lattakia Directorate:

- -There are 42 parties in Lattakia, among which 22 are not included in Insurance while the other 20 are included in.
- The number of employees and their family members included in Insurance tolls up to:/107.324/. While the toll of inhabitants residing in Lattakia in mid 2005 was /891.000/

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which is to mean that the number and the percentage of those included compared to total of inhabitants in the Governorate are:

107.324	12.05 %
891.000	

Annual Cost of Medical treatment: /80.961.900/

80.961.900	/754/ SYP is the annual cost of those in-	
107.324	cluded in Medical Treatment	

If, in case, the total number of are to be included in Health Insurance, the Annual Cost will be

891.000 X 754 = /671.814.000/ SYP.

3-Raqqa Directorate:

- -There are 66 parties in Raqqa, among which 32 are not included in Insurance while the other 34 are included in while there is 8 financing parties in consolidation.
- The number of employees and their family members included in Insurance tolls up to:/91.523/. While the toll of inhabitants residing in Raqqa in mid 2005 was /811.000/ which is to mean that the number and the percentage of those included compared to total of inhabitants in the Governorate are:

91.523	11.29 %
811.000	

Annual Cost of Medical treatment: /126.596. 100/

126.596. 100	/1383/ SYP is the annual cost of those in-
91,.523	cluded in Medical Treatment

If, in case, the total number of are to be included in Health Insurance, the Annual Cost will be

811.000 X 1383 = /1.121.613.000/ SYP.

Based on what we had earlier, we can notice the following:

- The largest percentage of people included in Health Services is in Daraa Governorate (14.70), Lattakia Governorate (12.05) second, and third is Raqqa Governorate (11.29).
- The largest number of resident people among those three Governorates is in Lattakia (891.000), second is Daraa (858.000), third is Raqqa (811.000).
- The nature of people's work in those three Governorates:
 - a. Daraa Governorate: the majority of people work in these professions: (Construction & Building 28%, Farming & hunting 15.1%, General Management & Defense 7.6%)
 - b. Lattakia Governorate: the majority of people work in these professions: (General Management & Defense 41.5%, Construction & Building 11.7%, Education 11%, %, Farming & hunting 9.1%)
 - c. Raqqa Governorate: the majority of people work in these professions:(Farming & hunting 46.1%, Construction & Building 17.4%, General Management & Defense 7.6%).

Based on what we concluded here, Daraa Governorate is able to start implementing Health Insurance, second is Lattakia Governorate, third is Ragga Governorate.

Objectives of this Study:

In the framework of the general policy of the Syrian Government to establish HI Scheme so extensive to include all citizens, beginning with employees in the government. This study manages collecting data about Partial Insurance Schemes in (Daraa , Raqqa, Lattakia) Governorates. The aim here is to find out about a unified HI that can be applied to all other Syrian Governorates.

The Methodology to carry out this Study:

This study was carried out on three stages as follows:

- a. Making research on the points that are appear in the tables of Health Services with view to achieving the targets of this study.
- b. Design lay-outs of these tables.
- c. Filling out these tables from Public Institutions & Companies in three Governorates (Daraa. Raqqa, and Lattakia)
 - d. Collect, analyze data.
 - e. Data Analysis.
 - f. Make presentations about the results of this study.

The activities of this study were as follows:

- 1- An integrated work team in cooperation with HSMP to agree on the tables in coordination with MoH.
- 2- The tables were filled out by Public Institutions & Companies in the three pilot Governorates.
 - 3- The tables were collected and the data were analyzed using MS Excel.
- 4- A draft report was prepared by NASCO, and it was discussed with specialists at MoH.
- 5- The final version of the report was issued with three copies in Arabic, together with a summary in English.

4-Daraa Governorate: (Facts & Status):

4-1 Introduction:

Daraa Governorate is located in the southwest region in Syria in Huran plain. It is 145 Kms far to the south of Damascus. Its territory is 3720 Sq. Kms. Its inhabitants are 859.287. It is divided to three local administration areas (i.e. Daraa District, Izra District, and Sanameen District). Its climate is Mediterranean, rainy in winter and hot in summer. It is one of the governorates whose economy depends mainly on agriculture (two-fold: cattle raising & farming) due to fertility its lands and its geographical location and its moderate weather. The Agricultural Sector is considered to be the original source of income. At this sector, about 30.8 of the population work.

4-2 Population Status & demographic Indicators:

Daraa Governorate is divided into 8 Health Areas, the population are distributed on Health Areas as follows:

Table No.1: Distribution of the population as in this table:

Health Area	Males	Females	Total
Daraa City	83012	83030	166042
Sanameen	67811	67797	135608
Bosra	57547	57559	115106
Nawa	6970	69987	139957
Al-Hrak	40064	40072	80136
Al- shajra	19005	19009	38014
Tafas	46526	46534	93060
Izra	46058	46067	92125
Total	429993	430055	860048

Source: Health Insurance Study in Daraa Governorate.

<u>Table No.2</u>: estimate of the number of population resident in Daraa Governorate on 1/7/2005.

Estimated for	Rural Places	Urban Places	Total
Daraa City	464000	394000	858000

Source: Statistical group /2005/ Page: 4.71

4-3 Marital Status & Gender for Daraa Governorate :

<u>Table No.3:</u> Proportional distribution of individuals (15 years and above) according to Marital status & Gender

Marital Status	Males%	Females %	Total %
Never Married	43.1	32.3	37.8
Married	56.2	62.8	59.4
Divorced	0.1	0.8	0.4
Widowed	0.5	4.1	2.3
Non-assigned	0.0	0.1	0.0
Total %	100.0	100.0	100.0

Source: Initial results of the overall count of buildings and population in 2004.

4-4 Health Status:

The Table shows Health Services Schemes in Ministries & Public Companies Daraa Governorate:

Key to the Table

<u>P:</u> Permanently Employed, <u>C</u>: Contractual Basis Employee, <u>T</u>: Temporarily_Assistance basis.

R: Rate, B: Basic Salary, N: No Benefit, BA Benefit Available.

<u>Table No.4: Health services Schemes in the Institutions and Public Companies at Daraa Governorate:</u>

Institution	Total N	lo. of <u></u>	employ-			family-		s Basic	Sala-	Total Mon	thly Basic S	<u>alaries</u>	Annual	Aver-	Coverag		per	Coverag		
	<u>ees</u>			member			ries						Cost of	age	employe			employ		
	<u>P</u>	<u>c</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	C	<u>I</u>	<u>P</u>	<u>c</u>	I	Health	Health Cost per em- ployee	<u>R</u>	<u>B</u>	<u>N</u>	<u>R</u>	<u>B</u>	BA
Technical Services Directorate	776	101	250	4596	505	1000	6	5	4	7450203	697408	122950	19000000	27536	100%	0	<u>0</u>	100%	<u>0</u>	<u>0</u>
Daraa Elec- tricity	699	0	344	4149	0	1720	6	0	5	7512102	0	3.000.000	11000000	10100	100%	0	0	50%	0	0
Credit Bank (limited in- comes)	24	0	1	91	0	1	4	0	1	183000	0	5300	950000	10300	100%	0	0	75%	0	0
Agricultural Bank	33	2	0	12	3	0	4	1	0	315269	9600	0	600000	10000	100%	0	0	75%	0	0
Commercial Bank	88	1	0	315	0	0	4	0	0	600.000	4000	0	2000000	22700	100%	0	0	75%	0	0
Productive Credit Bank	30	0	0	145	0	0	4	0	0	307120	0	0	810000	27000	100%	0	0	75%	0	0
Industrial Bank	24	0	0	81	0	0	3.37	0	0	207017	0	0	400000	16666	100%	0	0	75%	0	0
Real-estate Bank	40	0	0	95	0	0	3	0	0	995.000	32300	2044	931912	6903	100%	0	0	75%	0	0
Daraa Com- munication	790	4	4	2155	90	0	6	5	0	7556116	126103	20508	5000000	6150	100%	0	0	75%	0	0
Fuel Com- pany Daraa Branch	41	0	0	186	116	0	93	58	0	301373	137972	0	550000	7971	100%	0	0	0	0	0
Social Insur- ance	50	0	0	161	32	0	3	3	0	471926	49711	0	750000	12500	100%	0	0	0	0	0
Syrian Insur- ance	25	0	0	150	12	0	6	6	0	0	0	0	500000	20000	100%	0	0	0	0	0
Yarmuk Mills	111	0	0	777	0	0	7	0	0	978000	0	0	700000	6300	100%	0	0	75%	0	0
Education Directorates	14187	12	1634	70935	52	4950	6	4	3	12378914	260000	2475000	85122000	12000	100%	600	0	0	6000	0
Daraa Cereal	206	18	15	634	43	37	3.07	2.38	2.46	1612891	75320	77360	770000	3437	100%	0	0	50%	0	0
Daraa_Rail- way	75	2	17	450	12	102	6	6	6	<u>Da</u>	mascus Fina	nce	0	0	100%	0	0	0	0	0
Total	17189	195	2265	84932	865	7810				40868931	40868931	81737862	12908391 2	199563		600			6000	0

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Institution	Total empl	l No loyees		Gross familym	_	of	Ва	oss sic larie		Gross mo			Annual Cost of Health	Aver- age Health	· %)	age C Employee	ost e (Emp (%)	erage C loyee	ost per Family
	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I		Cost per em- ployee	<u>R</u>	<u>B</u>	<u>N</u>	<u>R</u>	<u>B</u>	<u>BA</u>
Daraaa Purchase center	4	0	3	21	0	19	0	0	0	30000	19000	0	0	0	100	0	0	0	0	0
Pharamix	33	3	0	204	15	0	6	5	0	330000	14300	0	500000	10000	100	0	0	0	0	0
Syian Air	17	0	0	102	0	0	6	0	0	125000	0	0	0	100%	100	0	0	0	0	0
Directorate of Transport	41	0	0	250	0	0	5	0	0	432111	0	0	160000	7000	20	0	0	80	0	0
Daraa Finance	339	3	1	271	0	1	0	0	0	1249000	0	5700	1705000	4000	0	1250	0	0	1250	0
Daraa Consumptive Est.	205	0	0	1230	0	0	6	0	0	2037000	0	0	250000	300	0	300	0	0	0	0
Daraa Building Co	187	0	0	1050	0	0	6	0	0	1300000	0	0	286000	2000	0	2000	0	0	0	0
Daraa Post	102	0	0	612	0	0	6	0	0	979000	0	0	20000	2000	0	2000	0	0	0	0
Secretariat of Daraa Gover- norate	100	14	4	600	70	20	6	5	5	950000	84000	2400	0	0	0	0	0	0	0	0
Laboreres Union	43	1	0	258	5	0	6	5	0	355283	8865	0	0	0	0	0	0	0	0	0
Daraa Planning Directorate	10	0	0	60	0	0	6	0	0	85000	0	0	0	0	0	0	0	0	0	0
Daraa Real- estate0	287	33	0	1722	156	0	6	5	0	2583000	189000	0	0	0	0	0	0	0	0	0
Daraa Adver- tisement Branch	59	0	12	350	0	35	6	0	4	624123	0	0	0	0	0	0	0	0	0	0
Directorate of Affairs	151	36	3	326	50	12	3	3	4	1607739	272000	2300	0	0	0	0	0	0	0	0
<u>Total</u>	157 8	90	23	7056	305	87				1268725 6	587165	3200 0	2421000	25301	0	5550	0	0	1250	0

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Institution	Total I		em-		No. of	family	Gros		Basic	Gross mont	hly Basic Sa	laries	Annual	Average		verage	Cost	Coverag		
	ployee			memb		1	Sala		1		T _		Cost of	Health		r employe		employe		
	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	I	Health	Cost per Employee	<u>R</u>	<u>B</u>	<u>N</u>	<u>R</u>	<u>B</u>	<u>B</u> <u>A</u>
Potable Wa- ter Est.	1145	39 0	0	5725	1170	0	5	3	0	11000000	4072000	0	0	0	0	0	0	0	0	0
Daraa Religious Endowments	24	0	14 7	54	0	882	3	0	6	313455	0	707980	417500	2500	0	2500	0	0	0	0
Central Corpus	27	0	0	85	0	0	6	0	0	280901	0	0	0	0	0	0	0	0	0	0
Daraa Directorate of Environment	15	3	1	53	0	3	4	0	3	170661	15000	4000	0	0	0	0	0	0	0	0
Directorate of Culture	63	8	2	378	54	12	6	6	6	567000	40000	8000	0	0	0	0	0	0	0	0
Saving Bank	34	6	5	204	36	20	6	7	4	204000	36000	27500	0	0	0	0	0	0	0	0
Daraa Directorate of Economy	7	0	0	27	0	0	4	0	0	56299	0	0	0	0	0	0	0	0	0	0
Daraa Directorate of Justice	235	0	0	0	1410	0	0	6	0	2124000	0	0	0	0	0	0	0	0	0	0
Daraa State Affairs	29	0	0	174	0	0	6	0	0	280440	0	0	0	0	0	0	0	0	0	0
Daraa_Directorate of industry	13	0	0	66	0	0	6	0	0	112000	0	0	0	0	0	0	0	0	0	0
Farmers Union	31	6	0	180	30	0	6	5	0	300000	36000	0	0	0	0	0	0	0	0	0
Daraa City Council	290	10 8	90	1740	540	360	6	5	4	2320000	648000	450000	0	0	0	0	0	0	0	0
Directorate of Tourism	35	17	0	210	85	0	6	5	0	395000	102000	0	0	0	0	0	0	0	0	0
Directorate of Agriculture	1651	2	0	6604	8	2656	4	4	5	178000000	16000	7650000 0	0	0	0	0	0	0	0	0
<u>Total</u>	3599	54 0	0	1550 0	3333	3933				196123756	4965000	7769748 0	417500	2500	0	2500	0	0	0	0

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Institution	Total ployee	No. o es	f <u>em-</u>	Gross Member		<u>Family</u>	Ва	oss sic Iarie		Gross mont	hly Basic Sala	ries	An- nual Cost	Average Health Cost per		age Cos yee (%)	t per	per		Cost loyee
	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	of Healt h	Em- ployee	<u>R</u>	<u>B</u>	N	<u>R</u>	<u>B</u>	<u>B</u> <u>A</u>
Daraa Health Di- rectorate	3060	612	0	18360	2448	0	6	4	0	27000000	6000000	0	0	0	0	0	0	0	0	0
Civil Affairs Directorate	85	88	0	510	440	0	6	5	0	704000	484000	0	0	0	0	0	0	0	0	0
Daraa Religious Endowments	29	0	142	174	0	852	6	0	6	261000	0	639000	0	0	0	0	0	0	0	0
Central Bank of Syria	27	11	0	162	55	0	6	5	0	190000	60000	0	5000 00	13158	100	0	0	75	0	0
Directorate of Irrigation	862	146	0	5172	584	0	6	4	0	8650000	73000	0	1500 000	1500	0	1500	0	0	30 00	0
<u>Total</u>	4063	857	142	24378	3527	852	6			36805000	6617000	639000	2000 0000	14658		1500			30 00	

Institu- tion	Total N ees	o. of <u>E</u>	mploy-	Gross member	No. of <u>s</u>	<u>Family</u>	Gro Bas Sala		S	Gross m	onthly Basic	Salaries	Annual Cost of Health	Aver- age Health		verage C r employee	ost	Cov per fam		Cost loyee
	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	Τ	<u>P</u>	<u>C</u>	I		Cost per Em- ployee	<u>R</u>	<u>B</u>	<u>N</u>	<u>R</u>	<u>B</u>	<u>B</u> <u>A</u>
	17189	195	2265	84932	865	7810							129083912	199563		6000			6000	
	1578	30	23	7056	305	87							2421000	25301		5550			1250	
	3599	540	0	15500	3333	3933							417500	2500		2500			0	
	4063	857	142	24378	3527	852							2000000	14658		1500			3000	
<u>Total</u>	26429	1682	2430	131866	8030	12682							133922412	242022		15550			10250	

5-Lattakia Governorate: (Facts & Status):

5-1 Introduction:

Lattakia Governorate is located in the western region in Syria on 80 Kms of the Mediterranean coast beginning from the Syrian-Turkish Borderline down to Tartus Governorate. Its territory is 203 Sq. Acres. Its inhabitants are around a million. It is linked with the rest of the world through its port on the Mediterranean, and in-land via Turkey. It is linked as well by Al- Bassel International Airport. The governorate is divided into 120 administrative districts, 4 Regions and 4 cities.

5-2 Population Status & demographic Indicators:

Lattakia Governorate & Health Areas as follows:

Table No.5: the Demographical Distribution as in this table according to Health Areas:

	9.00		
Health Area	Males	Females	Total
Lattakia Center	260520	250520	512300
Jebla Center	99860	96510	196370
Al- Hefeh Center	45140	43630	88770
Al-qerdaha Center	41480	40080	81560
Total	447000	432000	879000

Source: Health Insurance Study in Lattakia Governorate.

<u>Table No.6:</u> estimate of the number of population resident in Lattakia Governorate on 1/7/2005.

Estimated for	Rural Places	Urban Places	Total
Lattakia City	436000	455000	891000

Source: Statistical group /2005/ Page: 71

5-3 Marital Status & Gender for Lattakia Governorate :

<u>Table No.7</u>: Proportional distribution of individuals (15 years and above) according to Marital status & Gender

Marital Status	Males%	Females %	Total %
Never Married	46.2	38.4	42.4
Married	51.9	55.7	53.8
Divorced	0.2	0.6	0.4
Widowed	0.8	4.3	2.3
Non-assigned	0.9	0.9	2.5
Total %	100.0	100.0	100.0

Source: Initial results of the overall count of buildings and population in 2004.

5-4 **Health status**:

the table shows Health Service Schemes in the Institutions & Public Companies in Lattakia Governorate:

<u>Table No.8</u>: Health Service Schemes in the Institutions & Public Companies included in Health Insurance:

Institution	Total N		<u>m-</u>	Gross I	<u>ers</u>	amily						ic Salaries	Gross Cost of Health in	Coverage ployee (Percentage	ge)		emp	erage Cos loyee_fam	nily
	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	Ţ	Budget	Cover- age Cost per_em- ployee	Average Healt h Cost SYP	No Ben efit %	<u>R</u> %	<u>B</u>	No Ben efit %
Social Security Directorate	178	7	3	890	35	15	5	5	5	174693 6	65888	18971	1692000	100	0	0	0	0	0
Railway	1216	2	38	6080	10	190	5	5	5	119896 700	11256	285590	0	100	0	0	50	0	0
Electricity Co.	1800	340	0	9000	1700	0	5	5	0	235769 80	734587 5	0	1300000 0	100	0	0	50	0	0
Lattakia Port	3250	250	0	16250	1250	0	5	5	5	204394 32	454832 1	0	2000000	100	0	0	50	0	0
Post Service	248	0	4	1240	0	20	5	0	5	221025 6	0	24800	500000	1984	5%	0	0	0	0
Central Bank	108	3	0	540	15	0	5	5	5	ATM	0	0	0	100	Open	0	75	Open	0
Real-estate Bank	90	10	2	270	30	6	3	3	3	836934	43750	8351	0	100	Open	0	75	open	0
Duty Free	215	12	0	645	36	0	0	3	0	215000	0	0	0	100	Open	75	op en	0	0
Credit Bank	42	0	0	210	0	0	5	5	5	390000	0	0	0	0	6000 yearl y		ed & for a v	3000 so vife	ns &
Productive Credit Bank	46	0	2	138	0	8	3	0	4	426901	492600 0	10645	7536000	0	2000 0	0	0	12000	0
Water Est.	1480	579	6	5920	2315	24	4	4	4	122500 00	0	45000	0	100	Open	0	0	0	0
Internal Transport Co.	333	0	0	1665	0	0	5	5	5	283239 6	0	0	0	100	Open	0	75	Open	0
Marble Co.	1206	1	160	6030	5	800	5	5	5	0	5830	0	6500000	100	0	0	0	0	0
Directorate of Industry	31	1	1	155	5	5	5	5	5	348586	20291	4958	0	0	4000 yearl	0	0	0	0

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Institution	Total N ployee	lo. of <u>e</u> <u>s</u>	<u>m-</u>	Gross 1		<u>amily</u>		oss E Sala		Gross m	onthly Bas	ic Salaries	Gross Cost of Health in	Coverage ployee (Percentage		r em-		erage Co lloyee_far	
	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	I	Budget	Cover- age Cost per_em- ployee	Average Healt h Cost SYP	No Ben efit %	<u>R</u> %	<u>B</u>	No Ben efit %
															У				
Pharmix	515	4	0	2575	20	0	5	5	0	557579 8	88865	0	4000000 0	100	0	0	0	0	0
Directorate of Tourism	190	14	0	950	70	0	5	5	0	196831 9	0	0	1020000	50	5000	0	50	0	0
Hmeisho Cars	0	0	205	0	0	615	0	0	3	0	0	943000	102500	65	0	0	0	0	0
Abu Musa Co	0	0	8	0	0	24	0	0	3	28000	88865	0	6400	65	0	0	0	0	0
Directorate of Culture	153	35	7	765	175	35	5	5	5	971845	184643	38000	1560000	50	8000	0	0	0	0
General To- bacco Co.	5200	320	113	26000	1600	565	5	5	5	520000 0	526000 0	791000	2500000 0	100	0	0	50	0	0
<u>Total</u>	16301	1578	549	79323	7266	2307				137804 083	225127 19	2170315	8091690 0						0

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Table No.9: Institutions & Public Companies not included in Health Insurance

<u>l able</u>						_					ith Insuran								
Institution	ployee			Gross No member	<u></u>		Sala				nthly Basic Sal		Gross Cost of Health in Budget	per er Perce	age Conploye ntage)	e (per e fami		yee
	<u>P</u>	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	<u>T</u>	P	<u>C</u>	<u>T</u>	<u>P</u>	<u>C</u>	<u>T</u>	SYP	<u>R</u>	<u>B</u>	<u>N</u>	<u>R</u>	В	<u>BA</u>
Directorate of Agriculture	4470	1805	700	22350	9025	3500	5	5	5	4570648 6	11374924	0	0	0	0	0	00	0	0
Insurance & Pensions	36	5	2	180	25	10	5	5	5	307510	26149	12400	0	0	0	0	0	0	00
Directorate of Finance	1140	1	3	5700	5	15	5	5	5	1230089 1	7200	20051	0	0	0	0	0	0	0
Courts	526	0	0	2630	0	0	5	5	5	4381652	0	0	0	0	0	0	0	0	0
Labor & Social Affairs	209	13	0	1045	65	0	5	5	5	1816989	81757	0		0	0	0	0	0	0
Real-estate Directorate	467	3	35	2325	15	175	5	5	5	5194284	0	418102	0	0	0	0	0	0	0
	89	26	5	445	130	25	5	5	5	1117287	160941	28806	0	0	0	0	0	0	0
Directorate of Supply	233	0	0	9145	0	0	5	0	0	2328317 0	0	0	0	0	0	0	0	0	0
Education (Technical)	1829	0	0	1165	0	0	5	0	0	2775578	0	0	0	0	0	0	0	0	0
Radio &Television	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Aviation Agencies	564	0	0	2820	0	0	5	0	0	6909000	0	0	0	0	0	00	0	0	0
Cereal Est.	316	146	18	1580	730	90	5	5	5	3416863	7203	87110	0	0	0	0	00	0	0
Electric Motors Co.	0	35	0	0	175	0	0	5	0	0	468000	0	0	0	0	0	0	0	0
Economy & Trade Directorate	0	0	0	115	0	0	5	5	5	196365	0	0	0	0	0	0	0	0	0
Education Di- rectorates	23	0	400	97035	0	2000	5	0	5	2029150 00	0	192000 0	0	0	0	0	0	0	0
Assad University	1942 700	62	30	3215	310	460	5	5	5	6431727	414450	146856	0	0	0	0	0	0	0
Sport Premises	1502	0	0	760	0	0	5	0	0	141809	0	0	0	0	0	0	0	0	0
Environmental	39	2	0	195	10	0	0	0	0	389919	14085	0	0	0	0	0	0	0	0

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Institution	Total No. of employees		Gross No. of <u>family</u> <u>members</u>		Gross Basic Salaries		Gross monthly Basic Salaries			Gross Cost of Health in Budget	Coverage Cost per employee (Percentage)		e (Coverage Cost per employee family					
	P	С	<u>T</u>	<u>P</u>	C	T	<u>P</u>	С	T	P	<u>C</u>	T	SYP	R	В	N	R	<u>B</u>	BA
Religious En- dowments	13	51	260	39	153	780	3	3	3	204254	167289	988276	0	0	0	0	0	0	0
Syriatel	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	00		0	0
Areeba	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
University	4780	80	650	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<u>Total</u>	3495 6	2229	2103	150854	1064 3	7055				3187617 84	12721998	362160 1	0	0	0	0	0	0	0

<u>Table No.10</u>: Overall Number of Employees in Public Establishments & Companies (Included/ Not-included in HI Scheme)

Institution	<u>ees</u>			members			No Far	Average No. of Family Members				Gross Health Cost in the	Aver- age Health Cost	per	erage Em centag	Cost nployee le)	Covera	ige F	₹ate	
	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	Ι	<u>P</u>	<u>C</u>	I	<u>P</u>	<u>C</u>	I	Budget	per Em- ployee	Co ver ag e Rat e per Em plo yee	Av er- age Co st per Em plo yee	No Bene fit	Cov- er- age Rate per Em- ploye e	<u>B</u>	No Bene fit
Total of non- included in HI	34956	2229	2103	150854	1064 3	7055				318761784	17221998	3621601	0	0	0	0	0	0	0	0
Total of Included in HI	16301	1587	549	79323	7266	2307				137804083	22512719	2170315	809196 00	0	0	0	0			
Grand Total	51257	3807	2652	230177	1790 9	9362				456565867	35234717	5791916	809196 00	0	0	0	0	0	0	0

6-1 Introduction:

Raqqa Governorate is located in the mid-nothern region in Syria on then northern Bank of the Euphrates about 160 Kms from Aleppo City. Its inhabitants are 838297. Economy in this Governorate depends on Al-Furat and the neighboring Oil wells in

6-2 Population Status & demographic Indicators:

Raqqa Governorate & its Health Areas as follows:

Table No.11: the Demographical Distribution as in this table according to Health Areas :

Health Area	Males	Females	Total
Raqqa City	290116	268877	558993
Tal Abyad	67946	62723	130669
Al-Thawra City	77141	71494	148635
Total	435203	403094	838297

Source: Health Insurance Study in Raqqa Governorate.

<u>Table No.12:</u> estimate of the number of population resident in Raqqa Governorate on 1/7/2005.

Estimated for	Rural Places	Urban Places	Total
Raqqa City	507000	304000	811000

Source: Statistical group /2005/ Page: 71

6-3 Marital Status & Gender for Raqqa Governorate:

<u>Table No.13:</u> Proportional distribution of individuals (15 years and above) according to Marital status & Gender

mantai otatao a cont	101		
Marital Status	Males%	Females %	Total %
Never Married	46.8	36.6	41.4
Married	52.4	59.0	55.7
Divorced	0.2	0.4	0.3
Widowed	0.4	3.7	2.0
Non-assigned	0.2	0.3	0.3
Total %	100.0	100.0	100.0

Source: Initial results of the overall count of buildings and population in 2004.

6-4 **Health status**:

the table shows Health Service Schemes in the Institutions & Public Companies in Ragga Governorate

Table No.14: Health Service Schemes in the Institutions & Public Companies included in Health Insurance:

	Public Institution	Total No.	Total No.	AverageNo.	Gross Basic		Average	Coverage	Family In-
	i ubiic iristitutiori	Employees	Employees	Employees	Salary	Allitual Cost	Cost of	Rate	surance
		Lilipioyees	Family	Family	Jaiary		Medical	Nate	Surance
			Members	Members					
			Members	Members			Treatment		
							per Em-		
	MCC . II		1001	0.00	0045500	4044000	ployee	 0/	
1	Military Housing Est.	528	1931	3.66	3845723	1041000	1972	75%	Nonassigned
2	General Construction Co.	471	2283	4.85	3630901	1471000	3123	100%	Worker only
3	General Ways& Bridges Co.	252	1287	5.11	2008195	1200000	4762	100%	Worker only
4	General Electricity Co	1043	6172	5.920	7987997	17000000	16299	100%	Family 50%
5	General Co. of Bak- eries	195	1140	5.85	1404337	150000	769	100%	Worker only
6	General Co. of Wa- ter Projects	1224	6282	5.13	10528500	450100	368	100%	Worker only
7	General Est. of Metals & construction Materi- als	106	450	4.25	844019	400000	3774	100%	Worker only
8	General Est. of Consumptive Mate- rials	193	1426	7.39	1596983	250000	1295	100%	Worker only
9	General Est. of Cereal	859	3586	4.17	5313237	1900000	2212	100%	Worker only
10	General Est for Development of Furat Basin	1140	5740	5.04	13261622	7718000	6770	100%	Family 50%
11	General Co. of Furat Dam	2327	9300	4	18853850	24000000	10314	100%	family par- tially
12	General Co. of Advertisement	169	277	1.64	1156099	Central	Nonassigned	100%	Worker only
13	General Co. of Social Security	69	210	3.04	498816	750000	10870	100%	Worker only
14	General Co. of Poultry	45	200	4.44	297715	50000	1111	50%	Worker only

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	Public Institution	Total No. Employees	Total No. Employees Family Members	AverageNo. Employees Family Members	Gross Basic Salary	Annual Cost	Average Cost of Medical Treatment per Employee	Coverage Rate	Family Insurance
15	General Co of Pottable Water	866	3898	4.50	5511141	5300000	6120	0	Worker annually accrued 3800 SYP
16	General Co.of Road Transport	14	39	2.79	104753	Central	Nonassigned	100%	Nonassigned
17	Radio & Television Center	6	5	0.83	34473	Central	Nonassigned	100%	Worker & Family
18	Commercial Bank of Syria	54	160	2.96	380316	1065000	19722	0	Family 75%
19	Cooperative Agricul- tural Bank & its Branches	174	834	4.79	5258012	3362000	19322	100%	Family 75%
20	Industrial Bank	21	71	3.38	185000	310000	14762	0	Family 75%
21	Real-estate Bank	28	77	2.75	204112	Central	Nonassigned	100%	Family 75%
22	Syrian Co.for Stor- ing & Distribution of Materials	90	299	3.32	532789	700000	7778	100%	Worker only
23	Sundus Center	5	26	5.20	41460	Central	Nonassigned	100%	Worker only
24	Syronics	6	37	6.17	42950	Central	Nonassigned	-	Worker only
25	Raqqa Sugar Co.	349	2270	6.50	3905000	3600000	10315	100%	Worker only
26	Communication Directorate	550	2166	3.94	4028388	3679000	6689	100%	Worker only
27	Technical Services Directorate429	684	1361	1.99	4020353	7254000	10599	100%	Family 100%
28	Directorate of Agriculture	2333	11665	5	15403258	1000000	429	-	Worker only
29	Directorate of Transport	40	215	5.38	272980	300000	7500	100%	Only 5 Workers &their Fami-

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	Public Institution	Total No. Employees	Total No. Employees Family Members	AverageNo. Employees Family Members	Gross Basic Salary	Annual Cost	Average Cost of Medical Treatment per Employee	Coverage Rate	Family Insurance
									lies
30	Raqqa Mail Directorate	56	227	4.05	479536	150000	2679	50%	family par- tially
31	General Est. of Railway	225	1290	5.73	1767743	Central	Nonassigned	100%	Family 50%
32	Credit Bank	29	133	4.59	217000	500000	17241	100%	Family 75%
33	Central Bank of Syria	27	88	3.26	233370	Central	Nonassigned	100%	Family 100%
34	Land Reclamation	2200	10000	4.55	12000000	43000000	19545		
	Total	16378	75145	4.59	125850538	126596100	206339.657		

Table 15: Establishments, Institutions & Public Companies not included in Health Insurance Scheme:

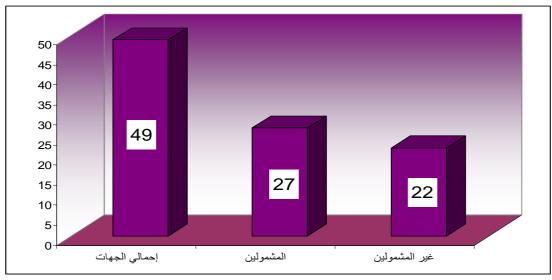
	Public Institution	Total No. Employees	Total No. Employees Family Members	AverageNo. Employees Family Members	Gross Basic Salary	Annual Cost	Average Cost of Medical Treatment per Employee	_	Family Insurance
1	Administration of State Affairs	31	119	3.84	0	0	0%		
2	General Est. of Seeds	107	549	5.13	0	0	0%		
3	Military Housing Est	99	290	2.93	0	0	0%		
4	Central Corpus of Financial Monitoring	39	156	4	0	0	0%		
5	General Co. of stor- ing and marketing	53	288	5.43	0	0	0%		
6	Civil Affairs	143	338	2.36	0	0	0%		
7	General Est. of School Books	36	163	5.43	0	0	0%		

	Public Institution	Total No. Employees	Total No. Employees Family Members	AverageNo. Employees Family Members	Gross Basic Salary	Annual Cost	Average Cost of Medical Treat- ment per Em- ployee	Coverage Rate	Family Insurance
8	General Est. of Pension & Insurance	6	39	6.50	0	0	0%		
9	General Est. of Geology and Minerals	9	49	5.44	0	0	0%		
10	General Est of Mills	134	683	5.10	0	0	0%		
11	Central Corpus of Monitoring& Inspec- tion	30	104	3.47	0	0	0%		
12	Governorate Secretariat	55	167	3.04	0	0	0%		
13	Local Councils of towns & village Municipalities	1527	6957	4.56	0	0	0%		
14	Raqqa Directorate of Justice	228	750	3.29	0	0	0%		
15	Raqqa Directorate of Statistics	10	41	4.10	0	0	0%		
16	Raqqa Directorate of Economy	6	20	3.33	0	0	0%		
17	Raqqa Directorate of Religiuos Endowments	42	173	4.12	0	0	0%		
18	Raqqa Directorate of Internal Trade	89	231	2.60	0	0	0%		
19	Raqqa Directorate of Planning	7	23	3.29	0	0	0%		
20	Directorate of Culture	67	180	2.69	0	0	0%		
21	Directorate of Tourism	23	115	5	0	0	0%		
22	Directorate of Social Affairs &Labor	90	313	3.48	0	0	0%		
23	Directorate of Civil Affairs	143	338	2.36	0	0	0%		
24	Raqqa Directorate of Health	2046	3722	1.82	0	0	0%		
25	Raqqa Directorate of Industry	11	65	5.91	0	0	0%		
26	Directorate of Finance	338	1500	4.44	0	0	0%		

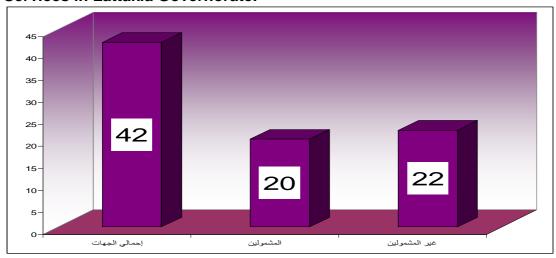
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	Public Institution	Total No.	Total No.	AverageNo.	Gross	Annual	Average Cost of	Coverage	Family In-
		Employees	Employees	Employees	Basic	Cost	Medical Treat-	Rate	surance
			Family	Family	Salary		ment per Em-		
			Members	Members			ployee		
27	Real-estate Director-	145	527	3.36	0	0	0%		
	ate								
28	Saving Bank	16	83	5.19	0	0	0%		
29	Transport of Goods Office	33	195	5.19	0	0	0%		
30	Eradication of Un- employment Office	13	30	2.31	0	0	0%		
31	Silage Est.	42	217	5.17	0	0	0%		
32	Directorate of Education	10814	33793	3.12	0	0	0%		
33	Total No. of those not included	16432	52218	3.18	0	0	0%		
	Total	32810	127363	3.88	0	0	0%	_	

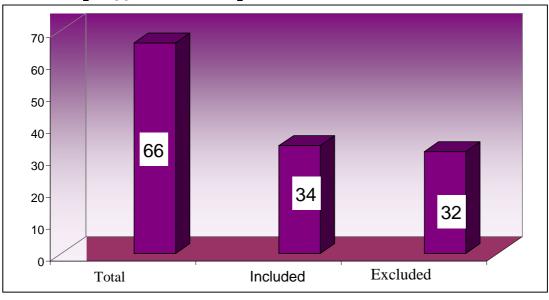
<u>Graph no.1:</u> Gross Number of Institution implementing & not implementing HI Services in Daraa Governorate



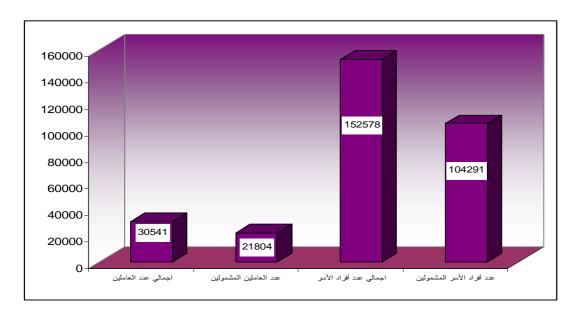
<u>Graph no.2:</u> Gross Number of Institution implementing & not implementing HI Services in Lattakia Governorate.



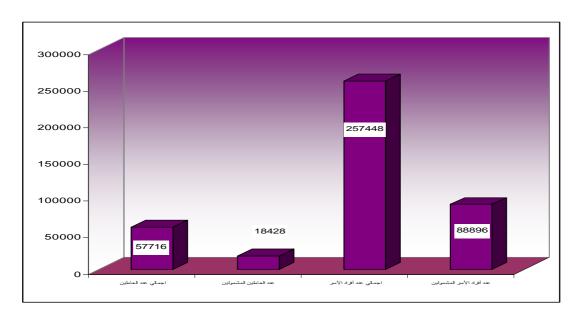
<u>Graph no.3:</u> Gross Number of Institution implementing & not implementing_HI Services in_Raqqa Governorate.



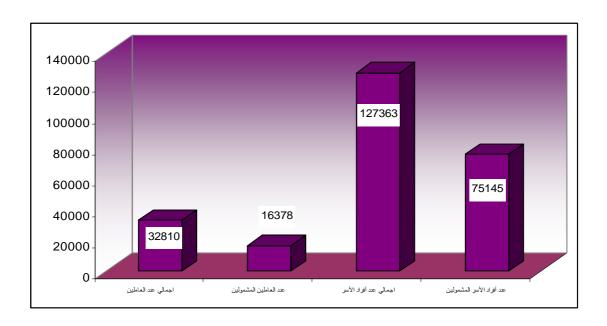
<u>Graph no.4</u>:.Comparison between No of Employees and Gross No. of their Families included in HI in Daraa Governorate.



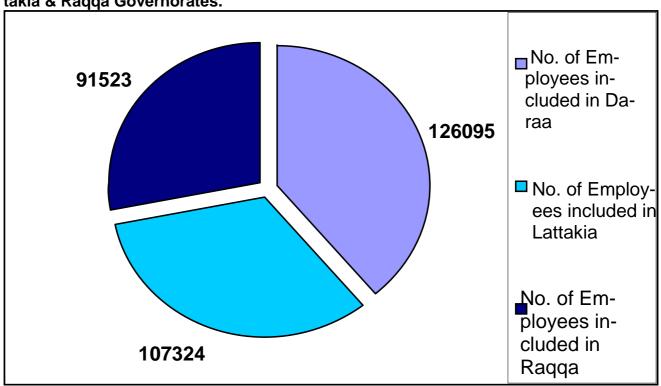
Graph no.5: Comparison between No of Employees and Gross No. of their Families included in HI in Lattakia Governorate.



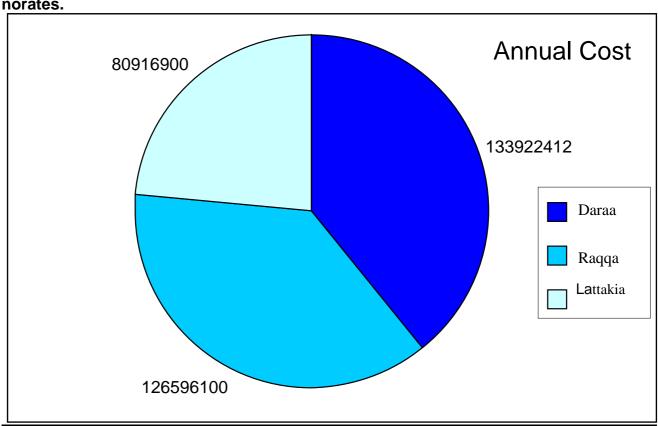
<u>Graph no.6:</u> Comparison between No 0f Employees and Gross No. of their Families included in HI in Raqqa Governorate.



<u>Graph no.7</u>: Overall Number of Employees included in HI Services in Daraa, Lattakia & Raqqa Governorates.



Graph no.8 Annual Cost of Medical Services in Daraa, Lattakia & Raqqa Governorates.



7- General Assessment of the Results: Daraa Governorate:

- There are some of the Public Institutions possessing the annual cost of medical treatment, so they remained not completed in this study. The annual cost of medical Treatment was considered in approximate estimates.

Lattakia Governorate:

- Not all the Public Institutions were stated in this study due to difficulty in obtaining & collecting information from them.
- Difficulties in collecting the gross number of family members, so it was approximately estimated on the average of number of family members.
- Due to the fact that the annual cost of medical treatment was not estimated by the parties included in Insurance, this led the into considering the Gross annual cost of medical treatment in approximation.

Raqqa Governorate:

Due to the fact that the annual cost of medical treatment was not estimated by the parties included in Insurance, this led the into considering the Gross annual cost of medical treatment in approximation as well.

8-Recommendations:

The implementation of Health Insurance Scheme in the Governorates through Public Health Sector makes the potential to incur negative and positive sides in it.

1-Positive Sides:

- Redistribution of the Public Hospitals & Health Centers in the Governorates in the country according to health map.
- Necessitation of Medical Staff: (Doctors, Nurses, Technical Staff).

2-Negative Sides:

- High rates of wasted resources because the Services are free of charge.
- Lack of the desire from individuals to voluntarily pay for Health Insurance due to the lack in explanatory techniques on the effectiveness of Health Insurance & the advantages it offers. This makes education on this Scheme a vital necessity to insure its spread all over the country.
- Lack of residence advantages for doctors, so we find them tend to work at city centers.
- Lack of Continuous Medical Training Programs.
- Non-existence of clear management, financial structures & maintenance workshops at Directorates of Health.
- Non-existence of computerized Schemes at hospitals which are enabled to provide accepted level of Health Services.

Based on the above -stated points, we recommend as follows:

- 1- Find out about a legal, regulatory form to organize the implementation of Health Insurance Scheme.
 - 2- Find out about a commonplace formula for the Partial Insurance Schemes that are available in three pilot Governorates.
 - 3- Apply Incentive Scheme for the staff Cadre in Health Sector.
 - 4- Raise the required funds and budgets at each health institution, and insure independency in expenditures.
 - 5- Development of Information Schemes in Health Sector.

9- Annexes: The forms prepared for this study

Establishments, and Companies not included in Health Insurance:

Institution	Total No of Employees	Total No. ployees Members	of Em- Family	Average No. of Family Members	Gross Salary	Basic	Annual Cost	Average Cost of Treatment per Employee	CoverageRate per Employee	CoverageRate per Employee Family
Total										

Establishments, and Companies not included in Health Insurance:

Institution	Total No of Em- ployees	Total No. ployees	of Em- Family	Average No. of Family	Gross Salary	Basic	Annual Cost	Average Cost of Treatment	CoverageRate per Employee	CoverageRate per Employee
	pioyees	Members	1 allilly	Members	Salary			per Employee	per Employee	Family
Total										

Gross Number of Employees in the Public Establishments & Companies:

Institution	Total No of Em- ployees	Total No. of Employees Family Members	Average No. of Family Members	Gross Basic Salary	Annual Cost	Average Cost of Treatment	CoverageRate per Employee	CoverageRate per Employee Family
No. of Co.		Members	Members			per Employee		ramily
No. of Em-								
ployees								
Included								
No. of Em-								
ployees Not								
Included								
Grand To-								
tal								

Study 3: Health benefit schemes in Dara'a



Study of Health Benefit and Health Insurance Schemes (In the Governorate of Daraa)

Presented to:
Health Sector Modernization Program
Ministry of Health
Damascus - Syria

Prepared by:

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www.scbdi.comSCB

Nov. 2006,

Report on Health Care Services (Benefits), HI Scheme for Private & Public Sector Employees and Syndicates in Daraa Governorate

Introduced to:
Health Sector Modernization Programs
Ministry of Health
Syria, Damascus

Prepared By: Syrian Consultation Bureau

Introduction:

The European Union in agreement with the Government of Syria represented by Ministry of Health herein referred to as (MoH), aided by 30 million Euros in Technical Assistance with view to implementing improvement on Management Process and offering Health Services (Benefits) to Syrian Citizens. The following methodologies are adopted in implementation of Health Sector Management Program:

- Spreading & widening Health Villages Program in order to improve and reinforce Protective Health Care.
- Stand up to face the population transformation and special care for population management through education campaigns on Reproductive Health Services.
- Reinforcement of Health Economics Principles, Fair Rational Financing of health expenditures, developing the concept of solidarity based in line with HI Scheme.

At the end of the program, we look forward to achieving the following results:

- Developing the ability to put policies forward, training and regulation on Health at the central & branch levels.
- Securing more coherent Health Services to meet the needs of the popula-
- Improving performance at hospitals and management of health care establishments.
- Activation of a permanent framework for Health Sector Financing.

MoH supervises and assesses the program supported by Strategic Health Studies Center initiated at the beginning of 2005 containing four Institutes.(i.e. Population Studies, Health Economics, Health System Management, Public Health). The program was put for implementation in three pilot Governorates, namely Daraa, Lattakia, and Raqqa. It was marked by six axial points of work:

- 1. Studying health expenditure for family to illustrate their willingness to spend money for HI Scheme .
- 2. Studying preparation of budgets to be spent on Health Services in Ministries.
- 3. Studying demand on Health Services at private clinics.
- 4. Studying demand on drugs, medicament, and laboratory services.
- 5. Studying abundance and quality of Secondary, Tertiary Health Care.
- 6. Studying abundance Health Care Services & HI Scheme for employees in Private & Public Sector establishments and Syndicates.

SCB was assigned by MoH to launch this study on Health Care Services & HI Scheme for employees in employees in Private & Public Sector establishments and Syndicates in Daraa Governorate, as in axial point no.6 above.

SCB has prepared a questionnaire form in collaboration with MoH Personnel to apply it a randomly picked sample from this pilot Governorate. It was formed of 15 establishments from the Public Sector and Syndicates together with some Private Sector Establishments. This report is the outcome of the study including an overview of Health Status countrywide, and another overview of Daraa in particular. Then, this report introduces results of the findings on HI Scheme.

(1)- Overview of Health Status in Syria:

Expenditure on Health Sector in Syria is considered to be less than the expenditures in other countries in the Arab Region. Expenditure in Syria for Health does not exceed 60 USD per capita, and its rate does not exceed 5.1% of the Gross National Outcome. While the same rate in Lebanon & Jordan has mounted up to 10.2% & 9.4% according to the WHO Reports in 2004. The Health Sector covers about 50% of Health Expenditures in Syria, Private Sector provides the other 50%.

The 10th Five- year Plan (2006-2010) had objectives for modernizing Health Sector in it with view to transforming it into a development sector to strengthen population's public health and developing its financing systems. Among the further objectives of the Public health Plan is to improve the average of individual share of the Overall Expenditure on health so as to reach up to 100 USD. Then, moving into increasing investments in Health Sector during this five-year plan to become 300% (3 times more on condition that foreign & local Private Sector by approximately 65% of this increase).

Health Sector provides Health Services to citizens of Syria via four parties namely: Ministry of Health, Ministry of Higher Education, Ministry of Defense, Ministry of Labor & Public Affairs. Health Services being provided through hospitals, specialized Health Centers and Public Health Centers together with other Health Units belonging to these Ministries.

As for Private Sector, it delivers health services to citizens via Private Hospitals, Doctors Clinics for all specialties (Recently through the Specialized Health Clinics these doctors are managing). Usually, hospitals these are short of the basic ingredients such as "Appropriate Technical Condition & Equipment" (Except for the Main Private Hospitals). The expenses of treatment at these hospitals are so high. We find a phenomenon: many of Public Health Sector Staff Cadre work at Private Sectors hospitals, clinics and health centers as an additional job.

In spite of the concrete development in Public Health conditions for Syrian citizens in the past ten years (i.e. high rates of life expectancy & children deaths, vaccine coverage; increasing number of hospitals & beds; increasing hospital workers & doctors in Public Health Survives), still Health System is suffering from a set of problems mostly important among which are: Low Economic Efficiency, increasing Waste of Resources, Low Actual Productivity of Staff, Duplicity in the Practices of both Public & Private Sectors and poor Monitoring for Private Sector.

(2)- Population Status in Daraa Governorate:

The number of population in Daraa Governorate in 2005 reached \860.000\ equal to 4.7 % of the Overall Population of Syria\18.200.000\. Distribution of Daraa Governorate population according to gender showed almost equal numbers of Males & Females. Classification according to Age Groups as follows:

Age Group	Males	Females	Total
Less than 1	12.870	13.728	36.598
year			
1- 5 years	57.057	56.199	113.256
6-15 years	117.975	117.117	235.092
16- 49 years	207.207	208.065	415.272
50-60 years	16.302	15.873	32.175
60 years &	18.18	18.876	36.894
above			
Total	429.429	429.858	859.287
Source: Daraa G	overnorate Health	Directorate	

Health Sector in Daraa Governorate witnessed a remarkable development; thus the number of private hospital increased from 1 to 5 in 2005. Health Centers increased From 58 to 81 in addition to 4 Specialized Centers (Tuberculosis, Malaria, Diabetic Clinic, Dental Clinic) besides some other hospital under investment & construction.

(3)- HI Scheme:

In general, HI Concept is absented from the minds of all people in Syria while employees in Public Sector make benefit of HI Scheme. Sometimes, employees in Private Sector make benefit of HI Programs and Plans which secure Health Services for them through one of the following ways either:

1. The employees of Private & Public Sectors included in Social Security Schemes (Social Insurance Code No.92 on 1959 amended by Norm No.78 on2006) make benefit of Health Services offered by these schemes which cover work injuries & diseases incurred from practicing some vocations exclusively. These schemes do not cover employees family members. The allowances given to employees included in HI scheme, follows the pricing imposed by MoH for hospitals, clinics, external laboratories Services.

With regard to refunding the invoices mechanism (e.g. Pharmacy Bills), an employee who incurred an injury or a pathologic condition is given referral to Pharmacy to get the medicaments & drugs without charge. The Pharmacy refers all these referrals to Pharmacist Syndicate whose further role is to cash the expenses for these Pharmacies. The Pharmacist Syndicate is to have these expenses refunded through accounting process with Social Security Fund.

2- Based upon the fact that Health Services in HI Scheme are restricted to employees only without there families and that this Scheme covers work injuries & diseases only without other pathological cases, Public Sector Establishments resort to organizing special HI Programs for them through special monthly deductions. Employees and their family members obtain health services they need without any charge through their membership either by a referral from the institution they work for (accounting process with Social Security Fund for the expenses of the invoices), or the employee on his own refers to these service providers in without a prior referral. Later on, he/she settles the invoicesof treatment expenses to the institution he works for. The institution therefore is going to settle and spend the invoicesfor the employee committing itself to the pricing of MoH for various health services, or within the maximum expenditures approved by these Funds.

The sample of this HI Scheme study in Daraa Directorate included both cases stated above. (i.e. Employees included in HI Scheme & Employees sharing in Cooperative Funds).

1. e.g. Doctors Syndicate issue a list of the doctors who are to be visited by employees.

(4)-The Purpose of the study & Methodology of Implementation:

The study of HI Scheme, and Health Care Services for employees of Private & Public Sectors & Syndicates in Daraa Governorate aims at estimating & assessing HI Scheme currently introduces to employees at Public/Private Sector institutions & Syndicates in the Governorate in preparation for initiating an integrated HI Scheme in it.

The size of this randomly chosen sample was 15 institutions out of the Public Sector Establishments, Private Sector Companies, and Syndicates in this pilot Governorate. This study showed that only 5 out of the above mentioned institutions are offering kind of Health Insurance to their employees as follows:

- Commercial Bank of Syria CBS, Daraa Branch, which is a governmental bank, with 90 employees in it, delivers banking services such as business financing, opening miscellaneous accounts, cheque issuance & cashing, etc. This Daraa Branch applies HI Scheme in line with the regulations issued by CBS HQ, these which are based on circulation No.165 from HE, Minister of Economy & Foreign Trade in 1978 on HI services implementation.
- Daraa Electricity Company (DEC), with 1140 employees in it, subsidiary from the General Company for Distribution & investment of Electric Power at Ministry of Electric Power. DEC adopts a Social Security Scheme that covers the injuries and vocational practice incurred diseases for employees and their families in the form of a Cooperative Fund. This fund is financed by the contributions deducted from the employees salaries. Moreover, it depends on the maximums affixed by the Cooperative Fund for compensation.
- Teachers Syndicate, Daraa Branch is linked with the Central Syndicate in Damascus, and managing the affairs of teachers in Daraa, looking after their needs who toll up to /14.000/ all included in HI scheme. A scheme funded by contributions deducted from monthly salaries.

- General establishment of Potable & Waste Water (GEPWW) in Daraa whose employees are / 1550/. The mission of this establishment is to secure fresh drinkable water for the citizens in Daraa Governorate. HI scheme in it is covered via designating a share of its budget.
- Al-Qusur Fuel Station, in it there are 7 workers which was the only Private Sector participant in this sampling.

As for other institutions chosen for this sampling, it was clear that they did not have any form of HI Schemes; they are as listed below:

- From Public Sector: Directorate of Post, port Union, Veterinarian Syndicate.
- From Private Sector: Laurence Gallery, Alaa Paints Co., MohamadAwad Homsy & Partners Co., Shams al-Aseel Co., Sari & Bros Co., Scientific Library Bookshop, and Harfoosh Vegetables & Fruits Trading Co.

(5)- The outcome (Results) of this Study:

In what comes after, we illustrate the outcome of interviews in the institutions adopting HI Scheme for their Staff. Each table indicates the results from each tested institution in light of the 7 dimensional major questions.

- Membership & Participation in HI Scheme
- o Funds & Financing of HI Scheme
- Benefits offered by HI Scheme
- o The Organizational & Management Structures of HI Scheme
- Conditions of Health Care
- Risk Factor Management

1. Membership & Subscription in HI Scheme:

Results Analysis demonstrates that making use of HI Scheme implemented in 5 institutions starts promptly following the assignment of an employee. All these Schemes stipulates compulsory participation due to some reasons among which is law procedure. (i.e. Social Security Codes, Internal Regulations). Therefore, HI scheme covers all employees at those institutions.

It is worth mentioning that the employees at CBS Daraa Branch are obliged to HI Scheme in coherence with the regulations issued by CBS HQ, these which are based on Circulation No.165 from HE, Minister of Economy & Foreign Trade in 1978 on HI services implementation & organization. This circulation covers all employees of CBS, Popular Credit, Cooperative Agricultural, and Industrial Banks.

Public Sector General Administrations has contributed to the branches & Syndicates belonging to them- i.e. those which were interviewed- (Ministry of Electric Power, Ministry of Education, Ministry of Housing, CBS Central Management) through participating in decision making to introduce HI Scheme to their staff. These scheme were not put forward in line with a specific need of these companies except for Electric Power Com-

pany which was able to organize its own HI Scheme due to its particular work conditions.

Health services employees of al-Qusor Fuel Station can get does not include any coverage of worker family employees based on the fact that Social Insurance does not originally cover workers family members. In addition, HI Scheme at Water Company does not cover any family members. Contrary to these, HI scheme implemented at CBS Daraa Branch, DEC, Teachers Syndicate Daraa Branch which covers average of 5 members per employee family and their pathological cases.

It is worth mentioning here that the new Worker Legislative Code (WLC) No. 50 issued in 2004 which limits the maximum number of children included in Health Care Systems to be /3/ only. HI scheme does not cover any additional children. WLC does not include employees begetting more than 3 children prior to its issuance. See below for **Table 1: Subscription & membership in HI Scheme.**

Table 1: Subscription & Membership in HI Scheme.						
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Sta- tion	
TYPE	Public Sector	Public Sec-	Public Sec-	Syndicate	Private Sec-	
		tor	tor		tor	
Employees	90	1140	1550	12	7	
Included in HI	90	1140	1550	14000	7	
HI Beneficiaries	400	7980	0	84600	0	
Total Included & Bene- ficiaries	490	9120	1550	98600	71	
Family Includes	Wife &Children	Wife&Children	No family cov- erage	Wife&Children	No family cover- age	
Subscription Date	1970	1989	1992	1970	1974	
Contribution collected on	Directly	Directly	Directly	Directly	Directly	
Benefits given on	On assignment	On assign- ment	On assign- ment	On assignment	On assign- ment	
HI Scheme Based on need or problem	No	Risk at work	No	No	No	
External Parties having relation to HI decision	HQ & Ministry of Economy 1	Ministry of Electric Power	Ministry of housing	Ministry of Education	None	
Members Subscription on	Entry on Duty Date	Entry on Duty Date	Entry on Duty Date	Entry on Duty Date	Entry on Duty Date	
Compulsory or Voluntary Subscription	Compulsory,Circulation No.165 from , Minister of Economy & Foreign Trade in 1978	Compulsory under Internal Regulations	Compulsory under Internal Regulations	Compulsory under Syndicate Internal Regulations	Compulsory by owner (Social Insurance Code)	
Maximum Family Mem- bers included	4	6	0	5	0	
* Wives	1	1	0	2	0	
* Husbands	1	1	0	1	0	
* Parents	0	2	0	0	0	
* Children	3	3	0	3	0	
Identification of Members	Collective Card	Collective Card	HI Card with photo	Collective Card	ID	
Any Special Cases for family members	Yes	yes	No	Yes	No	

Remark 1: Belongingness of CBS was transferred to Ministry of Finance upon Prime-ministry Decision No.49/2 on 16/10/1003.

2- HI Scheme Financing:

Analysis of samples demonstrated that both DEC & Daraa Teachers Syndicate Branch together with al-Qusor depend basically on contributions to finance their HI Scheme. These contributions are raised from members as in DEC case and Teachers Syndicate for instance, or they might be collected from workers & owner as in the example of al-Qusor Fuel Station according to social Security Code without having any additional financing source. However, in the case of CEPWW, it depends on allocations in its budget to cover expenses of its HI Scheme. While CBS Branch resorts to revenue of the financial processes it does to finance its HI Scheme in light of its needs & annual allocations. **Table 2: HI Scheme Financing.**

Table 2: HI Scheme Financing.						
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Sta- tion	
Sources of HI Financing	Revenue& interest	Members Contribu- tions	Boss	Members Con- tributions	Members Contri- butions & Boss	
Additional Financing Sources	Finance Aid to cover Deficiency	Finance Aid to cover Deficiency	None	Budgetary Support	None	

With regard to contributions to HI Scheme at DEC, they are raised from the Staff Subscribers at Cooperative Fund. These contributions are monthly 2% deductions of the salaries. Contributions of Daraa Teachers Syndicate members, 95% of these are basically from the salary deductions in line with every member's income. So, they are deducted monthly then collected by Syndicate by virtue of Bank notices to get the contributors to pay their contributions.

Al-Qusor Fuel Station deducts its employees contributions from monthly salaries in cohesion with the rates in Social Security Code of 24% from Salaries the share of job owner is 17%, and the other 7% is charged on employee himself.

Neither of these three institutions apply exemptions or cut downs for these contribution rates. All depending on compulsory payment by contributors due to the fact that they are deducted as a guarantee for employees continuous contribution paid. See **Table 2-1 below**:

Institution	DEC	Teachers Syndi- cate/Daraa	Qusor Fuel Station 17% from Owner & 7% of Salary	
Contribution Source	2% of salaries	95% from teach- ers		
Quality of Contribution	According to in- come	According to income	According to income	
Amount of Contribution	2% of salaries / Partial	2% of salaries / Par- tial	Partial /400/ SYP from members	
Way of Payment	Deduction from Salary	Deduction from Salary	Deduction from Salary	
Deduction Time	Monthly	Monthly	Monthly	
Party Collecting Contribu- tions	Owner	Owner (Syndi- cate)	Social Insurance	
Monitoring Contributions Paid	None	Monthly Bank Notifications	Contribution Register Control	

Table 2-1 : Financing HI Scheme by contributions (Teachers Syndicate, Qusor Fuel Station)							
Institution	DEC	Teachers Syndi- cate/Daraa	Qusor Fuel Station				
Security Procedure to insure Payments of Contributions	Salary Deduc- tions	Salary Deductions	Salary Deductions				
Exemption, Reduction from Contributions	None	None	None				
Exempted Subscribers in- cluded	None	None	None				

3- HI scheme Benefits:

All these institutions who were interviewed depend on clarifying about Benefits a Contributor is going to obtain (Insured Employee) from HI Scheme through identification them in written standardized conditions. Identification or circulation of these conditions in brochures & kits or in meetings and/or via Service Providers (Doctors/ others).

The services and benefits are available in Programs of HI Scheme at these institutions at any time. Its value is compensated either by payment of the Overall Value of a bill (as in the case of CBS Branch, DEC, and CEPWW), or payment of part of Gross Value (as in the case of Teachers Syndicate & Al-Qusor Fuel Station). These compensation are to abide by MoH Pricing for Health Services. It id subject to the maximum fixed by HI Scheme resorted to in an institution (as in the case of Cooperative Fund at DEC).

All the institution interviewed possess additional services such as protective coverage for insured people, coverage according to what a patient pays, pension coverage, or a limited rate of private hospitalization fees. Out-of-the country treatment is also covered at CBS Branch, DEC, and Teachers Syndicate on the condition of getting the required approvals from Authorities (Prime Ministry).

It is worth mentioning with regard to the difficulty in obtaining benefits covered soon due to the procedures on getting the formal approvals which may take a long time. The interviews expressed that the most serious problems in implementing HI Scheme, by involved managements, is how to decide on the quantity of the benefits or estimation of Benefit Value (i.e. Medical Checks Expenses, Hospitalization fees, Prices of Drugs) at a lower expenses than its real value on the market, similarly referring back to the pricing of MoH which may not be correspondent to the actual value of the benefit, in addition to the technical problems & barriers facing the patients upon visiting Public Hospitals such as equipment failure & defects, long waiting times and other technical problems. See **Table 3**:

Table 3: Identificat	Table 3: Identification& Introduction of HI Scheme Benefits, Rules to obtain them						
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Sta- tion		
Introduction upon writ- ten Standardized Con- dition	Yes	Yes	Yes	Yes	Yes		
Insured People Noti- fied	Yes	Yes	Yes	Yes	Yes		
Service Providers No- tified	Yes	Yes	Yes	Yes	Yes		
Ways of giving Services	Available any time	Available any time	Available any time	Available any time	Available any time		
How Benefits are paid for	Compensation for Bills	Compensation for Bills	Compensation for Bills	Compensation for Bills	Directly Treated		
Compensation	Compensation for	Compensation for	Compensation	Compensate Per-	Compensate		

Table 3: Identification& Introduction of HI Scheme Benefits, Rules to obtain them						
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Sta- tion	
Rules	Total Bill	Total Bill accord- ing to maximum	Of Overall Bill Expenses	centage of Overall Bill Expenses	Percentage of Overall Bill Ex- penses	
Benefit Problems	Limit No. of Units according to MoH Pricing	None	None	Rarity of Services	None	
Additional HI Bene- fits	Protection	according to what a patient pays	Hospitalization Coverage 50%	Pension	Pension	
How to introduce Services	Brochures	Brochures	Via Service Providers	Through Public occasions ,meetings	Communication with Social Insurance Points	
Out-of-Country Treat- ment	Available upon Exception From PM	Available upon Exception From PM	Available upon Exception From PM	Available upon Exception From PM	None	

With regard to the main Services of Benefit Kit at these interviewed institutions, it included Laboratory Services, Hospitalization Care Services while in the hospital or Medical Treatment, add the expenses of Drugs; all these in majority are covered extensively 100% at these institutions except for DEC which covers only 50% of Drugs expenses via its Cooperative Funds. It is also noted that the compensation at some of institutions such as CBS Branch is not to exceed the expenses of Drugs (i.e. 75% for an employee family members, 100% for employee himself). However, Teachers Syndicate has a coverage rate of 50% for all benefits included in HI Scheme.

HI Scheme at DEC, CBS Branch covers Diagnosis, Chronic Diseases, Orthodontal Care, whereas it does not include Maternity at CEPWW, and Teachers Syndicate. As for Al-Qusor Fuel Station, HI Services are the ones included in Social Insurance Code which is implemented in it. That is to say, most benefits including out-patient care for chronic diseases resulting from work injuries and vocational diseases for the workers exclusively. So, it does not cover employees family members and there is not an existing maximum for compensation view to their abidance by MoH Pricing for hospitalization, Clinics, Out-clinics, See **Table 3**

	Table	e 3: Services in	cluded in HI Be	nefits	
Institution	CBS Branch	DEC	CEPWW	Teachers Syndicate/Daraa	Qusor Fuel Station
Primary Health Care	Yes,100%	Yes,100%	Yes,100%	Yes 50%	According to Social Security Code
Protective Services	-	-	-	-	-
Out-patient Care	Yes,100%	-	-	-	According to Social Security Code
Laboratory Services	According to MoH Pricing	Yes,100%	Yes,100%	Yes 50%	According to Social Security Code
Diagnosis Services	Yes,100%	Yes,100%	Yes,100%		According to Social Security Code
Inpatient Hospitaliza- tion	Yes,100%	Yes,100%	Yes 50%	Yes 50%	According to Social Security Code
Out patient Medical Care	According to MoH Pricing	Yes,100%	Yes 50%	Yes 50%	According to Social Security Code
Maternity	Yes,100%	-	Yes,100%	Yes 50%	
Drugs	Yes,100%	Yes 50%	Yes,100%	Yes 50%	According to Social Security Code
Transport		-	-		-
Chronic Diseases		Yes,100%	-	Yes 50%	According to Social Security Code
Orthodontal Care	Yes,100%	Yes,100%	-	Yes 50%	-

4- As mentioned earlier, most HI Schemes at the institutions interviewed is done through signing contracts with related Syndicates (Doctors, Dentists, Pharmacists,...). The members of these Syndicates different Services for employees either via organized referrals from institutions they work for, and the doctor, pharmacist, or dentists are to have their invoices refunded to them through the syndicate they belong to. The syndicate will have these expenses refunded to them after notifying the institution, or via direct relation between the doctor and the institution with no referral used, later on expenses are compensated to the employee by the institution according to MoH Pricing.

No remarks on registering HI Schemes at those five institutions except for Al-Qusor Fuel Station whose HI Scheme is part of Social Insurance Systems so it was registered at Social Security. At any rate, internal rules ®ulations are implemented to HI Scheme in the other four institutions. These rules are supervised by State Monitoring Authority.

Table 4: Legal Issues							
Institution	CBS Branch	DEC	CEPWW	Teachers Syn- dicate/Daraa	Qusor Fuel Station		
Legal framework of HI	Syndicate	Syndicate	Syndicate	Syndicate	General		
Is HI Scheme Registered	No	No	No	No	Yes		
Legalization applied	HI Internal regulations	Institution Inter- nal regulations	Institution Internal regulations	Syndicate Internal regulations	Social Security Code		
How HI is super- vised	Regular Audit	Supervised by Authorities	Supervised by Authorities	Supervised by Authorities	Supervised by Authorities		

5- HI Schemes Management Structures:

Direct assignment is commonly used in choosing HI Scheme Management staff at those interviewed institutions or through election by the institution they work for. Decisions made by Management Board in its meetings or via designation of Supervisory whose responsibility is to take decisions as in CBS Branch.

HI Scheme Management duties differ by institution. Sometimes, it is restricted in registering the members (at CBS Branch, al- Qusor Fuel Station), defining the terms for Health Care (at DEC,), collecting contributions from members (at Teachers Syndicate Branch), or contracting with service providers (at CEPWW). The regulations issued by this Management aim at organizing planning and financial management of HI Scheme, controlling procedures sometimes using a temporary system (at DEC, Teachers Syndicate Branch, al- Qusor Fuel Station).

It is noted that Staff Members of HI Scheme Management do not include with them devoted employees for its work. Oftenly, they include Financial Management & Administrative Staff who are responsible for follow up with HI Scheme in addition to their main duties.

Different duties such as registration of members, contribution collect, settling entitlements, planning and management, and other duties ascribed for them according to Central Management Regulations of the interviewed institutions according to specific types.

HI Scheme, in 4 Public Sector Institutions in this sampling, is financially independent. While it is independent in management since it is related to Social Security Code. See **Table 5**

7	Table 5: H	Schemes Mai	nagement S	tructures	
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Sta- tion
HI Scheme Manage- ment Staff Chosen	Assignment	Assignment	Assignment	Elections	Specified for Social Insurance
Internal Regulations made by	Supervi- sory group	Via Board meeting	Via Board meeting	Via general meeting	Specified for Social Insurance
HI Scheme Manage- ment Duties	Registra- tion	Defining Condi- tions of health care	Contracting with Providers	Contributions Collect	Registration
Members Registered by	Special format	Computerized	Management regulations	Computer- ized	Computerized
How to collect contri- butions	None	Management regulations	None	Computer- ized	Computerized
How to settle entitle- ments	Special formats	Management regulations	Management regulations	Computer- ized	Computerized
How to put conditions of Health Care	Manage- ment regu- lations	Management regulations	Management regulations	Management regulations	Special formats
How to plan & Manage Finance	Manage- ment regu- lations	Computerized	Management regulations	Computer- ized	Management regulations
How to compile Data	Special formats	Computerized	Management regulations	Computer- ized	Computerized
How to Control	Manage- ment regu- lations	Computerized	Management regulations	Computer- ized	Computerized
How to control regis- tries	Manage- ment regu- lations	Computerized	Management regulations	Special for- mat	Computerized
No. of workers in HI from staff members	0	0	1	0	Specified for Social Insur- ance
No. of Volunteers	0	0	0	0	-
Special independence for HI Scheme	finan- cial	financial	financial	financial	administra- tive

6- Health Care Conditions:

The distribution of Service Providers (Hospitals & Doctors) at the interviewed institutions includes all countryside and city in the pilot Governorate in accordance with their specialties (primary health care, specialized care for inpatients and outpatients). The patients choose visiting one of Service Providers freely according his/her pathological case out of the list of names provided by syndicates to institutions contacting with them. HI Scheme compensates in these five institutions for the out-clinics, laboratory, radiology centers, specialized syndicate hospitals invoices either via banks every 3 months or directly to the same institution.

It is worth mentioning here that CEPWW has a fixed number of medical invoicesper employee allowed to be paid back (8 Invoicesannually on condition that a bill does not exceed 300 SYP). See Table 6.

	Table	e 6: Health Ca	re Conditions		
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Station
Distribution of Providers					
*Primary Health Care	Rural+ City	Rural+ City	Rural+ City	Rural+ City	Rural+ City
*Outpatient Special- ized Care	none	Rural+ City	Rural+ City	Rural+ City	Rural+ City
*Inpatient Care (Hospital)	Rural+ City	Rural+ City	Rural+ City	Rural+ City	Rural+ City
Contracting with Pro- viders	yes	yes	yes	None	None
Compensation for out invoices	yes	yes	yes	yes	None
Choice of Providers	Free Choice	According to diagnosis	Free Choice	According to diagnosis	According to diagnosis
Clinic inside a Company	None	yes	None	yes	None
Payment for out clinics	Via Bank ever 3 moths	Via Doctors Syn- dicate monthly	Via Doctors Syndicate monthly/biannual	Directly via Syndicate	Special for Social Security
Payment for Radi- ologists & Labs	Via Bank ever 3 moths	Monthly via labs Commission / Radiologists via Doctors Syndi- cate	Via Doctors Syndicate monthly/biannual	Directly via Syndicate 50%	Special for Social Security
Payment for Hospitals	Via Bank ever 3 moths	Company Fund every 15 days	Monthly via institution or Syndicate	Directly via Syndicate 50%	Special for Social Security
Payment linked to Pharmaceutical items	According to productiondate	Per each item	According to Pharmacy Bills	Type of ma- terial	Special for Social Security
Pharmacies in Company Premises	None	None	None	yes	None
Refund to Pharma- cies	Via Bank ever 3 moths	Via Pharmacist Syndicate monthly	biannual	monthly	Special for Social Security
Monitoring the Pharmacies	Directly by bank	More than500 SYP via Medical Treatment Office	None	Directly via Syndicate	Special for Social Security
Payment basis for Drugs	Per Item	Per Item	Prescription price	Net price with fixed margin	Per Item

7- Risk Factor Management:

Danger and risks that HI Scheme may potentially undergo are diverse in general. There might be management risks resulting from regulations related to registration admission of the members in HI Scheme. They may be financial when compensation for the employee has taken place either, so Managements of HI Scheme take precautionary measures to avoid incurring such risks (e.g. focusing on employees with less risk factors or excluding others with chronic cases. AIDS cases are not covered at all). In principle, none of the pilot institutions adopts specified rules with regard to avoiding these two types of risks, even they consider compulsory subscription to HI Scheme according to the rules & laws as a means of avoiding risks.

Although any employee is not assigned to any public post except after producing a document from MoH, these documents are formalized and they do not mirrorize the Health Status of the employee. They do not also monitor potentials of employee incurring diseases in future; therefore, HI Scheme at one institution is likely to cause facing different risks. The clue for having no financial or management risk fighting procedures is that , for example at CBS Branch, when the expenses on an employee exceeds the

specified shares by Management, the extra burden is going to be loaded to the specified funds at Headquarters of the Bank. See **Table 7**.

Table7: HI Scheme Risk Management							
Institution	CBS Branch	DEC	CEPWW	Teachers Syndi- cate/Daraa	Qusor Fuel Station		
Compulsory Rules for avoid- ance of Risks	Compulsory for Members	Compulsory for Members	Compulsory for Members	Compulsory for Members	Compulsory for Members		
Managing Administrative Risks	Depend on MoH Document	No coverage of specific cases AIDS	No coverage of specific cases AIDS	No coverage of Administrative Risk	Special for social Insurance		
Managing Financial Risks	Support by HQ	External HI for specific risks	External HI for specific risks	External HI for specific risks	Special for social Insurance		
Out-of- Institution HI Scheme	None	None	None	None	Special for social Insurance		

(5)- CONCLUSION:

this study showed that total absence of HI strategies for citizens and Public Sector employees. Although, HI Scheme plans are available in some Public and Private Sector institutions, they do not cover except a minor part of treatment expenses & Healthcare Services. The citizens who are not employees as well do not have any form of Public HI Scheme.

Sample analysis from Daraa Governorate illustrated the Benefits of HI Schemes in institutions, syndicates subject of this study included a wide range of Healthcare Services including treatment (inpatients & outpatients), Hospitalization, Drugs. Other Schemes included healthcare and other services such as covering expenses of chronic diseases, maternity and orthodontal care.

Social Security Schemes also cover both Public and Private Sector employees but not their family members. They do not cover vocational injuries so far. Based on this , they resort to establishing Cooperative Funds which are funded via deductions from the salaries to cover Healthcare Services the employee or his/her family members need. These institutions depended on contributions of members to finance their HI Schemes. Those contributions are directly deducted from the salaries added to other Financing Resources (sometimes External ones), in most of the cases these are from the budgets of Central managements or of Institution.

HI Schemes at the pilot institutions were punctuated by abundance of benefits at any time. In many cases, the overall cost of a bill is compensated for, but in cohesion with MoH Pricing in estimation of the fees for services.

It is here worth to be mentioned with regard to MoH Pricing that it is not the actual value a patient bears. These HI Schemes were marked by direct supervision & monitoring of State Authorities or Internal Monitoring in the institution itself. It is also noted that there were no devoted employees in the Management of HI Schemes with no clear strategies for risk administration in the same HI Schemes.

Executive Summary

Study of Health Benefit and Health Insurance Schemes In The Governorate of Daraa

Objective of the assessment

The Ministry of Health in Syria has asked the Syrian Consulting Bureau (SCB) to conduct an assessment of health benefit and health insurance schemes in the governorate of Daraa. The project is part of the EU financed Health Sector Modernization Program, which aims at enhancing the health status of the Syrian population through improved equity, efficiency and quality of the health system. The main components of the Program are:

- 1. Strengthening the capacity at the central and regional levels for policy, planning and regulation;
- 2. Adapting the Ministry's health care delivery system to the needs of the population;
- 3. Enhancing the management capacity in health care facilities;
- 4. Improving the performance of hospitals;
- 5. Establishing quality management and accreditation processes; and
- 6. Establishing a framework for sustainable financing of the health sector;

For establishing a framework for sustainable financing of the health sector (the 6th component of the Program, mentioned above), the Program required assistance in assessing the health benefit and health insurance schemes of various institutions (Teachers Association, Workers Union, Dentists Association, private and public companies, etc.) in the governorates of Raqqa, Daraa and Lattakia. SCB was selected for assessing the health benefit and health insurance schemes in the governorate of Daraa. The overall objective of the assignment is to discover, describe and analyze existing health insurance schemes of private and public companies and syndicates in Daraa.

<u>Introduction</u>

Employees in the public and private sector in Syria benefit from health insurance and services in one or both of two ways:

1.A compulsory social insurance scheme administered by the General Establishment of Social Insurance (Law No 92 of 1959 amended by Law No 78 of 2006). This scheme only covers work-related injuries and does not provide insurance for the employee's family members. Members within this scheme are compensated for hospitals and lab services according to the Ministry of Health's pricing system. As for the payment of invoices, in the case of pharmacies for example, the patient is given a transfer document to give to the pharmacy in order to obtain his drugs. The pharmacy then transfers all the documents to the pharmaceutical syndicate who then

pays the pharmacy (the syndicate is reimbursed later by the General Establishment of Social Insurance).

1. Since the services provided by the above social insurance scheme are not sufficient to cover all the health needs of employees and also does not cover their families, some public institutions have opted for setting up an internal cooperative fund and contracted with various health related syndicates to provide services for their employees. The fund is financed through monthly contributions from members (direct reductions from their salaries). Members have access to health services through formal transfer documents provided by the employer. The member may also pay upfront and be reimbursed later.

The sample covered in our study included cases that fall under the first method and cases that fall under the second method

Methodology and Coverage:

SCB began by conducting field visits to public and private institutions and syndicates in Daraa, using an assessment questionnaire (based on the InfoSure Methodology) which was developed in collaboration with the project's Manager at the Ministry of Health. A total of 15 institutions were visited of which only 5 had existing health insurance schemes, these five institutions are the following:

- 1. The Commercial Bank of Syria (Daraa Branch): CBS is a public bank consisting of 90 employees and provides various banking services. A health insurance scheme is provided to the bank's employees, based on directive No165 of 1978 issued by the Ministry of Economy and External Trade, which requires all public banks in Syria to provide health insurance (other than social security) to its employees.
- 2. The General Electricity Company of Daraa: The Company consists of 1140 employees and has in addition to the regular social security services (which only covers work-related injuries), its own health insurance scheme covers all employees and their families in the form of a cooperative fund. The fund is financed by the employees' monthly contributions from their salaries.
- 3. **Teachers Syndicate (Daraa Branch)**: The syndicate consists of 14,000 members (i.e. teachers) who are covered by a health insurance scheme funded by monthly contributions from their salaries.
- 4. The General Establishment of Potable Water and Hygienic Drainage Daraa: The establishment consists of 1550 employees who are covered by a health insurance scheme funded by the Establishment's yearly budget.
- 5. **Al Qsour Petrol Station:** This is a private petrol station consisting of 7 employees and provides health services to its employees through the country's social security system.

The ten other establishments visited (3 from the public sector and 7 from the private sector) did not have any special health benefit or health insurance scheme.

Major Findings:

The study was divided into seven subparts covering each of the following areas of the interviewed insurance scheme:

- 1. Membership in the insurance scheme
- 1. Financing of the insurance scheme
- 2. Benefits of the insurance scheme
- 3. Legal issues of the insurance scheme
- 4. Administrative issues of the insurance scheme
- 5. Healthcare conditions
- 6. Risk management

The major findings within each of the above noted subparts are as follows:

1. Membership & Subscription

In all five institutions interviewed a member could benefit from the existing health scheme as soon as the employee joins the company. In addition, the membership in all the institutions was compulsory. The Commercial Bank of Syria in Daraa is obliged to cover all its employees according to guidelines based on Directive No.165 of 1978, referred to earlier. None of the schemes in place were set up based on a specific need with the exception of the General Electricity Company of Daraa due to its nature of work. Out of the five institutions interviewed, only three had their schemes benefiting members of the families (and not just the employee). These are: The Commercial Bank of Syria (Daraa Branch), The General Electricity Company of Daraa and the Teachers Syndicate (Daraa Branch).

2. Financing of the Insurance Scheme

The sample demonstrated that each of the General Electricity Company of Daraa, the Teachers Syndicate and the Al-Qsour Petrol Station depend on contributions to finance their heath insurance schemes. The contributions come either from the employees as in the case of the former two institutions or from both the employee and the employer as in the case of the Al Qsour Petrol Station (accordance to the country's social security scheme). The Water Establishment and The Commercial bank of Syria have allocations in their budgets for health services. Within the General Electricity Company of Daraa employees who are members in cooperative fund contribute an amount equivalent to 2% of their salary. Ninety five percent of the financing of the health insurance scheme within the Teachers Syndicate come from contributions of the teachers; the contribution amount is based on their income. Since the Al Qsour Petrol Station has the country's Social Insurance scheme in place, its employees pay 7% of their salary on a monthly basis while employers contribute amount to 17%.

3. Benefits of the insurance scheme

Employees within all the institutions interviewed have access to the benefits offered by the health insurance schemes at any time. Benefits are paid either by compensating the total value of the invoice (Commercial Bank of Syria, General Company of Electricity, General Establishment of Potable and Hygienic Drainage) or by compensating a percentage of the total value of the invoices (Teachers Syndicate & Al Qsour Petrol Station). Payment is either based on the Ministry of Health's pricing system or the ceiling of the cooperative fund in the case of the General Electricity Company of Daraa.

All institutions interviewed provided additional benefits such as retirement, half coverage of private hospitals or coverage for treatment abroad (which is available in the case of The Commercial Bank of Syria, the General Electricity Company of Daraa and The Teachers Syndicate). It is worth noting however that international coverage is quite difficult to obtain requiring many formal bureaucratic procedures.

The main problems of the health insurance schemes cited by most of the institutions include estimating the value of the benefits, identifying the quantity of benefits and the dependence on the pricing of the Ministry of Health, which does not reflect the prices in the market, in addition to technical difficulties faced by public hospitals.

The main benefits offered by the health insurance schemes covered in the study include laboratory services, hospital care (lodging & surgery) in addition to medical drugs benefits which are covered in most institutions by 100 % (The General Electricity Company of Daraa covers only 50 % of drugs). The Commercial Bank of Syria only covers 75 % of the value of drugs for the employee's family members (while employees are covered 100%). As for the Teachers Syndicate, all cases within their scheme are only covered by 50%. The health insurance scheme within each of the Commercial Bank of Syria and the General Company of Electricity covers dental care and chronic diseases while the Teachers Syndicate and the General Establishment of Potable and Hygienic Drainage cover maternity. As for Al Qsour Petrol Station, it covers all health services within the country's social security schemes which includes only work-related health injuries and does not cover family members.

4. Legal issues of the insurance scheme

As stated previously, all institutions interviewed contracted with syndicates (doctors, dentists, pharmaceutical) to implement the insurance coverage of their members through transfer documents given to patients with payment paid by the syndicate, or through direct payment by the patient who is later reimbursed according to the pricing of the Ministry of Health. None of the insurance schemes covered within the study was registered legally with the exception of that of Al Qsour Petrol Station since it is associated with the General Establishment of Social Insurance.

5. Administrative issues of the insurance scheme

Staff members working within the administrative body of the insurance scheme are either elected or designated from the institution's management. The tasks of the administrative bodies of the insurance schemes identified in the study vary from collection of contributions, memberships, identification of healthcare conditions to contracting with providers. The administration is also responsible for financial planning and control which is sometimes implemented using a computerized system as in the case of the General Company of Electricity. The study revealed that all the insurance schemes have financial autonomy with the exception of that of Al Qsour Petrol Station which has administrative autonomy, since it is linked to the country's social security scheme.

6. Healthcare conditions

The providers which have contracted with the insurance schemes are located within both urban and rural areas. The patient is free to choose the provider from a given list provided by the Syndicate. The insurance scheme compensates the providers such as private clinics, hospitals and laboratories either through the associated syndicates every 3 months or directly to the provider. It should be mentioned that in the case of the General Establishment of Potable and Hygienic Drainage, there is a limit regarding the number of invoices per patient (8 annual invoices each not exceeding 300 SYP)

7. Risk management

None of the institutions interviewed have any sort of risk management procedures (whether financial or administrative) in place for its health insurance scheme. Every new employee must submit a health document issued by the Directory of Health before being allowed into the health insurance scheme. However, the document submitted does not provide an accurate picture of the member's health status which in turn puts the health insurance scheme within major financial risks. To counteract such risks, some institutions such as the Commercial Bank of Syria transfer the financial cost of a patient who is costing a lot, to the Bank's main branch. But in general the study showed that there was no clear strategy for risk management within any of the institutions interviewed.

As a final statement, the medical and social insurance schemes at the governorate of Daraa are underdeveloped and lack strategies that govern such schemes. There is no government sponsored health scheme covering all citizens (employed or not employed in the country). At the same time employed citizens of governmental institutions are partially covered; the services offered do not cover needs, and the amount paid are modest compared to actual medical expenses

Study 4: Health benefit schemes in Lattakia

SYRIAN MINISTRY OF HEALTH





EU-Syria

Health Sector Modernisation Programme

Existing Insurance Schemes Evaluated and Approaches for a Unified System Proposed in Lattakia governorate

Study No.4

Final Report –July 2006



Prepared by: MCI International

Evaluation of Insurance Plans in Lattakia Governorate:

(Study No.4) Final Report July 2006

Prepared By: MCI International

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1-Scope & objective of this Study:

This Study aims at focusing on 11 different Governmental Establishments in Lattakia Governorate and its goal is:

- Modifying certain number of HI Schemes implemented in these 11 different Governmental Establishments in Lattakia Governorate.
- o Collect & analyze data on these HI Schemes and their characteristics.
- o Description of the major characteristics of the main Schemes.
- Description & diagnosis of barriers and difficulties in these Schemes, trying to sort them out then giving initial suggestions & recommendations to remedy them.

2- Methodology of this Study: It is divided into 3 major stages:

2-1**Stage 1**:

It is the Preparation stage, a series of workshops was held with MCI, HSMP Experts, Planning Directorate at MoH with view to agreeing on the forms of the Questionnaires in the most convenient way so as to be fit with the scope and the purpose of this study.

2-2 **Stage 2**:

This stage is considered to be the planning & training for the project. For this purpose, MCI International's experts were trained on how to deal with the data outcomes of Stage 1, and the factual resources required to complete the study were secured, particularly with regard to programs mostly appropriate for completion of this Study. The statistical program which was chosen is (SSPS version 13.0 for Windows)

2-3 Stage 3:

In this stage, the study implemented (SSPS version 13.0 for Windows) to use it in arranging & analyzing the results. We were aided by other statistics carried out by Central Office of Statistics. Essentially the version of statistics of 2005 which is up-to-date.

3- Essential information of Lattakia Governorate:

It is located 320 km to the North west of Damascus, and it has a major sea port in it. It is considered as the largest tourist attraction among Syrian Governorates.

3-1 Its Population & Demographical Facts:

The population of Lattakia Governorate is 890.000, their percentage to the overall population of Syria is 4.91%.

Table 1 shows the percentage of this Governorate to the overall population of Syria together with the Average of Population Growth through out other previous periods up till now.

<u>Table 1</u> : Percentage of Lattakia Governorate & Annual Average of Population Growth AVPG: Results of Population Count (1981-1994) AVPG: (1995-2000/ 2000-2005)											
Governorate	AVPG per 100	00		Governorate's	•	Percentage	to				
				Overall Count of Population							
	1981-1994	1995-2000	2000-2005	1981	1994	2004					
Lattakia	22.6	19.3	17.5	6.1	5.4	9.4					
Grand Total	33.0	27.0	24.5	100	100	100					

We can see from the table that a drop in the Growth at this Governorate (0.0017.5) compared to the Average of Population Growth in Syria (0.0024.5) during (2000-2005). The total Population No. of Lattakia Governorate out of Overall Population has dropped during (1981-2004) by 1.2%.

The source of Tables 1-15 is Statistical group/ E- version issued by Statistics Office-Damascus/ 2005.

Table 2 shows us the rates of Gender & Demographical Density in Lattakia Governorate:

Governorate		<u>Table2:</u> Rates of Gender & Demographical Density of Lattakia Governorate (1970-1981-1994-2004)								
	No. of	f Males for 0 Females		,						
	1994	2004	1970	1981	1994	2004				
Lattakia	104.8	102.0	169	241	324	383				
Grand Total	104.7	104.5	34	49	74	96				

Table 3 shows the Proportional Demographical constituents of Lattakia Governorate according to Gender ,Age Groups, Residence Place in Mid-2005.

<u>Table 3</u> : Proportional Demographical constituents of Lattakia Governorate according to Gender ,Age Groups,& Residence Place in Mid-2005.											
Governorate	Urban P	laces		Rural Places			Total				
	Males	Females	Total	Males	Females	Total	Males	Females	Total		
Lattakia	230	225	455	220	216	436	451	440	819		
Grand Total	4977	4728	9705	4291	4142	8433	9288	8870	18138		

3-2 Workforce:

this Table shows the No. of Proportional Distribution Unemployed Population in Lattakia Governorate.

Table 4: Prop	<u>Table 4</u> : Proportional Distribution Unemployed Population in Lattakia Governorate according to												
Gender Total Population of Syria.													
Governorate Previously Unemployed Unemployed(No job be- Total													
		T = .		fore)	· - ·			T					
	Males	Females	Total	Males	Females	Total	Males	Females	Total				
Lattakia	3.9	6.2	4.2	9.9 17.3 12.1 9.5 17.0 11.7					11.7				
Grand Total	100	100	100	100	100	100	100	100	100				

Table 5 shows distribution of work injuries in Lattakia Governorate. The percentage appears as 12.7% out of the Total Work Injuries in Syria. It is considered to be second highest rate in the country compared to other Governorates.

Table 5 : Work Injuries in Syria according to the nature of work the injury was incurred in during 2004 in Lattakia Governorate										
Gover- norate	Machinery	Lift Equipment	Other Equipment	Hazardous Material & Radioactivity	_	Other Types not mentioned	Total			
Lattakia	328	271	94	-	1481	75	2249			

2326	971	820	213	10613	2744	17687

Table 6 shows that work force in Lattakia Governorate depends mainly on Agricultural Sector. It constitutes 30.6% of the Workforce of the Governorate.

Table 6 : Distribution of Workforce in Lattakia Governorate according to Gender & economic sectors.									
1970 1994 1999 2001									
Workforce percentage/ Population	25.6	29.3	42.3	44.4	%				
Women workforce out of Gross Workforce	17.1	23.2	35.8	35.2	%				
Workforce according to the economic	sectors								
Agriculture	55.2	25.1	51.6	36.6	%				
Industry	10.6	11.3	11.2	20.5	%				
Other Activities	33.9	63.6	37.2	48.9	%				

3-3 Health Factors & Indicators:

It is noted that Lattakia Governorate occupies position no.5 if compared to the rest of Governorates in Syria with regard to the Number of Health Doctors, Pharmacists and Orthodontists in it. It also occupies position no.8 as for the number of Technical Assistants, and position no.6 for number of Licensed Midwives. However, all these indicators drop sharply with regard to population coverage rate per each doctor. We can see that this coverage rate has taken position no.12 for doctor, orthodontists as well.

Table 7: C	Table 7: Comparison of No. of Health Professionals in Syria & Lattakia Governorate(1999-2004)										
	Health Doctors		Orthod	ontists	Pharma-	Technical	Licensed	Nursing			
Years	Count	Average of population per doctor	Count	Average of population per doctor	cists	Assistant	Midwives	Staff			
1999	21393	753	10694	1506	8189	11233	4832	25680			
2000	22408	728	11160	1462	8868	12030	4909	27164			
2001	23784	703	12228	1267	9882	13339	5081	27913			
2002	25073	683	14610	1172	10055	14057	5171	28325			
2003	24473	717	14917	1176	10809	14798	5184	27045			
2004	25890	694	15312	1174	12724	16542	5443	28665			
Lattakia Gover- norate	2126	426	1223	740	717	814	411	3508			

Table 8 shows that Lattakia Governorate Average population per hospital bed is lower in the classification compared to other Governorates in the country. It occupies (No.10) and it is lower even at the Overall level in the country. This therefore necessitates efforts to be exerted to increase hospitals & beds as well.

Table 8: He	Table 8: Hospitals & Beds in Syria & Lattakia Governorate								
Years	Public F	lospitals	Private Hospitals Total		Total		Average Popu-		
	No.	Beds	No.	Beds	No.	Beds	lation per bed		
1999	63	12202	312	5567	375	17772	842		
2000	65	12518	325	5852	390	18370	830		
2001	67	12418	336	6003	403	18421	848		
2002	66	14311	343	6343	409	20654	829		
2003	76	15227	364	6590	440	21817	804		
2004	78	15487	376	6795	454	22282	807		
Lattakia Governorate	4	1029	12	225	16	1254	722		

Tables 9 to14 show Medical Indicators and the level of Medical Services offered.

Table 9:Total Services by MoH in Lattakia Governorate in 2004					
Governorates	Health Centers Hospitals Emergency Total				
Lattakia	1162895	980873	150765	2294533	
Total	25066201	14450391	3043440	45260032	

	Table 10: Health Centers: General & Specialized in Lattakia Governorate					
in 2004						
Year	General HCs	General HCs Specialized GrandTotal HealthPoints Polyclinics HCs				
Lattakia	98	2	100	12	-	
Total	1175	43	1218	255	14	

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Table 11:	Table 11: Progress of work in Health Centers in Lattakia Governorate in 2004													
Governorate	Children	Tetanus	Pregnant	Family	Safe	Healt	Health	Nutrition	Remedy	Dental	Labora-	Vaccina-	Poly-	Total
	Vaccines	For	Care	Plan-	Child	h	Moni-	program	Service for	Care	toy Ser-	tion Cam-	Clinic	
		Women		ning	Clinic	Edu-	toring		Patients		vice	paign		
						cation								
Lattakia	185796	1836	5890	31507	24494	28456	3997	71392	228269	141795	92132	79179	0	901070
Total	6155489	487107	98242	650582	434883	25359	10699	704960	3434346	106244	176999	1397233	1237157	17703036
						4	8			3	8			

Table 12 : Pa	Table 12: Patients Progress in MoH Hospitals in Lattakia Governorate in 2004							
Governorate	Out Clinics	Emergency	Surgeries	Laboratory	Radiography	Physiotherapy	Endoscopies	Dialysis
		out patient	_	Services				-
Lattakia	230761	150765	18271	577451	120858	1817	22252	9553
Total	2145161	3043440	425357	9556798	1646361	172185	370112	129848

Table 13 : Pa	Table 13: Patients Progress in Private Hospitals in Lattakia Governorate in 2004							
Governorate	Out Clinics	Emergency out patient	Surgeries	Laboratory Services	Radiography	Dialysis	Physiotherapy	Endoscopies & Graghies
Lattakia	6085	19	8938	2015	2239	-	-	-
Total	233165	254999	116606	800685	181218	3854	2087	18938

Table 14: Patients of	f MoH 1999-2004.		
Year	Total In patients	Total Out pa-	Average stay
		tients	days
1999	1653531	1680823	2.572
2000	1672139	1675694	2.48
2001	1912939	1653980	2.37
2002	1983883	1737268	2.36
2003	2038552	1736252	2.29
2004	2244386	1776178	2.201
Lattakia Gover-	169042	138536	2.85
norate			

3-4 Syndicates & Aid Funds:

Table 15 shows the number of Syndicates members and the number of their laborers in Syria. Comparing these numbers to the numbers of Lattakia Governorate. This Table shows us that Lattakia Governorate contains 8.8% of the Syndicates in Syria and 8.5% of the Overall number of Syndicates members in Syria.

As for the rate of benefit from Aid Funds 10.8% compared to the rest of Governorates in the country. It is comes third in benefit of these Funds.

Table 15: laborers Sy	Table 15: laborers Syndicates, Members & Aid Funds, Lattakia Governorate 1999-						
2004.	2004.						
Year	Syndicates	Members	Aid Funds				
1999	194	711527	187				
2000	194	738286	189				
2001	194	740739	188				
2002	194	752419	188				
2003	205	754380	207				
2004	204	783757	205				
Lattakia Governorate	18	76251	22				

4-Essential Data about Companies:

After completing field studies about 11 governmental establishments in Lattakia Governorate, those applying sorts of HI schemes. The contents and how to fill in the information of this study was passed over to these companies in cooperation with Directorate of Health (DoH), Lattakia. The establishments appeared to be promptly responsive.

Tables 16 shows the names of establishments that are studied:

Table 16 Nar	Table 16 Names of Institution/Establishment & the Overall No. of Employees					
Serial*	Name of Establishment	Overall No. of Employees				
1	Directorate of Technical Services	2172				
2	Productive Credit Bank	50				
3	General Company of Lattakia Port	2787				
4	Coast Basin Company	2700				
5	Fabrics Company	1188				
6	Railway Company	1130				
7	Company Electricity Company	2400				
8	General Company for Fuel Distribution & Storage	452				

Table 16 Names of Institution/Establishment & the Overall No. of Employees					
Serial*	Name of Establishment	Overall No. of Employees			
9	Post Establishment	250			
10	Directorate of Real-estate	483			
11	General Tobacco Company- Coast Branch	7552			

We mention Serial No. for convenience.

We agreed with the directors of these companies and in cooperation with DoH Lattakia to make field visits to meet HI Scheme principal Officers & Executives.

4-Essential Data about the Establishment of HI Scheme:

Time elapsed foe getting the information and ranged from 1 hour to an hour and a half or two hours. This is a good indicator to obtaining information easily and the desire of people to pass these information. Table No. 17 shows the duration of interviews with the Officers of HI Schemes

Table 17 sh	Table 17 shows the duration of interviews					
Serial	Establishment / Institution	Duration of Interview (Hour)				
1	Directorate of Technical Services	1.5				
2	Productive Credit Bank	1.5				
3	General Company of Lattakia Port	2.00				
4	Coast Basin Company	2.00				
5	Fabrics Company	1.5				
6	Railway Company	1.00				
7	Company Electricity Company	2.00				
8	General Company for Fuel Distribution & Storage	1.5				
9	Post Establishment	2.00				
10	Directorate of Real-estate	1.5				
11	General Tobacco Company- Coast Branch	2.00				

The analysis of the forms identifies that 63.6 % of the 11 establishment cases were able to tell the date of establishing their HI Scheme. Whereas, 36.4 were not able to tell these dates, simply unknown to them.

Table 18 in	Table 18 indicates the dates of HI Schemes Establishment					
Serial	Establishment / Institution	Dates (Period)HI Schemes Estab- lishment				
1	Directorate of Technical Services	From2-3 years but the exact date not known				
2	Productive Credit Bank	Since the Fifties of 20 th Century				
3	General Company of Lattakia Port	1950				
4	Coast Basin Company	1985-1990				
5	Fabrics Company	1976				
6	Railway Company	Not Known				
7	Company Electricity Company	Not Known				
8	General Company for Fuel Distribution, Storage	1977				
9	Post Establishment	Since post was first established ,not exactly known				
10	Directorate of Real-estate	1976				
11	General Tobacco Company- Coast Branch	1958				

Upon analysis of the data that are related to the information about the foundation period of these HI Schemes, we found that there were not any information at hand. So, any shortage is attributable to the period of establishment which mostly date back to more than 29 years. This, of course, necessitates these Schemes to be reviewed and updated to fit in for the current situation in these establishments or institution.

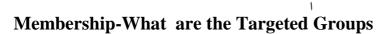
6-Membership in HI Schemes:

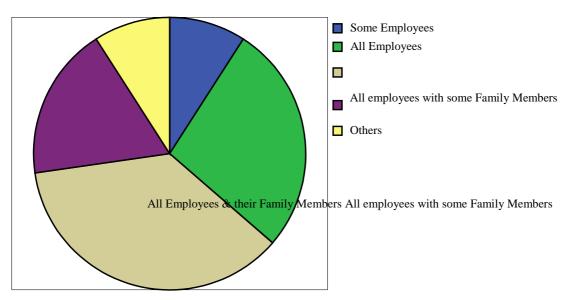
Table 19 indicates Membership in HI Schemes Establishment			
Serial	Establishment / Institution	Membership in HI Schemes	
1	Directorate of Technical Services	All employees, 1 st wife, children, their	
		mothers& fathers	
2	Productive Credit Bank	Employee, 1 st wife, 3 children	
3	General Company of Lattakia	All employees, family members in a	
	Port	limited scope	
4	Coast Basin Company	All employees, all their families	
5	Fabrics Company	All employees, without their families	
6	Railway Company	All employees, all their families	
7	Company Electricity Company	All employees, all their families	
8	General Company for Fuel Dis-	All workers, without their families	
	tribution, Storage		
9	Post Establishment	All workers, without employees or	
		families	
10	Directorate of Real-estate	All employees, all their families	
11	General Tobacco Company-	All employees, all their families	
	Coast Branch		

Upon analysis of the data that are related to the information related to membership in HI Scheme (Table No 19), we can see 36.4% of HI Schemes cover the employees and their families, and 27.3% cover the employee alone. 27.3% of these partially cover the employees and their families (limitations such as a first wife and three children). 9.1% of these HI Schemes cover all the employees as much as it is restricted to a group making distinction between workers & employees. Table No. 20 shows facts as such:

Table 20: Types of Membership in HI Schemes			
Types of Targeted Catego-	Number	Percentage	Cumulative
ries			Percentage
Some employees	1	9.1	9.1
All employees	3	27.3	36.4
All employees, all their family members	4	36.4	72.7
All employees, some of their family members	2	18.2	90.9
Other	1	9.1	100.0
Total	11	100	-

Figure 1: Illustrates the distribution of the targeted categories: Membership. What are the targeted categories?





Having analyzed & studied the status of the figures & numbers that have been collected about the beneficiary members of this HI Scheme, we found out that many of the numbers were not documented or known. Therefore, we made the option to consider the average of family members is (6 members: Father, Mother & 4 children). Except for the cases in which the number of wives & children was mentioned, so we adjusted the criteria of analysis. See please Table No. 21. the Estimated Overall Number of family members, who are beneficiaries of HI Scheme, is stated. Together with the number of beneficiaries.

Table 21: Mer	<u>Table 21</u> : Membership in HI Schemes			
Serial No.	Overall No. of Employees	Number of Beneficiary Employees	the Estimated Overall Num- ber of family members	
1	Directorate of Technical Services	2172		
2	Productive Credit Bank	50		
3	General Company of Lat- takia Port	2787		
4	Coast Basin Company	2700		
5	Fabrics Company	1188		
6	Railway Company	1130		
7	Company Electricity Company	2400		
8	General Company for Fuel Distribution & Storage	452		
9	Post Establishment	250		
10	Directorate of Real-estate	483		
11	General Tobacco Company- Coast Branch	7552		

The number of family members considered to be 5 according to the criteria set by the establishment.

7- Financing in HI Schemes:

As a matter of fact, to find a sustainable financing for HI is considered to be one of the most important things which pose limitations to the efficiency & comprehensiveness of HI Schemes. Upon comparing the results, according to Table No. 22, we found out that 90.9% of the institution depend on self-financing via allocation of lump sums out of the Budget of an establishment to be refunded to Health Insurance for the employees.

Table No.22 Financing- Financial Resources- are they raised from the Establishment/Company			
	Number	Percentage	Cumulative Percent-
			age
Yes	10	90.9	90.9
No	1	9.1	9.1
Total	11	100	100

On the other hand, according to table No.23- we can see that 27.3% of these establishments depend on deducting certain percentage of the salaries to cover Insurance of the employees and their families. This is in three cases as we can find.

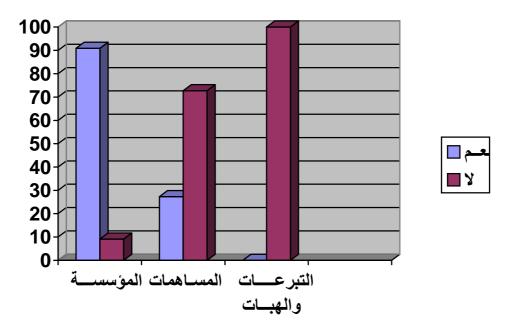


Table No.23: Financing- Financial Resources- are they raised from Contributions			
	Number	Number Percentage	
			age
Yes	3	27.3	27.3
No	8	73.7	73.7
Total	11	100	100

However, we can find that financing does not depend on any studied schemes, depending this time on Contributions.

Table No.23: Financing- Financial Resources- are they raised from the donations			
	Number Percentage		Cumulative Percent-
			age
Yes	0	0	0
No	11	100	100
Total	11	100	100

Figure 2: Illustrates the distribution of the financial Resources on HI Schemes according to the financing source

Legend:

Fromleft to right, (Institution, Contributions, Donations)

Blue: means "Yes" Purple: means "No".

<u>8- Services (Benefits) HI Scheme offers</u>:8-1 Nomination & designation of these benefits:

The benefits offered by HI Scheme to the beneficiaries can be classified into 15 categories as in Table No. 25:

Table 25: HI Scheme Benefit/ Services			
Serial No.	Benefit/ Services		
1	Protective Services		
2	Out-clinics		
3	Laboratory Services		
4	Diagnosis services		
5	Medical Care(in-patient)		
6	Medical Care at hospital		
	(drugs)		
7	Minor Surgeries		
8	Major Surgeries		
9	Treatment out-of-the country		
10	Maternity Care		
11	Acute Cases Drugs		
12	Chronic Cases Drugs		
13	Transportation		
14	Orthodontic Care		
15	Chronic Diseases		

All the above stated Benefits shall take the format of one of the following cases, "Obligatory, Optional, or Not included in HI Scheme ". Table No. 26 indicates the distribution of the Benefits: according to Establishments.

Table 2	Table 26: Distribution of Benefits according to Establishments												
Estab- lish- ment Code*	Protec- tive Ser- vices	Specialized Out Clinics	Laboratory Services	Diagno- sis Services	Minor Surgeries	Major Sur- geries	Out-of-the Country Treatment	maternity	Acute Case Drugs	Chroni c Case Drugs	Transport	Dental Care	Chronic Diseases
1	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	-
2	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes
3	No	Yes	Yes	Yes	Yes	Yes	Yes	Optional	Yes	Yes	No	Yes	Yes
4	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
8	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	No	Yes	Yes	Yes	Optional	Yes	No	Yes	Yes	Yes	No	Yes	Yes
10	No	No	Yes	Yes	Yes	Yes	Optional	Yes	Yes	Op- tional	No	Yes	Optional
11	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Total	11	11	11	11	11	11	11	11	11	11	11	11	11

^{*} Same Serial No. as in Table No. 16.

The results of analysis will be stated each result of a service aside with regard to its inclusion in HI Scheme.

8-1-1 Protective Services:

Table No.27: Protective Services				
	Number	Percentage	Cumulative Percent-	
			age	
Yes	6	54.5	54.5	
No	5	45.5	100	
Optional	0	0	100	
Total	11	100	-	

8-1-2 Specialized Out- clinics

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Table No.28: Financing- Financial Resources- are they raised from the donations						
	Number	Number Percentage Cumulative Percen				
			age			
Yes	1	9.1	9.1			
No	10	90.9	100			
Optional	11	0	100			
Total	11	100	-			

8-1-3 Laboratory Services:

o . o Euporato	O 1 O Edbordtory Corvicco.				
Table No.29: Laboratory Services					
	Number	Percentage	Cumulative Percent-		
			age		
Yes	11	100	100		
No	0	100	100		
Optional	0	0	100		
Total	11	100	-		

8-1- 4 Diagnosis Services:

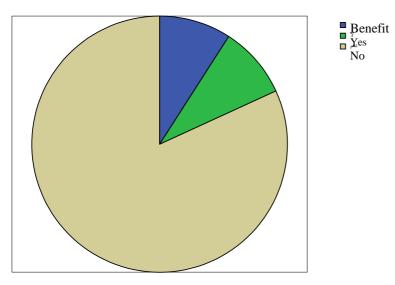
or a Blagheole Colvidee.					
Table No.30: Diagnosis Services					
	Number	Percentage	Cumulative Percent-		
			age		
Yes	11	100	100		
No	0	0	100		
Optional	0	0	100		
Total	11	100	-		

8-1-5 Medical Care at Hospitals: "Admission"

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Table No.31: Medical Care at Hospitals "Admission"					
	Number	Percentage	Cumulative Percent-		
			age		
Yes	9	81.8	81.8		
No	1	9.1	90.1		
Optional	1	9.1	100		
Total	11	100	-		

Figure3: Illustrates distribution of the available Medical Care Benefit at Hospitals " Admission":





Legend:

Blue is "Benefit", Green is "Yes", Gray is "No".

8-1-6 Medical Care at Hospitals "Drugs"

Table No. 32: Medical Care at Hospitals "Drugs"				
	Number	Percentage	Cumulative Percent-	
			age	
Yes	11	100	100	
No	0	0	100	
Optional	0	0	100	
Total	11	100	-	

8-1-7 Minor Surgeries:

Table No. 33: Minor Surgeries				
	Number	Percentage	Cumulative Percent-	
			age	
Optional	1	9.1	9.1	
Yes	10	90.9	100	
No	0	0	100	
Total	11	100	-	

8-1-8 Major Surgeries

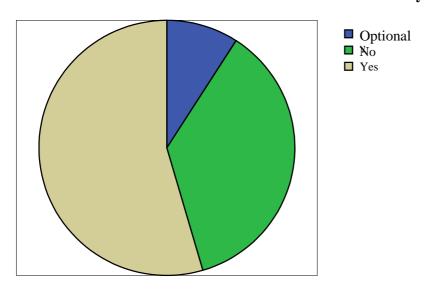
Table No. 34: Major Surgeries				
	Number	Percentage	Cumulative Percent-	
			age	
Optional	1	9.1	9.1	
Yes	10	90.9	100	
No	0	0	100	
Total	11	100	-	

8-1-9 Out- of -the- country Treatment::

Table No. 35: Out- of -the- country Treatment:				
	Number	Percentage	Cumulative Percent-	
			age	
Optional	1	9.1	9.1	
No	4	36.4	45.5	
Yes	6	54.4	100	
Total	11	100	-	

Figure 4: Illustrates distribution of out -of -the-country Treatment

Definition of the Benefits/ out-of -the -country Treatment



8-1-10 Maternity Services

O-1-10 Materini	0-1-10 Materiaty oct vices				
Table No. 36: Maternity Services					
	Number	Percentage	Cumulative Percent-		
			age		
Optional	1	9.1	9.1		
Yes	10	90.9	100		
No	0	0	100		
Total	11	100	-		

8-1-11 Drugs of Acute Cases

Table No. 37: Drugs of Acute Cases				
	Number	Percentage	Cumulative Percent-	
			age	
Yes	11	100	100	
No	0	0	100	
Total	11	100	-	

8-1-12 Drugs of Chronic Cases:

Table No. 38: Drugs of Chronic Cases				
	Number	Percentage	Cumulative Percent-	
			age	
Optional	1	9.1	9.1	
Yes	10	90.9	100	
No	0	0	100	
Total	11	100	-	

8-1-13 Transport:

Table No. 39: Transport				
	Number	Percentage	Cumulative Percent-	
			age	
No	6	54.5	0	
Yes	5	45.5	100	
Optional	0	0	100	
Total	11	100	-	

8-1-14 Dental Care:

Table No. 40: Dental Care				
	Number	Percentage	Cumulative Percent-	
			age	
Yes	11	100	0	
No	0	0	100	
Optional	0	0	100	
Total	11	100	-	

8-1-15 Chronic Diseases

Table No. 41: Chronic Diseases				
	Number	Percentage	Cumulative Percent-	
			age	
Yes	9	81.8	81.8	
No	1	9.1	90.9	
Optional	1	9.1	100	
Total	11	100	-	

Figure 4: Illustrates distribution of Chronic Diseases Treatment Benefit

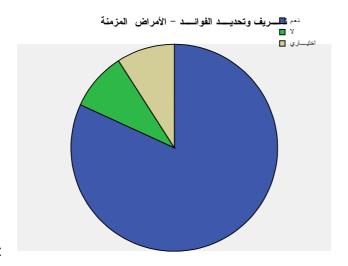


Figure4:

8-2 Ways for Beneficiaries to obtain Benefits (Services):

In 9 cases out of 11 establishments, the Beneficiaries should obtain Direct Medical Referral from his/her supervisor, the doctor of the company, or the General Manager. These cases are 81.8% of the total number of the pilot establishments.

Exceptionally, in a single case, when costs are to be refunded directly to the beneficiary, following the treatment according to the documents that indicate the amounts of money he/she has paid.

There are other different cases of the beneficiary receipt of services but in most of the cases, the main focus is on transferring the costs to the Providers of the Services directly other than through the beneficiary. (Through the Syndicates or the Cashiers).

9- Financial Arrangements & Regulations:

9-1 Mechanisms of Payment to the Providers:

In 50% of the cases the cost of benefits (Services) are paid through the banks or Syndicates to the Providers. In 20% of cases, the beneficiary receives part of or all the sum he/she has paid to the Provider. In the rest of the cases, the establishment itself deals with the Providers directly so as to pay all the costs of services given to the beneficiaries.

9-2 The Costs of Services (Benefits), in sums through last year:

Table No.42 shows the sums paid through last year, 2005 to operate HI Schemes.

Table No.42: Membership in HI Schemes					
Serial No.	Name of Establishment	Estimated Number of Beneficiaries	Expenditure/2005	Individual Share/ SYP annually	
1	Directorate of Tech- nical Services	13032	7697564	591	
2	Productive Credit Bank	250	450000	1800	
3	General Company of	16722	1996100	1194	

Table No.42:	Membership in HI Sche	emes		
Serial No.	Name of Establish- ment	Estimated Number of Beneficiaries	Expenditure/2005	Individual Share/ SYP annually
	Lattakia Port			
4	Coast Basin Company	16200	15832221	978
5	Fabrics Company	1188	556000	468
6	Railway Company	6780	5000000	738
7	Company Electricity Company	14400	17000000	1181
8	General Company for Fuel Distribution & Storage	425	4703652	10407
9	Post Establishment	204	430000	2108
10	Directorate of Real- estate	2700	1380000	512
	General Establish- ment of Tobacco	7552	2300000	424

Table No. 42 illustrates that the average annual Share of the individual is / 1855 SYP/, while Maximum is /10407 SYP/ and Minimum is /424 SYP/. This attributable to the nature of the implemented Scheme. Not to forget about the maximum Financial Value in addition to the extensive Services to the beneficiaries.

10- Legal Affairs:

in 80% of the cases of HI Scheme, they are considered part and parcel if the Internal Regulations of the Establishment . As for the other 20 % were following the Unified Labor Law.

Table No. 43: indicates the Legal Reference of HI Scheme in the pilot Establishments:

Table No	o.43: Legal Reference	of HI Scheme liab	le for Supervision	& Accounting
Serial	Name of Establish-	Legal Reference	Financial Liability	Legal Supervi-
No.	ment	of HI Scheme		sion
1	Directorate of Tech-	Internal Regula-	Administration	Medical Treat-
	nical Services	tions	Accountant	ment Depart-
				ment
2	Productive Credit	Internal Regula-	Director of	Director of
	Bank	tions	Admin. Affairs	Admin. Affairs
3	General Company of	Internal Regula-	Finance Officer	Finance Officer
	Lattakia Port	tions		
4	Coast Basin Com-	Unified Labor	Administration	General Man-
	pany	Law	Accountant	ager
5	Fabrics Company	Unified Labor	Finance Officer	General Clinic
		Law		Supervisor
6	Railway Company	NA	NA	NA

Table N	able No.43: Legal Reference of HI Scheme liable for Supervision & Accounting				
Serial No.	Name of Establishment	Legal Reference of HI Scheme	Financial Liability	Legal Supervision	
7	Company Electricity Company	Internal Regula- tions	Finance Officer	Medical Treat- ment Depart- ment	
8	General Company for Fuel Distribution & Storage	Internal Regula- tions	Finance officer	Finance Directorate, Syndicates & Branches	
9	Post Establishment	Internal Regula- tions	Finance officer	Finance officer	
10	Directorate of Real- estate	Internal Regula- tions	Cooperative Fund Head & Ac- countant	Fund Branch Head	
11	General Tobacco Company –Coastal Region Branch	Internal Regula- tions	Finance officer	General Man- ager	

11- Administrative Affairs:

Table No.44 shows the classification of responsibilities & liability in connection with registration of the members in HI Scheme, we can note that 45.5% of these schemes, doctors or Medical Treatment Department are the ones doing registration of the members in the Scheme. While in 27.3% of the cases, Administrative Affairs is to do this process. There is one case where the labor Syndicate Having direct involvement in this.

Table No.4	Table No.44: Administrative Supervision & Quality Control			
Serial No.	Name of Establishment	The Liable Party for Registration of members	Who Collects Contributions	Quality Con- trol
1	Directorate of Technical Services	Personnel Sec- tion	_	Treatment Department
2	Productive Credit Bank	Admin Affairs	Admin Affairs	_
3	General Company of Lattakia Port	Personnel Sec- tion	_	Management, Admin Affairs, & Legal Affairs
4	Coast Basin Company	Company Doc- tor	_	General Manager, Party Committee & Syndicate Committees
5	Fabrics Company	Clinic Supervi- sor	NA	NA
6	Railway Company	Treatment De- partment	Company Doctor	Treatment Dep. & Directorate of Medical Affairs in Aleppo

Table No.4	Fable No.44: Administrative Supervision & Quality Control			
Serial No.	Name of Establishment	The Liable Party for Registration of members	Who Collects Contributions	Quality Con- trol
7	Company Electricity Company	Treatment De- partment	NA	NA
8	General Company for Fuel Distribution & Stor- age	Company Doctor	NA	NA
9	Post Establishment			
10	Directorate of Real- estate	Head of Funds Section	Finance Ac- countant	NA
11	General Tobacco Com- pany –Coastal Region Branch	Labor Syndi- cate	Salaries Ac- countant	Medical Af- fairs Branch

12- Conclusion:

at the end of this report we present thanks to MoH, HSMP, Directorate of Panning and International Cooperation & Directorate of Health, Lattakia and all people who contributed to the completion of this study.

Executive Chairman MCI International Dr. Ammar Abdulhameed

Annexes:

Annex 1- Questionnaire Form:

Surve	Questionnaire	on the Basic Fe	eatures of HI	Schemes in Lattakia:
-------	---------------	-----------------	---------------	----------------------

Company		
Overall No. of Staff		
Overall No. of Benefici-		
ary Staff from the exist-		
ing HI Scheme		
Name of the person giv-		
ing Data		
Place of interview		
Duration of interview		
Name of Person collect-		
ing Data		
Notes from Person col-		
lecting Data		
4 1 4 64 61		
1- Layout of the Schem	e:	
	or preparing the Layout or the	
Scheme?		
		• • • • • • •
 What was the Data a 		
?		
0. Manual and the		
2- Membership:		
 How was Membershi 		
lated?		
		• • • • • • •
Have many mambana are	though in this	
How many members are	there in this	
•••••		
•••••		• • • • • • •
Is there exclusive memb	pership? Who are the members?	
Yes I	No I	

3- Financing		
Financial Resources, are they from: - Company\ Establishment	0	
- Contributions	0	
- Donation	0	
- Are there any shared Funds? What a	re they? Nol	
- Are there any exemptions ? Who is	exempted?	
Yes I	No	

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4- What are the desired benefits of HI Scheme?

- Definition & modification of the benefits:

Protective Services	Yes 🏻	No 🏻	Optional I
Specialized out- clinics	Yes [No I	Optional [
Laboratory Services	Yes [No I	Optional [
Diagnosis	Yes I	No I	Optional [
Health (Care in-patient)	Yes [No I	Optional [
Medical Treatment at Hospital (Drugs)	Yes [No I	Optional [
Minor Surgery	Yes [No [Optional [
Major Surgery	Yes [No [Optional [
Out- of- the country Treat- ment	Yes [No [Optional [
Maternity	Yes I	No [Optional [
Acute cases Drugs	Yes I	No 🏻	Optional [

Chronic Cases Drugs	Yes I	No 🏻	Optional I	
Transport	Yes [No 🏻	Optional I	
Dental Care	Yes 🏻	No 🏻	Optional I	
Chronic Diseases	Yes 🏻	No 🏻	Optional I	
Other Benefits:			•	
		• • • • • • • • • • • • • • • • • • • •		
•••••				
Excluded Bene-				
fits:				
				J
How to get these Benefits?				
How are the Benefits p	aid			
101 :				
•••••				
•••••				
- What is the mechanis				
?				
		•••••		
- What is the Overall Exp year ?	penditure of the	company	on Health Care	during last
Ana than a second to B				
 Are there any other Be Yes I 	netits offered b	y HI Sche No	me in your com	pany?.

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	•••••
••••••	
	•••••
	•••••
	•••••
C. Lorel Issues / Stoff Bules)	
6- Legal Issues (Staff Rules)	
- What is the Legal Structure of HI	
Scheme?	
 Are there any Written Codes in the establishmen 	nt / Internal Law ?
Yes I NoI	
-Who is Liable for this Scheme	
?	•••••
- Who is liable for Supervision & Follow	
up?	
7- Management:	
- Who is responsible for registration of the mem)-
bers?	
- Who is responsible for collecting the contribution	ons
?	
- Who is responsible for checking that Health Car	e is done, contracting with
the providers, and Quality Control of HI Scheme	
the providers, and equality control of the contents	

Health Sector Modernisation Programme of the Ministry of Health funded by European Union

8- Health Institution Responsible (the Role of the Government):

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	Who is responsible for Supervising HI Scheme?
. -	What is the role of MoH or other Ministries in assisting HI Scheme ?
	Do you have any other plans for the coming years? If any please indicate
-	Any remarks you like to add? If any please indicate. Yes No

Study 5: Health benefit schemes in Al Raqqa



Study of

Health Benefit and Health Insurance schemes

(In the Governorate of Raqqa)

to:

Presented

Health Sector Modernization Program

Ministry of Health

Damascus - Syria

Prepared by:

Ms. Yassmin Atassi Damascus - Syria

TEL: 963-11-3315194

E-mail:yasmin_atassi@hotmail.com

Report on Health Care Services (Benefits), HI Scheme for Private & Public Sector Employees and Syndicates in Raqqa Governorate

Introduced to:
Health Sector Modernisation Programmes
Ministry of Health
Syria, Damascus

Prepared By: Miss. Yasmin Atasi

Introduction:

The European Union in agreement with the Government of Syria represented by Ministry of Health herein referred to as (MoH), aided by 30 million Euros in Technical Assistance with view to implementing improvement on Management Process and offering Health Services (Benefits) to Syrian Citizens. The following methodologies are adopted in implementation of Health Sector Management Programme:

- Spreading & widening Health Villages Programme in order to improve and reinforce Protective Health Care.
- Stand up to face the population transformation and special care for population management through education campaigns on Reproductive Health Services.
- Reinforcement of Health Economics Principles, Fair Rational Financing of health expenditures, developing the concept of solidarity based in line with HI Scheme.

At the end of the programme, we look forward to achieving the following results:

- Developing the ability to put policies forward, training and regulation on Health at the central & branch levels.
- Securing more coherent Health Services to meet the needs of the populations.
- Improving performance at hospitals and management of health care establishments.
- Activation of a permanent framework for Health Sector Financing.

MoH supervises and assesses the programme supported by Strategic Health Studies Center initiated at the beginning of 2005 containing four Institutes.(i.e. Population Studies, Health Economics, Health System Management, Public Health). The programme was put for implementation in three pilot Governorates, namely Raqqa, Lattakia, and Raqqa. It was marked by six axial points of work:

- 1. Studying health expenditure for family to illustrate their willingness to spend money for HI Scheme .
- 2. Studying preparation of budgets to be spent on Health Services in Ministries.
- 3. Studying demand on Health Services at private clinics.
- 4. Studying demand on drugs, medicament, and laboratory services.
- 5. Studying abundance and quality of Secondary, Tertiary Health Care.
- 6. Studying abundance Health Care Services & HI Scheme for employees in Private & Public Sector establishments and Syndicates.

Miss Yasmin Atasi, Economics& Administrative Researcher, was assigned by MoH to launch this study on Health Care Services & HI Scheme for employee in Private & Public Sector establishments and Syndicates in Raqqa Governorate, as in axial point no.6 above.

Miss Yasmin Atasi has prepared a questionnaire form in collaboration with MoH Personnel to apply it a randomly picked sample from this pilot Governorate. It was formed of 15 establishments from the Public Sector and Syndicates together with some Private Sector Establishments. This report is the outcome of the study including an overview of Health Status countrywide, and another overview of Raqqa in particular. Then, this report introduces results of the findings on HI Scheme.

(1)- Overview of Health Status in Syria:

Expenditure on Health Sector in Syria is considered to be less than the expenditures in other countries in the Arab Region. Expenditure in Syria for Health does not exceed 60 USD per capita, and its rate does not exceed 5.1% of the Gross National Outcome. While the same rate in Lebanon & Jordan has mounted up to 10.2% & 9.4% according to the WHO Reports in 2004. The Health Sector covers about 50% of Health Expenditures in Syria, Private Sector provides the other 50%.

The 10th Five- year Plan (2006-2010) had objectives for modernizing Health Sector in it with view to transforming it into a development sector to strengthen population's public health and developing its financing systems. Among the further objectives of the Public health Plan is to improve the average of individual share of the Overall Expenditure on health so as to reach up to 100 USD. Then, moving into increasing investments in Health Sector during this five-year plan to become 300% (3 times more on condition that foreign & local Private Sector by approximately 65% of this increase).

Health Sector provides Health Services to citizens of Syria via four parties namely: Ministry of Health, Ministry of Higher Education, Ministry of Defense, Ministry of Labor & Public Affairs. Health Services being provided through hospitals, specialized Health Centers and Public Health Centers together with other Health Units belonging to these Ministries.

As for Private Sector, it delivers health services to citizens via Private Hospitals, Doctors Clinics for all specialties (Recently through the Specialized Health Clinics these doctors are managing). Usually, hospitals these are short of the basic ingredients such as "Appropriate Technical Condition & Equipment" (Except for the Main Private Hospitals). The expenses of treatment at these hospitals are so high. We find a phenomenon: many of Public Health Sector Staff Cadre work at Private Sectors hospitals, clinics and health centers as an additional job.

In spite of the concrete development in Public Health conditions for Syrian citizens in the past ten years (i.e. high rates of life expectancy & children deaths, vaccination coverage; increasing number of hospitals & beds; increasing hospital workers & doctors in Public Health Survives), still Health System is suffering from a set of problems mostly important among which are: Low Economic Efficiency, increasing Waste of Resources, Low Actual Productivity of Staff, Duplicity in the Practices of both Public & Private Sectors and poor Monitoring for Private Sector.

(2)- Population Status in Raqqa Governorate:

The number of population in Raqqa Governorate in 2005 reached \810.000\ equal to 4 % of the Overall Population of Syria\18.200.000\. Distribution of Raqqa Governorate population is /304.000/ in towns &/507.000/ in countryside according to gender showed almost equal numbers of Males /397.000/& Females /413.000/ in this same year. Population Growth in this Governorate is /26.7%/ from 2000-2005.

Health Sector in Raqqa Governorate witnessed a remarkable development; thus the number of doctors reached /711/ at the end of 2004 with an average of /1021/ people per doctor, dentists are /411/, the Governorate has in it a number of private hospitals /14/ with /2/ Public Hospitals. Health Centers are /32/ in addition to /4/ Specialized Centers.

(3)- HI Scheme:

In general, HI Concept is absented from the minds of all people in Syria while employees in Public Sector make benefits of HI Scheme. Sometimes, employees in Private Sector make benefit of HI Programmes and Plans which secure Health Services for them through one of the following ways:

1. The employees of Private & Public Sectors included in Social Security Schemes (Social Insurance Code No.92 on 1959 amended by Norm No.78 on2006) make benefit of Health Services offered by these schemes which cover work injuries & diseases incurred from practicing some vocations exclusively. These schemes do not cover employees family members. The allowances given to employees included in HI scheme, follows MoH pricing imposed by MoH for hospitals, clinics, external laboratories Services.

With regard to refunding the invoices mechanism (e.g. Pharmacy Invoices), an employee who incurred an injury or a pathologic condition is given referral to Pharmacy to get the medicaments & drugs without charge. The Pharmacy refers all these referrals to Pharmacist Syndicate whose further role is to cash the expenses for these Pharmacies. The Pharmacist Syndicate is to have these expenses refunded through accounting process with

Social Security Fund.

2- Based upon the fact that Health Services in HI Scheme are restricted to employees only without there families and that this Scheme covers work injuries & diseases only without other pathological cases, Public Sector Establishments resort to organizing special HI Programmes for them through special monthly deductions. Employees and their family members obtain health services they need without any charge through their membership either by a referral from the institution they work for (accounting process with Social Security Fund for the expenses of the invoices), or the employee on his own refers to these service providers in without a prior referral. Later on, he/she settles the invoices of treatment expenses to the institution he works for. The institution therefore is going to settle and spend the invoices for the employee committing itself to the pricing of MoH for various health services, or within the maximum expenditures approved by these Funds.

The sample of this HI Scheme study in Raqqa Governorate included both cases stated above. (i.e. Employees included in HI Scheme & Employees sharing in Cooperative Funds).

1.MoH issue a list of names of Doctors subscribers can visit

(4)-The Purpose of the study & Methodology of Implementation:

The study of HI Scheme, and Health Care Services for employees of Private & Public Sectors & Syndicates in Raqqa Governorate aims at estimating & assessing HI Scheme currently introduces to employees at Public/Private Sector institutions & Syndicates in the Governorate in preparation for initiating an integrated HI Scheme in it.

The size of this randomly chosen sample was a group of institutions out of the Public Sector Establishments, Private Sector Companies, and Syndicates in this pilot Governorate. This study showed that none of these institutions is offering kind of Health Insurance to their employees as follows:(Private Sector: Khaltib & Awwad for Transport, Alkan Confectionary Industries, M. Sh. Sultan Ice-cream, and others) as for (Public Sector institutions as indicated below:

- Cooperative Agricultural Bank of CAB, Raqqa Branch, which is a governmental bank, with 26 employees in it, delivers banking services for agriculture (Cattle, Farming) in Raqqa Governorate miscellaneous services related to it or to its products. It also encourages savings, and purchase production equipment .. etc. This Raqqa Branch applies HI Scheme in line with the regulations issued by CAB HQ, these which are based on circulation No.165 from HE, Minister of Economy & Foreign Trade in 1978 on HI services implementation.
- Popular Credit Bank (PCB) Raqqa Branch, with 33 employees in it. It offers banking services such as Savings, Investment Invoices. It adopts HI Scheme based on circulation No.165 from HE, Minister of Economy & Foreign Trade in 1978 on HI services implementation.
- Raqqa Post Establishment (RPE) whose staff are /67/ employees in it. It uses HI Scheme together with Social Security Scheme covering employees for vocational diseases & work injuries exclusively & their family members via Cooperative Fund financed by contributions deducted from

- the salaries monthly depending in compensation on the maximums allowed.
- O General Tele-Communication Establishment in Raqqa (GTE), a governmental institution of /720/ employees in it. In addition to Social Security Scheme which covers vocational diseases & work injuries, it implements HI Scheme for employees & their family members via Cooperative Fund financed by contributions deducted from the salaries monthly depending in compensation on the maximums allowed same as in (RPE).
- O Directorate of Agriculture & Land Reclamation, Raqqa (DALR) which is a Public Sector institution with/1500/ employees in it. It does not implement HI Scheme in the full sense. It provides healthcare services to its employees through contracting with a doctor on monthly salary basis. Any further case might supersede this doctor via referrals to specialists would be at the expense of the employee himself/ herself.

(5)- The outcome (Results) of this Study:

In what comes after in this part of study, we illustrate the outcome of interviews in the institutions adopting HI Scheme for their Staff. Each table indicates the results from each tested institution in light of the 7 dimensional major questions.

- Membership & Subscription in HI Scheme
- o Funds & Financing of HI Scheme
- o Benefits offered by HI Scheme
- o The Organizational & Management Structures of HI Scheme
- Legal issues
- o Conditions of Health Care
- o Risk Factor Management

1. Membership & Subscription in HI Scheme:

Results Analysis shows that making use of HI Scheme implemented in 5 institutions starts promptly following the assignment of an employee. All these Schemes stipulates compulsory subscription due to some reasons among which is law procedure. (i.e. Social Security Codes, Internal Regulations) As in the case of DALR. Therefore, HI scheme covers all employees at those institutions.

It is worth mentioning that the employees at PCB & CAB are obliged to HI Scheme according to Healthcare Service Code and its Regulations, which are based on Circulation No.165 from HE, Minister of Economy & Foreign Trade in 1978 on HI services implementation & organization. Of course, this circulation covers all employees of Popular Credit, Cooperative Agricultural Banks.

It is noted that HI Scheme in all interviewed institutions has been put forward in line with a specific real need of these companies, No Governmental authority took part in putting HI Scheme except for the Scheme implemented at branches of PCB & CAB due to their belongingness to Central Managements (HQs) and Ministry of Economy as was done previously. Healthcare services at DALR in Ragga as an integrated HI Scheme in the

full sense. This Directorate contracted with a doctor paying him a lump sum of /8.000 SYP/ monthly to cover the expenses of employees checks with the doctor. In case the case develops, the employee shall be referred to a specialist doctor so the patient employee will cover all the expenses at his cost including Drugs expenses.

As for Raqqa GTE & Raqqa Post, we have to make distinction between two types of Employees:

- Those employees falling under Social Security Code which covers the employees exclusively for work injuries without their family members.
- of the employees). In principle, Insurance & Pension Code (not exceeding 4% of the employees). In principle, Insurance & Pension Code does not include HI Scheme as Social Security Code does, so Cooperative Funds were initiated at these institutions to aid the employees & their families with healthcare issue. 2%deduction of the salaries plus 2% of the incentives & compensations as contribution to these Cooperative Funds at institutions as the Table below shows (abidance by MoH Pricing in case treatment was in a private sector hospital). It abides by limited maximums view to the weak capacity of these Funds. Maximum compensation rate for a surgery is 60% of the Overall expenses of an operation. Maximum compensation rate for dental treatment is /3.000 SYP/. Maximum compensation rate for Drugs is /7.000 SYP/ some of these might be exceeded in cases of chronic diseases.

It is worth mentioning here that HI Scheme via Funds includes employee family members with some benefits and additional services such as compassionate compensation when an employee or one of his/her family members dies added to Termination of Services Compensation.

With regard to HI Scheme in PCB, CAB, RPE & GTE cover all family members in an average of /4/ (Spouse & 3 children) whereas Health Services at DALR, does not include employee family members (**Table 1**). It is also worth mentioning that New Worker & Labor Code (WLC) No. 50 issued in 2004 which limits the maximum number of children included in Health Care Systems to be /3/ only. HI scheme does not cover any additional children. WLC does not include employees begetting more than 3 children prior to its issuance. See below for **Table 1: Subscription & membership in HI Scheme.**

Institution	CAB Branch	PCB Branch	RPE	GTE	DALC	
TYPE	Public Sector	Public Sector	Public Sector	Public Sector	Public Sector	
Employees	36	33	67	720	1500	
Included in HI	36	33	67	710	1450	
Beneficiaries-family	1o4(Wife& Chil- dren)	132(Wife& Chil- dren)	156	2166	0	
Total Included & Beneficiaries	130	165	223	2976	1450	
Family Includes	Wife &Children	Wife& Children	No family coverage	Wife& Children	No family coverage	
Subscription Date	-	-	-	1775	-	
Contribution collected on	-	-	-	Directly	-	
Benefits given on	-	-	-	On assignment	On assignmen	
HI Scheme Based on need or problem	No	No	No	No	No	
External Parties having relation to HI decision	HQ & Ministry of Economy.(1)	HQ & Ministry of Economy	None	None	None	
Members Subscription on	Entry on Duty Date	Entry on Duty Date	Entry on Duty Date	Entry on Duty Date	Entry on Duty Date	
Compulsory or Voluntary Subscription	Compulsory, Circulation No.165 from , Minister of Economy & Foreign Trade in 1978	Compulsory under Internal Regula- tions	Compulsory un- der Internal Regulations	Compulsory under Syndicate Internal Regulations	Compulsory by owne Social Insurance Cod	
Maximum Family Members included	4	4	4	5	-	
* Wives	1	1	1	1	1	
* Husbands	1	1	0	1	0	
* Parents	0	0	0 (2)	0 ⁽²⁾	0	
* Children	3	3	3	3	-	
Identification of Members	HI Card	Collective Card	HI Card	Collective Card	HI Card	
Any Special Cases for family members	No	No	No	No	-	

Remark 1: Belongingness of PCB was transferred to Ministry of Finance upon Prime-ministry Decision No.49/2 on 16/10/2003.

Remark 2: Coverage include Parents if employee has proven they are alive and they depend on him

2- HI Scheme Financing:

Analysis of samples demonstrated that all interviewed institutions depend basically on contributions to finance their HI Scheme. These contributions are raised from members without having any additional financing source. **Table 2: HI Scheme Financing.**

Table 2: HI Scheme Financing.								
Institution CAB Branch PCB Branch RPE GTE DALC								
Sources of HI Financing	Contributions from owners	Contributions from owners	Members Contribu- tions	Members Contribu- tions	Boss Contribu- tions			
Additional Financ- ing Sources	None	None	None	None	None			

With regard to financing contributions to HI Scheme at CAB Branch, PCB Branch& DALC are to be raised from the institutions themselves by 100% at CAB & PCB (the amount of HI financing is 50-60 million SYP covering the needs of all Branches countrywide). As for DALC, has had a maximum of /8000 SYP paid to the establishment nominated Doctor monthly to cover staff checks. However, at RPE & GTE, HI Scheme financing is covered 2% salary deductions for Cooperative Fund. These staff contributions are specific for (members under Social Security & Pension Code).

Since CAB Branch, PCB Branch& DALC finance their own HI Scheme, they do not have a clear-cut procedure to collect contributions. The other two collecting from contributions from staff, they do not practise monitoring on payment depending on direct monthly deductions from salaries. No exemptions or exceptions for members from paying their contributions. See **Table 2-1 below**:

Table 2-1: Financing HI Scheme by contributions							
Institution	CAB Branch	PCB Branch	RPE	GTE	DALC		
Contribution Source	100% from bank	100% from bank	2% salary deductions	2% salary deductions	100% from Owner (Directorate)		
Type of Contribution	None	None	According to income	According to income	None		
Amount of Contribution	Full 100%	Full 100%	partial	partial	Partial /8000/ SYP paid monthly to a doctor		
Way of Payment	annually	annually	Salary de- duction	Salary de- duction	Monthly		
Deduction Time	No deduction	No deduction	Monthly	Monthly	No deduction		
Party Collecting Contributions	Cooperative Fund	Cooperative Fund	Cooperative Fund	Cooperative Fund	(Joint Fund at Doctors Syndicate) Providers		
Monitoring Contributions Paid	None	None	None	None	None		
Security Procedure to insure Payments of Contributions	Salary De- ductions	None	Salary De- ductions	Salary Deduc- tions	None		
Exemption, Reduction from Contributions	None	None	None	None	None		
Exempted Subscribers in- cluded	None	None	None	None	None		

3- HI scheme Benefits:

None of these institutions who were interviewed depend on clarifying about Benefits a Subscriber is going to obtain (Insured Employee) from HI Scheme through identifying them in written standardized conditions in brochures & kits or meetings. Identification depends on Subscribers prior knowledge about the services even If in he/ she are newly recruited post-holders. Except for DALR, where they depend on written brochures to identify the Benefits of HI Scheme.

The services and benefits are available in Programmes of HI Scheme at these institutions at any time. Its value is compensated either by payment of the Overall Value of expenses according to MoH Pricing in the case of visiting the doctor of the institution without a formal referral from the institution, through compensating Overall value of invoices to the syndicates on a regular basis except for DALR which pays the monthly agreed on salary to the doctor, so there will be no direct compensation of Benefits Value to the employees. It can be noted here that all implemented HI Schemes in these pilot institutions do not possess additional services such as protective treatment coverage for insured employees, a rate of private hospitalization fees, or Pension coverage. However, RPE & GTE offer coverage of pension coverage & compassionate death of an employee coverage. Out-of-the country treatment is not covered since it is not available due to the lengthy time for getting the required approvals from Authorities (Upon exception from Prime Ministry).

With regard to the difficulty in obtaining benefits, the interviews expressed that the most serious problems in implementing HI Scheme, is how to assess the package of benefits by involved managements, and how to decide on estimation of Benefit Value (i.e. Medical Checks Expenses, Hospitalization fees, Prices of Drugs) at a lower expenses than its real value on the market, similarly referring back to the pricing of MoH which may not be correspondent to the actual value of the benefit. See **Table 3**: Identification& Introduction of HI Scheme Benefits, Rules to obtain them

Table 3: Identificat	ion& Introductio	n of HI Schem	e Benefits, R	ules to obtain them	l
Institution	CAB Branch	PCB Branch	RPE	GTE	DALC
Introduction upon writ- ten Standardized Con- dition	No	No	No	No	Yes
Insured People Noti- fied	No	No	No	No	Yes
Service Providers No- tified	No	No	No	No	Yes
Ways of giving Ser- vices	Available any time	Available any time	Available any time	Available any time	Available any time
How Benefits are paid for	Compensation for Invoices or directly to syndicates upon referral	Compensation for Invoices or directly to syndicates upon referral	Compensation for Invoices	Compensation for Invoices	Directly via doctor's salary
Compensation Rules	Compensate Overall Bill Ex- penses\ MoH Pricing	Compensate Overall Bill Ex- penses\ MoH Pricing	Compensate Overall Bill Expenses\ MoH Pricing	Compensate Overall Bill Expenses\ MoH Pricing	No compensation since employees directly treated by institution's doctor
Benefit Problems	MoH Pricing not coherent with actual costs	MoH Pricing not coherent with actual costs	MoH Pricing not coherent with actual costs	None	Providers,members complain about ways of payment/ expenses not cov- ered by compensa-

Table 3: Identification& Introduction of HI Scheme Benefits, Rules to obtain them							
Institution	CAB Branch	PCB Branch	RPE	GTE	DALC		
					tion		
Additional HI Bene- fits	None	None	Pension/Death Coverage	Pension/Death Cov- erage	None		
How to introduce Services	No formal way	No formal way	No specified way	No specified way	Brochures		
Out-of-Country Treat- ment	Available upon Exception From Prime Ministry	Not available except via Prime Ministry					

With regard to the main Services of Benefit Kit (package) at these interviewed institutions especially (CAB, PCB,RPE & GTE) it includes Healthcare, Laboratory, Hospitalization Care, Diagnosis Services & while in the hospital or Medical Treatment, add the expenses of Drugs, Maternity, Dental Care & Chronic Diseases. No coverage for Transport or healthcare expenses at out-clinics. It is also noted that all these institutions adopt MoH Pricing for all treatments particularly if in a private hospital.

It is worth noting here that HI Scheme at CAB, PCB does not cover normal childbirth expenses for an employed woman while it covers the Caesarian Sect cases according to MoH Pricing in addition to covering 100% of other healthcare cases for employees. With regard to an employee family members, they are covered 100% for all sorts of healthcare, but for their drugs, only 75% of expenses is covered.

As for Cooperative Fund at GTE, RPE HI Scheme covers expenses 100% for employees family except prescriptions not exceeding /7000 SYP/ maximum together with surgeries in 60% of their expenses, See **Table 3-1** Identification of Services included in Benefits Package at interviewed institutions

	Table 3-1: Se	ervices includ	led in HI Ben	efits Package	
Institution	CAB Branch	PCB Branch	RPE	GTE	DALC
Primary Health Care	Yes100% according to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% accord- ing to MoH Pric- ing	100%
Protective Services	100%	Yes100% ac- cording to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% accord- ing to MoH Pric- ing	None
Out-patient Care	None	None	None	Yes100% accord- ing to MoH Pric- ing	None
Laboratory Services	100%According to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% accord- ing to MoH Pric- ing	None
Diagnosis Ser- vices	100%According to MoH Pricing	100%According to MoH Pricing	None	100%According to MoH Pricing	None
Inpatient Hospitalization	100%According to MoH Pricing	100%According to MoH Pricing	60%According to MoH Pricing	60%According to MoH Pricing	None
Out patient Medical Care	100%According to MoH Pricing	None	60%According to MoH Pricing	60%According to MoH Pricing	None
Maternity	None except for Cesarean	None except for Cesarean	100%According to MoH Pricing	100%According to MoH Pricing	None
Drugs	100%for employee 75% for family members	100%for em- ployee 75% for family mem- bers	100% not exceeding /7000/ SYP	100% not ex- ceeding /7000/ SYP	None
Transport	None	None	None	None	None
Chronic Diseases	Yes100% according to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% accord- ing to MoH Pric- ing	None, sometimes According to case
Orthodontal Care	Yes100% according to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes100% ac- cording to MoH Pricing	Yes around /3000/ SYP	None

4- Legal Affairs:

Regulations at HQ CAB, PCB are issued in accordance with Circulation No.165 from HE, Minister of Economy & Foreign Trade in 1978 on HI services implementation & organisation. While HI Schemes at RPE, DALR & GTE follow Internal Regulations put by Managements of course. Most HI Schemes for interviewed institutions is done through signing contracts with related Syndicates (Doctors, Dentists, Pharmacists,...) to give different services for patient employees. Later on, their invoices are going to be refunded to them from institutions they work for except for DALR, which signs a contract with a doctor for a monthly salary of /8000 SYP/.

No registration or Licencing of HI Schemes at those five institutions has been observed, but they are supervised by State Monitoring Authority or via regular auditing in the institution itself. See Table 4 on Legal Issues

Table 4: Legal Issues						
Institution						
Legal framework of HI Scheme	Syndicate	Syndicate	Syndicate	Syndicate	General	
Is HI Scheme Registered	No	No	No	No	Yes	
Legalization ap- plied	HI Internal regulations	HI Internal regulations	Internal Rules of Cooperative Funds	Internal Rules of Cooperative Funds	General State Rules, Decisions	
How HI is supervised	Regular Audit	Regular Audit	Regular Audit	Regular Audit	Supervised by State Authorities	

5- HI Schemes Management Structures:

Direct assignment is commonly used in choosing HI Scheme Management staff at those interviewed institutions or through election by the institution they work for. Decisions made by Management Board in its meetings.

HI Scheme Management duties differ by institution. Sometimes, it is restricted in registering the members at DALD, collecting contributions from members at RPE, or making referrals and register checks at CAB & PCB Branches. The regulations issued by this Management aim at organizing subscription of members, contribution collect, settling entitlements due to pre-prepared formats or Management Regulations. Also, those Managements depend on Healthcare Conditions & planning processes and financial management of HI Scheme & collecting statistics. Sometimes, doing these procedures used in a temporary system at PCB Branch.

It is noted that Staff Members of HI Scheme Management do not include with them devoted employees for its work. Oftenly, they include Financial Management & Administrative Staff who are responsible for follow up with HI Scheme in addition to their main duties.

For example, HI Scheme organizational structure at CAB Branch(Raqqa): in it 2 management entities are involved:

1- Financial Affairs Directorate whose responsibilities are exclusive to auditing and refunding of invoices either directly to the employees(according to MoH

- pricing), or to different Syndicates (Doctors, Dentists, Pharmacists or Laboratories Commission).
- 2- Administrative Affairs Directorate whose duty is to organize referrals.

See Table 5:

Table 5: HI Schemes Management Structures					
Institution	CAB	PCB	RPE	GTE	DALR
HI Scheme Manage- ment Staff Chosen	Assignment	Assignment	Assignment	Elections	Elections
Internal Regulations made by	Via Board meeting	Via Board meeting	Via Board meeting	Via Board meeting	Via Board meeting
HI Scheme Manage- ment Duties	Registra- tion	auditing	Contribu- tions Collect	Contacting with Providers ,Registration specify Healthcare terms &Data Col- lect	Registration
Members Registered by	Special Format	Computerized & Special Format	Special For- mat	Computerized	Management Regulations
How to collect contri- butions	No Contri- butions	No Contributions	Special For- mat	Computerized	Management regulations
How to settle entitle- ments	Special formats	Computerized & Special Format	Management regulations	Computerized	Management regulations
How to put conditions of Health Care	Special Format	Management regulations	Special For- mat	Management regulations	Special For- mats
How to plan & Manage Finance	Manage- ment regu- lations	Computerized & Special Format	Special For- mat	Computerized	Management regulations& Special Format
How to compile Statistics	Special formats	Computer- ized& Special Format	Special For- mat	Computerized	Special Format
How to Control	Manage- ment regu- lations	Management regulations	Management regulations	Computerized	Special Format
How to control regis- tries	Manage- ment regu- lations	Management regulations	Special Format	Computerized	Special Format
No. of workers in HI from staff members	0	0	0	0	0
No. of Volunteers	0	2	1	6	0
Special independence for HI Scheme	Financial &adminis trative	Financially independent	Financially independent	Financially independent	Financially independent

6- Health Care Conditions:

The distribution of Service Providers (Hospitals & Doctors) at the interviewed institutions includes all countryside and city in the pilot Governorate (Raqqa) in accordance with their specialties (primary health care only at CAB Branch & DALR, whereas specialized care for inpatients and outpatients services were added to primary healthcare at hospitals at RPE, PCB Branch). The patients choose visiting one of Service Providers freely according his/her pathological case out of the list of names provided by Doctors Syndicates or others.

HI Scheme compensates in the majority of these five institutions for expenses of outclinics, laboratory, radiology centers, specialized hospitals invoices through refunding to relevant Syndicates or Laboratory Commission in accordance with the agreement with them via bank on a regular basis. In case members paying these invoices or check fees to private hospitals or doctors first, HI Scheme compensates for invoices according to MoH Pricing list.

See Table 6.

Table 6: Health Care Conditions							
Institution	CAB Branch	PCB Branch	RPE	GTE	DALR		
Distribution of Providers according to Specialty							
*Primary Health Care	A Doctor Governorate wide	Rural+ City	Rural+ City	Rural+ City	A Doctor Gov- ernorate wide		
*Outpatient Special- ized Care	-	Rural+ City	Rural+ City	Rural+ City	Rural+ City		
*Inpatient Care (Hospital)	-	Rural+ City	Rural+ City	Rural+ City	Rural+ City		
Contracting with Providers	None	None	None	None	None		
Compensation for out invoices	yes	yes	No	No	No		
Choice of Providers	Limited Choice among Pro- viders	Limited Choice among Providers	Limited Choice among Providers	Limited Choice among Provid- ers	Limited Choice among Provid- ers		
Clinic inside a Company	None	None	None	None	None		
Payment for out clinics	Via Bank every month or employees directly to doctor	Via Doctors Syndicate monthly or every 6 months	Via Doctors Syndicate monthly/biannual	Via Doctors Syndicate or employees di- rectly to doctor	Via monthly salary I for specialists a member pays in full		
Payment for Radi- ologists & Labs	Via Labs Commission	Via Labs Com- mission	Via Labs Com- mission	Company pays monthly to Labs or a member pays for radiog- raphy	Employees pays in cash		
Payment for Hospitals	Either em- ployee pays or via doctors syndicate	Via Fellowship Fund or Doc- tors Syndicate	via Doctors Syndicate Fund according to maximums	member pays in full later on company com- pensates/ MoH Pricing	Employees pays in cash		
Payment linked to Pharmaceutical items	According to productiondate	Via Pharmacist Syndicate	According to Pharmacy Invoices	Contracting with Laborers Phar- macy	Per item		
Pharmacies in Company Premises	None	None	None	None	None		
Refund to Pharma- cies	Employee directly or value of pre- scription com- pensated or via Pharmacist Syndicate	Employee di- rectly or value of prescription compensated or via Pharmacist Syndicate	Employee di- rectly or value of prescription compensated	Monthly via accounts pre- pared in the pharmacy	Per Item		
Monitoring the Phar- macies	Pharmacist Syndicate	Via company doctor	None	via Pharmacist Syndicate	None		
Payment basis for Drugs	Per Prescrip- tion	Per Item / MoH Pricing	Prescription price	Distribution per item	Distribution per item		

7- Risk Factor Management:

Danger and risks that HI Scheme may potentially undergo are diverse in general. There might be management risks resulting from regulations related to registration admission of the members into HI Scheme. They may be financial when compensation for the employee has taken place either. In fact none of Managements of HI Scheme take precautionary measures to avoid incurring such risks. Even when first assigned to any public post, employees producing a document from MoH, these documents are formalized and they do not mirrorize the Health Status of the employee. They do not include

statements of potentially incurred diseases. Therefore, management should have HI Scheme risk fighting procedures, not to forget about a fact that these institutions depending on their Central managements to face any incurred risks.

See Table 7.

Table7: HI Scheme Risk Management					
Institution	CAB Branch	PCB Branch	RPE	GTE	DALR
Compulsory Rules for avoid- ance of Risks	Compulsory for Members	Compulsory for Members	None	Compulsory for Pensioners	Compulsory for Members
Managing Administrative Risks	Depend on MoH Document	Depend on MoH Document	None	Depend on MoH Document	Inquiry about health issues
Managing Financial Risks	None	External HI for specific risks	None	None	External HI for specific risks
Out-of- Institution HI Scheme	Government	Government	Government	None	Government

(5)- CONCLUSION:

this study showed that Public/Private Sectors institutions, Syndicates at Raqqa Governorate HI Scheme plans are there, but they do not cover except a minor part of treatment expenses & Healthcare Services(Hospitalization, Drugs expenses. The citizens who are not employees as well do not have any form of Public HI Scheme.

Sample analysis from Raqqa Governorate illustrated the Benefits of HI Schemes in institutions, syndicates subject of this study included a wide range of Healthcare Services including treatment (inpatients & outpatients), Hospitalization, Drugs expenses, Maternity& Dental care). Other citizens who are not employees do not have any form of HI Services within a General HI Scheme.

Some Public and Private Sector resort to establishing Cooperative Funds which are funded via deductions from the salaries to cover Healthcare Services the employee or his/her family members need. Due to Health services offered by Social Security, governing the status of employees not their families, covers work injuries or vocational diseases in cohesion with MoH Pricing in estimation of the fees for services. These Pricing are not true refection of real expenses for Healthcare services. Hence, it is important to say that Integrated Strategies for HI Schemes in Raqqa Governorate are not available for employees both in Public & Private Sectors.

Executive Summary

STUDY OF HEALTH BENEFIT AND HEALTH INSURANCE SCHEMES IN THE GOVERNORATE OF RAQQA

Objective of the study

The Ministry of Health in Syria has asked management consultant Ms. Yasmeen Atassi to conduct an assessment of health insurance schemes in the governorate of Raqqa. The project is part of the EU financed Health Sector Modernization Program, which aims at enhancing the health status of the Syrian population through improved equity, efficiency and quality of the health system. The European Union, the main components of the Program are:

- 1. Strengthening the capacity at the central and regional levels for policy, planning and regulation
- 2. Adapting the Ministry's health care delivery system to the needs of the population;
- 3. Enhancing the management capacity in health care facilities;
- 4. Improving the performance of hospitals;
- 5. Establishing quality management and accreditation processes; and
- 6. Establishing a framework for sustainable financing of the health sector;

For establishing a framework for sustainable financing of the health sector (the 6 components of the Program, mentioned above), the Program required assistance in assessing the health benefit and health insurance schemes of various institutions (Teachers Association, Workers Union, Dentists Association, private and public companies, etc.) in the governorates of Raqqa, Dara'a and Lattakia. Miss Yasmeen Atassi was appointed for assessing the benefit and health insurance schemes in the governorate of Raqqa. The overall objective of the assignment is to discover, describe and analyze existing health insurance schemes of private and public companies in Raqqa.

Introduction

Employees in the public and private sector in Syria benefit from health insurance and services in one or both of the following methods:

- 1. A compulsory social insurance scheme administered by the General Establishment of Social Insurance. This scheme only covers work-related injuries and does not provide insurance for the employee's family members. Members within this scheme are compensated within the Ministry of Health's pricing system. As for the payment of invoices, in the case of pharmacies for example, the patient is given a transfer document to give to the pharmacy in order to obtain his drugs. The pharmacy then transfers all the documents to the pharmaceutical syndicate who then pays the pharmacy and the syndicate is reimbursed later by the General Establishment of social Insurance.
- 2. Since the services provided by the social insurance scheme are not sufficient to cover all the health needs of the employees and also does not cover their families, some public institutions have opted for setting up an internal cooperative fund and contracted with various syndicates to provide services for their employees. The fund is financed through health related monthly contributions from members (direct reductions from their salaries). Members have access to health services through formal transfer documents provided by the employer. The member may also sometimes pay upfront and the employer reimburses him later.

Methodology and Coverage

Miss Yasmeen Atassi began by conducting field visits to public and private institutions and syndicates in Raqqa, using an assessment questionnaire (based on the InfoSure Methodology) which was developed in collaboration with the project's Manager at the Ministry of Health. A total of 8 institutions were visited of which only 5 had existing health insurance schemes. These are

- 1. The Agricultural Cooperative Bank (Raqqa Branch): This is a public bank branch consisting of 26 employees and provides various banking services, promoting savings and works on purchasing and trading agricultural equipment and supplies. A health insurance scheme is provided to the bank employees, based on Directive No165 of 1978 issued by the Ministry of Economy and External Trade, which requires all public banks in Syria to provide health insurance (other than social security) to its employees.
- 2. The Popular Credit Bank (Raqaa Branch): This is a public bank which consists of 33 employees. He provides various credit facilities and, promotes savings; A health insurance scheme is provided to the bank's employees, based on Directive No 165 of 1978 issued by the Ministry of Economy and External Trade, which requires all public banks in Syria to provide health insurance (other than social security) to its employees.
- 3. The Postal Establishment (Raqqa Branch): This is a part of the Public Postal Establishment, consists of 67 employees; the branch applies health insurance scheme in addition to the country's social security which covers work related injuries and illnesses. The health insurance scheme covers employees and family members who make payments to the fund by monthly contributions from salaries.
- 4. The Telecommunications Establishment (Raqqa): He consists of 720 employees. The establishment applies health insurance scheme in addition to the

country's social security scheme which covers work related injuries and illnesses. The health insurance scheme covers employees and family members who make payments to the fund by monthly contributions from salaries.

5. The Directorate of Agriculture and Agrarian Reform (Raqqa): A public institution managed by the Ministry of Agriculture and Agricultural Reform and consists of 1500 employees. The Directorate does not apply a medical insurance scheme; however it provides medical services and treatment through a contract with one doctor who receives a monthly salary.

Major Findings:

The study was divided into seven subparts covering each of the following areas of the interviewed insurance scheme:

- 1. Membership in the insurance scheme
- 2. Financing of the insurance scheme
- 3. Benefits of the insurance scheme
- 4. Legal issues of the insurance scheme
- 5. Administrative issues of the insurance scheme
- 6. Healthcare conditions
- 7. Risk management

The major findings within each of the above noted subparts as follows:

1. Membership & Subscription

In all the five institutions interviewed a member could benefit from the existing health scheme as soon as the employee joins the company. In addition, membership in all the institutions is compulsory. The branches of the Agricultural Cooperative Bank (Raqqa) and the Popular Credit Bank (Raqqa) are obliged to cover all their employees according to guidelines based on Directive No.165 of 1978, issued by the Ministry of Economy and External Trade. None of the schemes in place were set up based on a specific need with the exception of the Agricultural Cooperative Bank (Raqqa) and Popular Credit Bank (Raqqa).

As for both the Telecommunications Establishment and the Postal Establishment in Raqqa, a distinction should be made between employees subject to the social security scheme law (96% of the total) and employees subject to the Insurance and Pension law (4% of employees). The Social security law covers work related injuries and do not cover family relatives, while the Insurance and Pension law does not include any health insurance for employees covered by it. Therefore a cooperative fund was set up to cover employees subject to both laws to help them and their families. Two percent of the employee monthly salary and two percent of incentives paid to him are deducted as contribution to the fund. The scheme covers employees and their families, but ceilings are set for compensations: 60% of the surgery cost, SYP 3000 for dentistry and SYP 7000 for Pharmaceutical drugs.

Medical insurance schemes at the Popular Credit Bank, Agricultural Cooperative Bank, as well as the Postal and Telecommunications Establishments cover an average of 4 dependants for each employee, while the medical services at the Directorate of agriculture does not cover family members.

2. Financing of the Insurance Scheme

It was demonstrated that all the institutions in the sample depend on internal generation of contributions to finance their heath insurance funds. The contributions come either 100% from the employer as in the case of the Popular Credit Bank and the Agricultural Cooperative Bank and The Directorate of Agrarian Reform or from employee contributions as in the case of Postal and Telecommunication Establishments (where 2% are deducted from salary and incentives to contribute to the fund.

3. Benefits of the insurance scheme

Employees within all the institutions interviewed have access to the benefits offered by the health insurance schemes at any time and as soon as employed. Benefits are paid by compensating the total value of the invoice based on the Ministry of Health's pricing system except for the case of Directorate of Agriculture and Agricultural Reform (Raqqa) with directly pays a fixed salary to the contracted doctor.

The institutions interviewed do not provide additional benefits to employees such as retirement compensations, preventive medicine, coverage for a percentage private hospitalization. However, the Telecommunications Establishment and the Postal Establishment of Raqqa pay certain compensations to retirement and funeral costs. Coverage for hospitality outside Syria is not available.

The main benefits covered under the schemes offered by the Agricultural Directorate and Popular Credit Bank as well as the Postal and Telecommunication Establishment include payments for first aid, laboratory services, diagnostic services, hospital care (lodging & surgery) in addition to pharmaceutical benefits as well as motherhood hospital care, elderly care, non curable illnesses and dentistry .The pricing is officially set by the Ministry of Health. The Agricultural Cooperative Bank and The Popular Credit Ban pay 100% coverage for basic medical care for employees and their families.

Cooperative fund of the Postal and The Telecommunication Establishment cover 100% of the basic medical care of the staff. Surgery is covered up to 60% of cost and drugs up to SYP 7000.

4. Legal issues of the insurance scheme

The insurance schemes at the Agricultural Cooperative Bank (Raqqa Branch) and the Popular Credit Bank (Raqqa branch) are guided by Directive No 165 of 1978 issued by the Ministry of Economy and External Trade. Whereas the Postal, The Telecommunications Establishments and the Directorate of Agriculture and Agrarian Reform (Raqqa) apply internal regulations to manage their insurance schemes. These institutions contract with the relative syndicates (doctors' syndicate, dentists' syndicate, pharmaceutical syndicate) for services.

5. Administrative issues of the insurance scheme

All employees who manage the insurance schemes are elected or designated from the internal financial and administrative departments of each institution.

The tasks of the administrative bodies of the insurance schemes identified in the study vary from collection of contributions, memberships, identification of healthcare conditions to contracting with providers. The administration is also responsible for financial planning and control which is sometimes implemented using a computerized system as in the case of the Popular Credit Bank.

6. Healthcare conditions

The providers which have contracted with the insurance schemes are located within both urban and rural areas in Raqqa governorate. The patient is free to choose the provider from a given list (usually provided from the syndicate). The insurance scheme compensates the providers such as private clinics, hospitals and laboratories either through the associated syndicate or directly paid by the member to the provider. The members then get compensations from the institution subject to the pricing system of the Ministry of Health.

7. Risk management

None of the institutions interviewed have any sort of risk management procedures (whether financial or administrative) for its health insurance scheme. Every new employee must submit a health document, issued by the Directorate of Health before being allowed into the health insurance scheme. However, this document does not provide an accurate situation of the member's health status at all which in turn subjects the health insurance scheme to major financial risks. To counteract such risks, some institutions transfer the financial cost of a patient who is costing them a lot, to the head management. In general the study demonstrated that there is no clear strategy for risk management within any of the institutions interviewed.

Finally, the medical and social insurance schemes at the governorate of Raqqa are underdeveloped and lack strategies that govern such schemes. There is no government sponsored health scheme covering all citizens (employed or not employed in the country). At the same time employed citizens of governmental institutions are partially covered; the services offered do not cover needs, and the amount paid are modest compared to actual medical expenses.

Study 7: Household health expenditure survey in al Raqqa







Studies on Health Seeking Behaviours and Capacity to Pay

-Study No.7-Household Income, Expenditures and Willingness to Pay for Health Insurance

R6.A2.P1-2

Final Report

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1-EXECUTIVE SUMMARY:

Al-Raqqa governorate is situated in the North-East of Syria and includes two oasis. Two rivers pass through it (Al-Forat and Al-Bleikh) as well as Al-Assad lake which is shared with the governorate of Aleppo. Being a crossroad of Al-Fourat basin and situated on the northern border of Syria, Al-Raqqa became a strategic center for agricultural crops, exchange of commercial goods, and export.

This study is a pilot case including surveys which evaluate the will and power to purchase health insurance package in the Al-Raqqa Governorate. It aims at creating a survey for a wider area including Daraa and Lattakia Governorates through other projects. This project is not to be confused with others within the Health Sector Modernization Programme.

The study took place in the following stages:

- 1. Studying the points which have to be covered by the surveys in order to meet the goals of the study.
- 2. Designing the template for surveys in both the rural and urban areas.
- 3. Gathering and filling 100 surveys for families in the rural area and another 100 for families in the urban area.
- 4. Encoding and analyzing data
- 5. Analyzing processes and results
- 6. Presenting the results of the study

We can summarize the findings of the study in the following points:

- The population of Al-Raqqa forms 4.5% of the population of Syria. It is a small portion given that this governorate forms 11% of the area of Syria.
- The unemployment rate in Al-Raqqa is relatively high (10.3%). This percentage is mainly composed of females for whom the unemployment rate is 14%, whereas that of males is only 9.5%.
- Labor forms the majority of the labor force (48%), followed by employees (23%).
- 60% of surveyed families do not own agricultural land and only 40% own some. The average area of owned agricultural land is 69.5 Acres. Al-Raqqa is mainly an agricultural governorate. 92% of agricultural land is cultivated and is a source of support of family income. The average yearly income from agricultural land is S.P. 70,911 per family.
- The study shows that the percentage of families with chronic diseases or disabilities is 8%.
- The percentage of families with sudden diseases is 12%. Of those, only 69% diagnosed their diseases whereas 31% did not.
- The most frequently diagnosed diseases are digestive and infectious diseases (19%) followed by nose and throat diseases (11%).
- Most of the surveyed families own the main electric appliances. This gives the impression that they have the required purchasing power to buy health insurance.
- The proportion of medical centers and hospital beds to the population is very low. Each center serves on average 16000 people.
- The currently applied health insurance systems covers only a small portion of the population (32,810).
- A large portion of the population is not currently studying and most of them are illiterate.
 This shows that health awareness in this governorate is somewhat low.
- 73% of surveyed people with chronic diseases diagnosed their sickness whereas 27% didn't.
- The most frequently diagnosed chronic diseases are heart (27%) followed by neural and gland diseases (both at 15%).
- 49% of the sample visits pharmacies for medical consultation, 34% visit private centers, 8% visit public centers, 8% visit dentists, and only 1% use popular treatment.

- The study shows that monthly health related expenditures reach S.P. 3769 per family and S.P. 446 per individual. Family expenditures are divided in the following way: S.P. 381 at public medical centers, S.P. 1648 at private ones, and S.P. 1710 for medication. Each individual spends S.P. 203 per month on medication.
- 57% of surveyed families find it very difficult to get the money for medical treatment, 24% find it difficult and only 19% find it easy.
- 20% of the families were unable to provide treatment for a member of their family 4 times during the last year, 10% were unable to provide treatment for a member of their family 2 times during the last year, 8% were unable to provide treatment for a member of their family 1 time during the last year, and 54% didn't have to deal with this problem.
- The study shows that the major reason for the inability to provide treatment is the high cost of the latter (40%). 9% of the families don't provide treatment because the sickness doesn't require it, 5% find it difficult to reach medical center, 1% don't trust the party providing treatment. 30% of the families provide treatment to their members.
- 52% of the surveyed families don't know what health insurance is while 48% do know.
- The average amount that each family can pay on a yearly basis for health insurance is S.P. 1224 to cover medication, S.P. 2187 to cover treatment of high cost diseases, S.P. 1048 for primary care, and S.P. 723 for mother and child care. Each family can pay up to S.P. 1907 for health insurance coverage, in addition to a S.P. 100 fee per medical visit. The average amount that each family can pay on a yearly basis for complete coverage is S.P. 3886.

Given all the above, following are our recommendations:

- A media awareness campaign is necessary to increase knowledge about health insurance (its goals, benefits, and importance). The governorate is in need of a health insurance system since 40% of the families cannot afford medical treatment.
- The system should be very simple administratively. Its cost should match the income level of the population of Al-Raqqa where the average amount each family can pay for complete coverage is S.P. 3886 and 52% don't know what health insurance is.
- Medical centers are not widely spread throughout the governorate and transportation cost to reach them is relatively high. We suggest a better distribution of those centers throughout the governorate.
- Public medical centers should be changed to independent ones in order to provide a better quality of services and recruit more highly qualified staff.
- The system should secure the rights of all covered individuals.
- Prior to the implementation of the system, staff members should be trained to use this system efficiently.
- Health insurance costs should be revaluated on a yearly basis through the creation and use of databanks.

2- Purpose:

This study aims at making establishing an experiment due to the continuous need to establish extensive HI Scheme especially for workers with the Government. These requirements are repeated continually by Government and the purposes of 10th Five-year Plan together with requirements of Popular Work Organisations. All these requirements are result of limited incomes categories need to secure cures & treatment for them and their families too. A pre-requisite for identifying HI Scheme is willingness & ability to pay the expenses by citizens.

This study intends to have a leading experiment to assess coverage of HI Scheme expenses in Raqqa Governorate. A wider questionnaire was designed to cover wider issues than those covered in Daraa & Lattakia via other projects on condition that this

Questionnaire in Raqqa shall not mix with other questionnaires in 2 pilot Governorates at HSMP.

This study was implemented in the form of filling up questionnaires in cooperation with HSMP on family health expenditures.

3- Methods for Conducting this Study:

The following stages were adopted in this study:

- Research on the points that are to be put into the questionnaire with view to achieving the targets of the study.
- 2 Designing models for questionnaire applying to both Town & countryside.
- 3 Collect & fill up 100 forms from countryside, another 100 for city.
- 4 Encodement & analysis of data.
- 5 Analysis of Procedures & results.
- 6 presentation of this study results.

Summary of the activities in this study:

3-1 Questionnaire form:

An integrated work team was formed up to fulfill this mission in cooperation with HSMP. Questionnaires were prepared in coordination with MoH Syria in order to make sure about the quality of these questionnaires prior to circulating them, and to check for the capacity of the people in charge for the mission to execute it. For this purpose, we distributed some experimental models of questionnaires to some families to fill them with view to establish an idea about the competence of questionnaires and the willingness of families to fill these forms. We trained responsible staff on filling these forms to secure accuracy & quality in doing this study.

3-2 The team traveled with Consultancy Office Staff to Raqqa Governorate to start distribution of questionnaires to families there. The team (4 people) divide into two groups. One was responsible for city and the other was responsible for countryside.220 questionnaires were filled in two weeks time which was the time of the project. Under supervision of a specialist who was there for responding to any queries or problem might arise while doing the survey.

3-3 Data Collection:

After filling the questionnaires, Consultancy Office assigned an employee for Data entry to computer using a special computer programme, another employee was there to supervise, check for the quality of data entry & to secure an extent of truthfulness in doing the work.

3-4 Release of Report:

After all, preparation for wording of the report by Consultancy Office by a specialised team to discuss the report with HSMP representatives.

4-Status of Ragga Governorate:

4-1Introduction:

Raqqa is located to Northeast of Syria, including two deserts, River Euphrates & its tributary River Baliekh pass through this Governorate. It also shares a large part of Assad Lake with Aleppo Governorate. Due to being located in the corner of two rivers then extending north to the Syrian-Turkish Border line, Raqqa Governorate became a strategic linking point for all crops, exchange of products for export.

Among the most remarkable places in Raqqa is al-Baath Dam which was achieved in 1990 upon which this Governorate depends. The storage capacity of this Dam is up to 90 million m³.

Table 1: Information about al-Baath Dam:

Storage Capacity Per 1000 m ³	Water Basin Per 1000 m ²	Maximum Height (m)	Length (m)
90000	27150	12	2650

Information source: Statistical Group Page 49.

Table 2: Territory per Square Acres:

Brown Agronomy Soil	90
Desert Soil	273
White Soil	2596
Black Soil	248
Soil formed up fromground water sources	
Total	3306

Source: Statistical Group- land Survey department.

4-2 Population Status & Demographical indicators:

Population in Raqqa Governorate are distributed as follows:

Table 3: Distribution of Population according to Civil Registration Records (Gender) on 1/7/2005.

Record	Gender	Gender (Per 1000 people)		Percentage from	
	Males	Females	Total	Total Population of Syria	100 Females (Gender Rate)
Raqqa Governorate	413	398	811	4.5 %	96

Source: Study on HI Scheme at Raqqa Governorate Page: 2.

We notice of what was mentioned above that Population Rate of Raqqa Governorate is 4.5 % of the Total Population of Syria. It is a very little percentage compared to the territory of land which is 11% of Syrian Territory.

Table 4: Population Estimate currently resident in Raqqa on 1/7/2005 according to Gender & Lifestyle(in thousands)

Record	(City/ Town			Countrysid	le	Grand Total
	Males	Females	Total	Males	Females	Total	811
Raqqa Governorate	155	149	304	258	249	507	

Source: Study on HI Scheme at Ragga Governorate Page: 3.

We notice that the majority of Raqqa inhabitants are in countryside.

3-4: HRs & Workforce Status in Ragga Governorate:

Workforce in is centered Raqqa Governorate on Agronomy & Farming activities due to having two rivers and a lake in which makes land more fertile than ever. Raqqa Governorate comes in the first place as for employment of workforce both Males & Females. Building & Construction activities comes in the second place for Males. Education activities comes second for Females.

Table 5: Proportional distribution of Workers above 15 Years according to Gender (%)

Activity	Males	Females	Total
Farming, forestation & Hunt	41.1	70.1	46.1
Fishing	0.2	-	0.2
Stone & Metal Industry	0.3	-	0.2
Transformation Industry	6.2	3.5	5.7
Electricity, Gas & Water	1.6	0.3	1.4
Building & Construction	20.4	3.3	17.4
Wholesale	8.4	1.0	7.1
Transport, Storage& Telecom	5.5	0.5	4.6

Financial Brokers	0.1	-	0.1
Real-estate Broker & Lease	0.6	0.1	0.5
Public administration& Defense	8.3	3.8	7.6
Education	3.9	14.8	5.8
Social Services	1.6	0.4	1.4
Domestic Services	0.1	0.3	0.1
International Organisations	1.6	2.0	1.7

Source: Gross Population & Habitat Count: Primary Results in 2004 Page: 54

Unemployment Rate in Raqqa Governorate is 10.3 % which is high where Females have most of it 14% of them are unemployed. Whereas, Unemployment Rate for Males is 9.5%.

Table 6: Employees Count above19 Years old:

Males	Females	Total
198810	192330	391140

Source: Study on HI Scheme at Raqqa Governorate Page: 8

Table 7: Unemployment Rate above 15 Years according to Gender: (Percentage)

Workforce	Males	Females	Total
Employed	90.5%	86.0%	89.7%
Unemployed	9.5%	14.0%	10.3%
Total	100%	100%	100%

Source: Gross Population & Habitat Count: Primary Results in 2004 Page: 53

Health Status at Raqqa Governorate:

The table below indicates all sorts of Healthcare services at Raqqa Governorate. Though these services are not sufficient for population.

Table 8: basic Physical Indicators of Healthcare Sector in 2005:

Indicator	S	Unit	Available	Average Population per Unit
No. of Healt Specialised	h Centers & Units	Centers	48	16000
Public Ho	spitals	Hospital	3	
Public Hosp	itals Beds	Bed	400	2052
Private Ho	ospitals	Hospital	7	
Private Hos	pitals Beds	Bed	161	6000
No. of	Public	Doctors	367	1150
Doctors	Private	Doctors	347	
No. of	Public	Dentist	63	3284
Dentists	Private	Dentist	187	
No. of Ph	armacists	Pharmacist	304	2700
No. of Nu	rses	Nurse	557	
No. of Mic	dwives	Midwife	178	
No. of Pa	ramedics	Technician	201	_

Source: Study on HI Scheme at Raqqa Governorate Page: 6+7

Having analysed some of the figures related to HI Scheme implemented now at Raqqa Governorate, we found that Total No. of employees at Public Sector who are beneficiaries of HI Scheme was as follows:

- Employees at Public Sector are /32810/ who are still incumbents holding their posts till now.
- Pensioners at Public Sector are /3000/ distributed in belongingness to Social Security Establishment & Pension and Insurance.
- No. of Unemployed who are registered at Employment Office are /39125/³

.....

Source: Study on HI Scheme at Ragga Governorate Page:8

5- General Assessment of Results:

The Research Team has prepared a Questionnaire Form in order to get figures & data that help in defining the Social Status of Raqqa Governorate. The sampling of this Questionnaire Form is annexed to this study report. All data entry was done by MS Excel & Ipstus Stat programme to facilitate data analysis and avoid confusion and overlapping in the questions.

220 Questionnaire Forms were filled out for 17 Families to get information, while 6 Forms were incomplete in a way they were invalid for analysis. Therefore, total No. of Questionnaire Forms was 197.

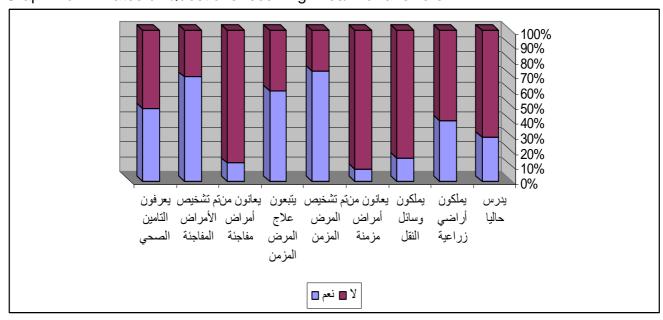
Questions on the Questionnaire were sorted out, then analysed on different stages. The table below shows "yes/No" answers and their results (Percentage):

Table 9: Outcome of "Yes/No" answers:

Record / Question	Yes	No
Currently Studying	29%	71%
Possessing Farming Land	40%	60%
Possessing Transport Means	15%	85%
Suffering from Chronic Diseases	8%	92%
Chronic Diseases Diagnosed	73%	27%
Take Cure for Chronic Diseases	60%	40%
Suffering from Sudden Diseases	12%	88%
Sudden Diseases Diagnosed	69%	31%
Have info about HI Scheme	48%	52%

Source: Questionnaire Forms+ Tabulation of AMC

Graph No.1: Rates of Questions receiving "Yes/ No" answers.



Source: Questionnaire + AMC Tabulation:

Legend: from left to right: (Blue means "Yes". Purple means "No")

People know about HI Scheme, Diagnosis of Sudden Diseases, People suffering from Sudden Diseases, People having Therapy for Chronic Diseases, Chronic Diseases Diagnosed, People suffering from Chronic Diseases, Possess Transport Means, Possess Farming Land.

5-1Societal Rates:

<u>Gender</u>: the study showed that Males percentage is 49% of the family members who were surveyed, Females percentage is 51%.

<u>Marital Status</u>: Figure below shows the rate of unmarried individuals as 64.4% which is the largest in the targeted social category. This study was directed for families having children, so it shows that bachelors rate is the largest category. Married rate is 33.86 %, widowed rate is 1.5%, and divorced rate is 0.24%.

الحالة الاجتماعية الرملة W مطلق D مطلق W معروج M معروج M معروج 34%

Figure 2: Marital Status for this sample:

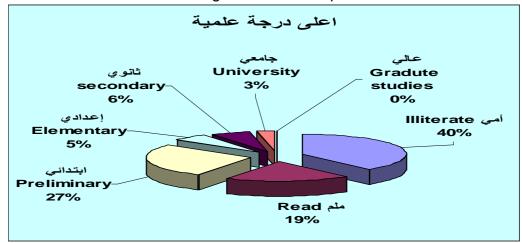
Source: AMC Statistics& Questionnaires.

<u>Individuals still studying:</u> Study showed that their rate is 29% of surveyed families. Those not studying are 71%. The latter rate is considered to be very high. Given that boys are majority in family member in the smple but they don't join any teaching institution.

Schooling & Education Levels of Surveyed individuals:

Figure below shows the highest rates an individual obtained. We find the highest rate is for the illiterate who don't read or write which is 38.97% of surveyed families. Those who read without knowing how to write are 19.3%. Elementary certificate holders are 27.3%. Preparatory certificate holders are 5.47%. Secondary certificate holders are 5.47%. University graduates are 2.77% only. Post-graduate certificate holders are none. This ensures what was mentioned above for illiteracy rates in Raqqa Governorate to be high. School & university education rates are very low.

Figure 3: Distribution of Scientific Degrees in the sample:



Source: AMC Statistics& Questionnaires.

Residence Place:

There are a large rate of surveyed families permanently resident in countryside up to 63%. 37% are city residents.

5-2: Work related Rates:

Workers rate of family members: study showed that rate of people working in Raqqa Governorate is 21% only of surveyed families. Whereas unemployed rate is 79% due to members being children. This rate is fairly acceptable, where we found that a large number of family members work to earn a living. Study showed average annual work for worker members is 8 months in a year only (i.e. majority of works are temporary or non-contractual).

Status of Individuals Work:

Figure below showing rates work fields for Raqqa Governorate population where workers (labourers) are the majority in workforce 48%. Then, in the second place are employees 23%. Drivers rate are 6.3% only. Farmers & handcraft are 5.8% and 5.5% in sequence. Traders (merchandise) are 2.3%. Engineers are 1.2 %. Pharmacists, lawyers, and doctors are less than 1%.

Figure 4: Work Fields in Raqqa Governorate



Source: AMC Statistics& Questionnaires

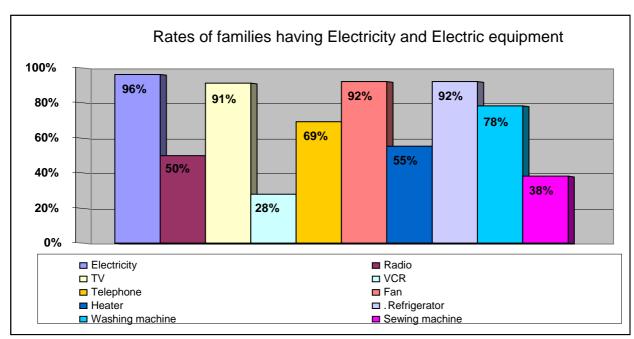
Study estimates Average Gross Annual Revenue of employment and labour as (154.722 SYP) for each surveyed family. Individual share is (18.887 SYP).

5-3 Purchase capacity Data:

Rate of Surveyed families possessing Home Appliances:

- 96% of them have electricity at home.
- 92% of them have refrigerators.
- 91% of them have television sets.
- 78% of them have washing
- 68% of them have telephones.
- 55% of them have heaters.
- 50% of them have radio sets
- 38% of them have sewing machines
- 28% of them have VCR sets.

Figure 5: shows rates of families having electricity and electric equipment:



Source: AMC Statistics& Questionnaires

Individuals Possessing Farming Land: study showed that 60% of families in the survey do not possess property as farming land. Furthermore, gross land property of land for surveyed families was /5491/ acres. Individual share of these lands is /69.5/ acre. Revenues related to farming land is so important in Raqqa Governorate. This is attributable to the high large number of these lands and abundance of water. Study showed that 92% of these lands are invested and they support the income of people in Raqqa Governorate. It also showed that Annual Average Revenue of these lands is / 70.911 SYP/ per family.

<u>Individuals Possessing Real-estate Property other than the one residing in it:</u> 96% of surveyed families do not possess any real-estate property other than the one residing

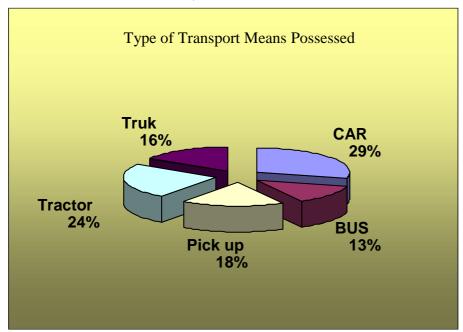
in. only 4% percent of families possess one. Net Annual Revenue of these real-estate is /62.938 SYP/ per family.

<u>Individuals Possessing Transport Means for Investment</u>: the rate of those possessing is 15% of surveyed families & 85% of them don't. Annual Revenue of these invested transport means is /60.100 SYP/ per family.

29% of these families possess cars, 24% possess tractors, and18% possess Pick-up cars.

Figure 6: shows Type of Transport means possessed by families:



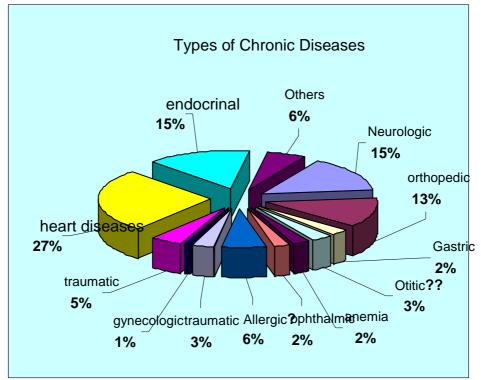


5-4 Rates related to Health:

<u>Chronic Diseases & Impairment</u>: rates of population suffering from chronic or diseases or impairment is 8% for surveyed families. 92% don't. Figure below shows that 73% of family members suffering from a chronic disease or impairment and it was diagnosed, whereas 27% don't have their chronic diseases diagnosed.

In the figure below, we can see the mostly common diseases among surveyed families are heart diseases (27%), and neurotic, endocrinal ones (15%).

Figure 7: Types of Chronic Diseases



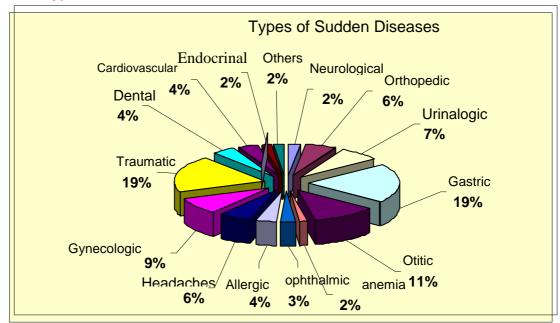
Source: AMC Statistics& Questionnaires

Study showed that 60% of surveyed family have had treatment for chronic diseases or impairment they suffer from, 40% don't. Moreover, total days of ceasing work due to disorders because of chronic diseases or impairment was 17 days per month.

<u>Sudden Disease (Disorders):</u> Study shows that 12% of surveyed families incur sudden disorders, 88% don't. 69% of family members surveyed for suffering from sudden disorders had diagnosed such a disease. Whereas, 31% had not.

Figure below indicates the most common Types of Sudden Diseases among surveyed families being "Gastric & Traumatic" 19%, next is "Otitic Disorders"

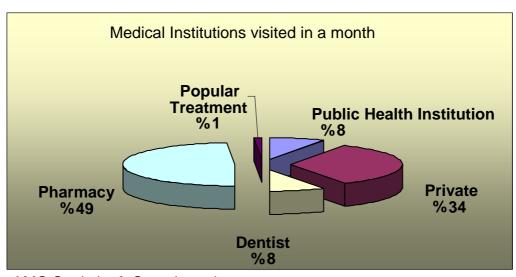
Figure 8: Types of Sudden Diseases



Source: AMC Statistics& Questionnaires

Study also showed that individuals suffering from sudden disorders were off duty for 10.6 days per month.

Figure 9: Medical Institutions visited in a month:



Source: AMC Statistics& Questionnaires

Study indicates that total number of times for individuals in surveyed families visiting a medical institution is /1.349/. Figure below indicates number of times they visit pharmacies is the highest rate 49%, then comes visiting a private healthcare medical institution 34%, checks with dentists is 8% same for visiting public healthcare institutions, and visiting a popular treatment place is 1%.

Distribution of money afforded for Medical Checks

Popular
Treatment
Public healthcare institution
% 0 % 10

Pharmacies
% 44

Private healthcare institution

Figure: Distribution of money afforded for Medical Checks

Dentist

% 3

Source: AMC Statistics& Questionnaires

Average Monthly Payment for Health per family is about /3769 SYP/. Average expenditure for healthcare is /466 SYP/ per capita. A family pays /381 SYP/ for public healthcare institutions, /1648 SYP/ for private healthcare institutions. The share of a family of drugs expenditures is /1710 SYP/. Per capita expenditure for drugs is /203 SYP/. The largest rate out of sums afforded for Healthcare belongs to expenditure for drugs as 43%, in the second place is expenditures for private healthcare institutions, but expenditures for public healthcare institutions is 10%. Expenditure for dentists is 3%. We hardly can mention costs for popular treatment.

% 43

Study indicated that average monthly expenditure per family for services such as blood analysis and radiography is /857 SYP/ whereas average monthly expenditure for transport to reach public healthcare centers is /410 SYP/. It is indicated that 57% of surveyed families find it difficult to a certain extent to afford costs of healthcare treatment , 19% of families find it easy to afford these costs. As in the following pie.

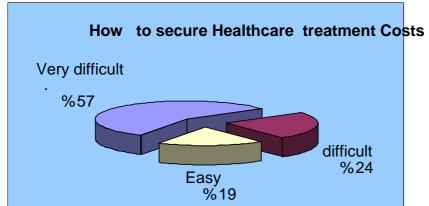


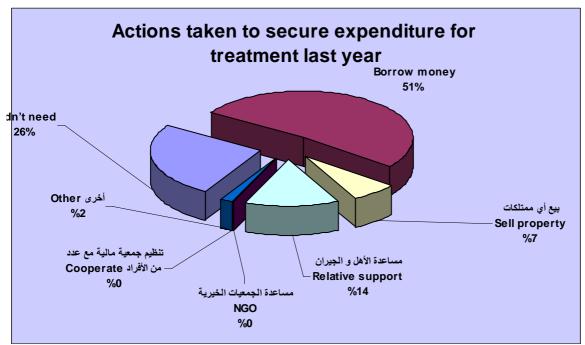
Figure 11: Ways to secure expenditure for healthcare treatment:

Source: AMC Statistics& Questionnaires

Study showed that majority of surveyed families borrowed money to afford costs of treatment. Borrowed money rate is 52% f families needed coverage of these costs. 14% secured money from relatives & friends. 7% were forced to sell their property out in or-

der to secure money for treatment. While 26% of families didn't need to do such actions (i.e. they have external assistance).

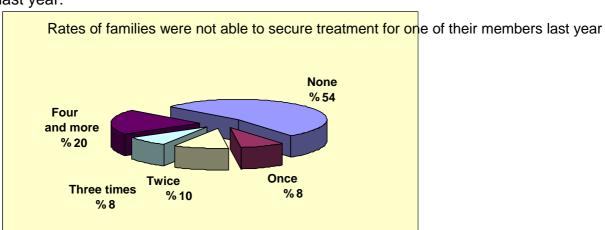
Figure 12: Actions taken to secure expenditure for treatment last year:



Source: AMC Statistics& Questionnaires

As it appears, 20% of families were not able to give treatment to one of their members for more than 4 times this year(Figure 13), 10% families were not able to give treatment to one of their members for more 2 times. 8% families were not able to give treatment to one of their members for 3 times 8% families were not able to give treatment to one of their members for once. 54 % of surveyed families in Raqqa Governorate didn't have such an experience last year.

Figure 13: Rates of families were not able to secure treatment for one of their members last year:



Source: AMC Statistics& Questionnaire

The root cause to this was the high cost of treatment in 40% of families surveyed because of its high cost, 9% of families do not have treatment because it was not urgent. 5% of the families didn't due to difficulties in reaching it. 1% did not because they do not have confidence in providers. 30% of families had treatment done.

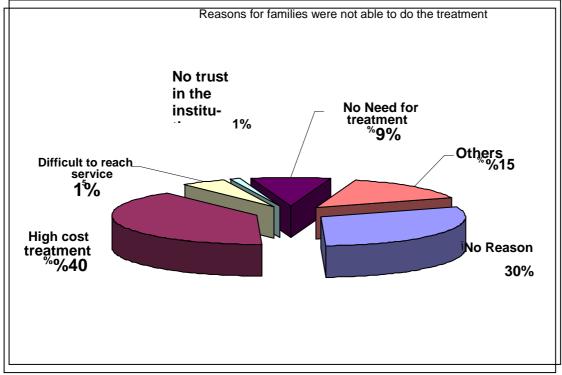


Figure 14: Reasons for families were not able to do the treatment

Source: AMC Statistics& Questionnaire

52% of surveyed families do not know about HI Scheme. 48 know what it is like. The sum a family can pay for it is /1224 SYP/ annually on average in return for coverage of drug expenses &/2187 SYP/ in return for covering diseases of high cost. /1048 SYP/ can be paid for primary healthcare coverage./723 SYP/ can be paid for maternity & childhood care.

A single family can pay /1907 SYP/ for healthcare in addition to paying /100 SYP/ per visit to health centres. As for overall Health Insurance, a family is willing to pay /3886 SYP/.

6- Recommendations:

- There has to be done education process among population to increase their knowledge on HI Scheme. (its purpose, budget & importance). There is no doubt that this governorate, as in the case of other governorates in the country, need to have an Overall HI Scheme to all families where we find 40% of them not able to afford high costs of treatment.
- Suggested HI Scheme must be simple in its procedures & regulations and its cost is proportionate with income. Study showed that every family can afford up to / 3886 SYP/ for a subscription in HI Scheme. 52% of popu; ation do not know anything about it.
- Study showed that Healthcare Centres are not spread in a sufficient way in the Governorate. A family pay high cost for reaching to these centres to obtain treatment.
- Transformation of public healthcare institutions into independent ones with view to pushing them to give high quality services and recruiting suitable Medical Staff Cadre.

- Having suggested any HI Scheme, this scheme must be simple and clear to maintain the rights of all individuals.
- Before implementing HI Scheme, there must be an integrated and trained staff in order to invest and apply this scheme in a perfect way.
- Annual reassessment of HI Scheme costs through having information banks.

Sources:

- -Statistical Group, Central Statistics Office, Syrian Prime Ministry, 2005.
- -Primary Results, Houses & Population Count, Central Statistics Office, Syrian Prime Ministry, 2005
- www.made-in-syria.com/ragga.htm
- Study about HI Scheme in Raqqa, Raqqa Directorate of health, MoH, Syria.

Formats of Questionnaires:

Questionnaire No.:
Questionnaire Filled by:
Date:
Time:

1- Introductory Data:

Area	
Town	
Address	
Result Code	
1-Successfully completed	Remarks specify please:
2- No one in the house	remaine openy pieces
3- Interview refused	
4- others	

	s Family Members		1	T	_	1		
1	2	3	4	5	6	7		
Serial No	Family members	Gender	Age /	Marital	Currently	Highest Grade of		
		1-Male 2-Female	Years	Status	studying 1- Yes 2- No	Education		
1								
2								
3								
4								
5								
6								
7								
8	3							
9	9							
10								
Family Members Code					atus Code	Education Code		
1- Husband		7- daughter's fa	ather in law	1- Bachelo	r	0- illiterate		
2- Wife		8- Brother/ sis	ter of hus-	2- Married		1-know how to read 2- Elementary education		
3- Son/ Daughter		band/wife		3- Widowed		3- Preparatory education		
4- Son	/ daughter in law	9- other relative	Э	4- Divorce	d	4- Secondary education		
5- Gra	nd son/daughter	10- Adopted so	n			5- University graduate		
	-	11- Step son				6- Higher education		
		12- No relation						

2- Family members who work:

Now I am going to ask you for the work of each member of your family

	Basic v	vork					Overt	ime				
No of line	Has he worked last month	Is it per- manent?	How many months he works aver- age	Average No of Months he works	Is it paid	How much a month	Has he had over- time last month	Is it perma nent?	Average no of month s he works	Wh at sort of wor k is it?	Is he paid for the job	Monthl y av- erage wages
	1-yes 2-no	1-yes 2-no	Write number	Write Code	1- yes 2-no	Write num- ber	1-yes 2-no	1-yes 2-no	Write num- ber	Writ e Cod e	1- yes 2-no	Write num- ber
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

Job Code	3-doctor	6-farmer	9- merchant	12- military	
1- employee	4- lawyer	7- pharmacist	10- manufacturer	13-	
2-Engineer / assistant	5- worker	8- handicraft	11- driver	14- others	
Engineer					

- Sewing machine 1- yes 2- no	3-	Do your family have - Electricity at home? - Radio set - Television set - VCR - Telephone - electric fan - Electric heater - Refrigerator - Washing machine - Sewing machine	1- yes 2- no	
-------------------------------	----	--	--	--

5	Do the family possess farming land?	Yes
		No
6	How much is its overall territory?	
7	Is this land invested?	Yes
		No

8 What is the Average Revenue of it?

9	Do family possess any real-estate property other than	Yes
	its residence?	No
10	Average net revenue of these real-estate?	

11	Do family have	1- yes 2- no
	A car	1- yes 2- no
	A bus	1- yes 2- no
	A pick-up	1- yes 2- no
	A tractor	1- yes 2- no
	A lorry	1- yes 2- no
		1- yes 2- no
12	Average Revenue of these transport	SYP
	means	

13- Health Status (Chronic Diseases)

Row	Attribute	Sufferir chronic ease	ng from : dis-	Since he suff	when ers	Did tor agno it	doc- di- ose	What was the disease	Do yo medicat	ou have ion for it	Does it you fror daily acti	n doing	How days	many last
		1-yes	2-no	year	mont h	ye s	no		yes	No	yes	No	Days	
1														
2														
3														
4														
5														
6														
7														
8														
9													·	
10														

13- Health Status (Sudden Diseases)

Row	Row Attribute Suffer from sudden disease 1st time		sudden dis- he suffers tor di-		What was the disease	Do you have medication for it		Does it prevent you from doing daily activity		How days month	many last			
		1-yes	2-no	year	mont h	ye s	no		yes	No	yes	No	Days	
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														

		Institution visited	How many checks	Any ment checl		Money paid	Any pres for diseas	scription se	What ex- penses you paid	, ,		What was the cost
				1- yes	2-no		1-yes	2-no		1-yes	2-no	
1	Public institu- tion											
2	Private institu- tion											
3	Dentist											
4	Pharmacist											
5	Popular treatment											
total												

16	How difficult was it for	ou to secure ex- Very difficult	Very difficult			
	penses of treatment?	Fairly difficult				
		Easily				
	•	•				
17	Have you done any of	Borrowing money	1			
	these things to afford	Sell out a property	2			
	expenses of treatment	Asking for help from neighbours or	3			
	for any of your family	relatives				
	members?	Charity/ NGO help	4			
		Organize collection of money with	5			
		some friends				
		Others (please specify)	6			
18	How many times any of	None	1			
	your family members		2			
	needed treatment and	111100				
	you didn't afford ex-	Thrice	4			
	penses of ?	Four times & more				
19	What was the reason	High cost	1			
	you didn't afford ex-	Difficulty in reaching the place	2			
	penses of treatment to		3			
	any of your family mem-					
	h a ra O					

20	To which extent a citizen	Have you ever heard about HI, if yes answer
	wishes to subscribe for	please next question.
	HI (1) yes, (2)no	HI Scheme can cover all expenditure for
		healthcare including serious cases in return
		for regular subscription fees paid in advance
		on monthly basis. Is this clear to you?

others

bers?

21	To which extent you are willing to pay for a	Coverage of drug for family members
	subscription in HI Scheme? In case, what	Coverage of high cost diseases(open heart
	·	surgery, lever plantation
	money you can afford?	Coverage of Primary healthcare(vaccines,
		clinical checks, radiography, lab services
		Maternity & child care coverage
		In case all healthcare needs are covered with
		no exceptions for paying a little amount of
		money (100 SYP)
		In case all healthcare needs are covered with
		no exceptions for paying no money

MINISTRY OF HEALTH





EU-Syria

Health Sector Modernisation Programme

HSMP

Existing Demand for drugs in urban and rural areas in Lattakia and Dara'a governorates

Study No.8

Final Report - November 2006



Prepared by: MCI International

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Executive Summary

The scope of this study is identifying the demand of drug demands in urban and rural areas of Lattakia and Dara'a governorates and to determine the funding processes and integrate them in health insurance schemes, in addition, this study will be considered as a pilot study in other governorates.

This study has been implemented as follows:

- 1- Identifying nine pharmacies in Lattakia governorate(five in urban and four in rural areas),
- 2- Identifying eight pharmacies in Dara'a governorate(four in urban and three in rural areas),
- 3- Identifying basic properties of the related questionnaires with cooperation of the ministry of health experts,
- 4- Conducting staff training about obtaining information and the ways of filling out the questionnaires,
- 5- Encoding and validation the authenticity of the information.
- 6- Analyzing data obtained through " SPSS Ver.13 program "
- 7- Submitting the final report about this study results.

This study gives a fundamental idea about the demand of drug in Lattakia and Dara'a governorates and identifies the frequency, therapeutic group percentages; it also gives an idea about the treatment costs.

Tow questionnaires were used in this study, the first one was about pharmacies indicators, and the second about the therapeutic groups sales and properties.

The following points have been surveyed through out the first questioner:

- New prescriptions,
- Old prescriptions,
- Self prescriptions,
- Consultation on signs and symptoms,
- Demand for cheap drugs,
- Demand for just part of the prescriptions,
- Demand for just few units(due to cost),
- Recommendation for home remedy,
- Prescription for foreign drugs,
- Prescription for smuggled drugs,
- Demand for smuggled drugs

The following points have been surveyed through out the first questioner:

- Brand name,
- Therapeutic group,
- Form
- Composition
- Price and size.
- This study results could be summarized as follows:

- In most pharmacies, the demands of new or self prescriptions were the highest percentage among the rural areas, but in urban areas the highest percentages were for the old or new prescriptions.
- It is also notable that, both in rural and urban areas, the highest demands were for Anti inflammatory drugs, Analgesics antipyretics, and Cardiovascular drugs,

Finally, as this kind of studies plays a major role in health care household expenditures and in forming health insurance schemes, we suggest similar studies to be implemented to cover all the conditions and locations of pharmacies.

1- Scope and Purpose:

Scope of this Study is to have a selected group of 10 private clinics in Lattakia Governorate (5 in rural places, 5 in city).

Purpose of this study is to achieve:

Agree on types of demand on private clinics in Lattakia Governorate both in rural, city places.

Data collect and analysis about basic characteristics of demand on private clinics.

2- Methodology:

Three basic stages were used:

2-1 Stage 1:

We called it 'Preparing Stage'. In it workshops were held in MCI International or with HSMP Experts with Directorate of Planning at MoH to agree on questionnaire forms with view to reaching into the most appropriate format to fit the scope and purpose of this study.

2-2 Stage 2:

This is supposed to be 'training and planning stage' in the project, so experts of MCI International on how to deal with outcome questionnaires from stage 1. physical resources required for launching this study particularly computer programmes used for such studies. The following programmes are chosen:

SSPS Statistics, Ver. 13.0 for Windows

3-2 Stage 3:

Implementation of study is in this stage when data is collected taking basic questionnaires t be fed to the above mentioned computer programmes then moving further into analysis and arranging the results.

These questionnaires were filled under supervision and full coordination with specialised staff in Directorate of Health, Lattakia.

We were aided in this study all through its stages by statistics issued by Central Statistics Office, especially Statistic Group, 2005 Version which is the latest version available right now.

3- Essential Information about Lattakia Governorate:

Located to northwestern side of Syria, 320 Km far from Damascus. It has a major seaport in it on Syrian coast. It is considered to be a major tourist attraction place.

3-1 Population & Demographical Indicators of Lattakia Governorate:

Population of Lattakia toll up to /891.000/, so the portion of Lattakia population from overall Syrian population Count is /4.91 %/ as I Table No.1 together with population growth average during past years and recent times.

Table 1: Percentage of Lattakia Governorate & Annual Average of Population Growth AVPG: Results of Population Count (1981-1994)

AVPG: (1995-2000/ 2000-2005)

7.1.1 G. (1.000 = 0.00)										
Governorate	AVPG per 1000	0		Governorate Population Percentage Overall Count of Population						
	1981-1994	1995-2000	2000-2005	1981	1994	2004				
Lattakia	22.6	19.3	17.5	6.1	5.4	9.4				
Grand Total	33.0	27.0	24.5	100	100	100				

We can see from the table that a drop in the Growth at this Governorate (0.0017.5) compared to the Average of Population Growth in Syria (0.0024.5) during (2000-2005). The total Population No. of Lattakia Governorate out of Overall Population has dropped during (1981-2004) by 1.2%.

The source of Tables 1-15 is Statistical group/ E- version issued by Statistics Office-Damascus/ 2005.

Table No. 2 shows us the rates of Gender & Demographical Density in Lattakia Governorate:

Governorate	Table 2	Table 2: Rates of Gender & Demographical Density of Lat-							
	takia G	takia Governorate (1970-1981-1994-2004)							
	No. of	Males for per	Density per Sq. Km						
	100 Fe	males							
	1994	2004	1970	1981	1994	2004			
Lattakia	104.8	102.0	169	241	324	383			
Grand Total	104.7	104.5	34	49	74	96			

Table 3 shows the Proportional Demographical constituents of Lattakia Governorate according to Gender ,Age Groups, Residence Place in Mid-2005.

Table 3: Proportional Demographical constituents of Lattakia Governorate according to Gende	r ,Age Groups,& Resi-
dence Place in Mid-2005	

Governorate	Urban Places Rural Places				Total					
	Males	Females	Total	Males	Females	Total	Males	Females	Total	
Lattakia	230	225	455	220	216	436	451	440	819	
Grand Total	4977	4728	9705	4291	4142	8433	9288	8870	18138	

3-2 Workforce:

This Table shows the Number of Proportional Distribution Unemployed Population in Lattakia Governorate.

Table 4: Proportional Distribution Unemployed Population in Lattakia Governorate according to Gender Total Population	oula-
tion of Syria.	

tion of Syna.										
Governorate	Previo	ously Unemp	loyed	Unemployed(No job before)			Total			
	Males Females Total			Males	Females	Total	Males	Females	Total	
Lattakia	3.9	6.2	4.2	9.9	17.3	12.1	9.5	17.0	11.7	
Grand Total	100	100	100	100	100	100	100	100	100	

Table No.5 shows distribution of work injuries in Lattakia Governorate. The percentage appears as 12.7% out of the Total Work Injuries in Syria. It is considered to be second highest rate in the country compared to other Governorates.

Table 5 : Work Injuries in Syria according to the nature of work the injury was	s incurred in during 2004 in Lattakia Gov-
ernorate	

Governorate	Machinery	Lift Equipment	Other Equipment	Hazardous Material & Radioactivity	Surrounding Of the Work	Other Types not mentioned	Total
Lattakia	328	271	94	-	1481	75	2249
Total	2326	971	820	213	10613	2744	17687

Table No.6 shows that work force in Lattakia Governorate depends mainly on Agricultural Sector. It constitutes 30.6% of the Workforce of the Governorate.

Table 6: Distribution of Workforce in Lattakia Governorate according to Gender & Economic Sectors.										
	1970	1994	1999	2001						
Workforce percentage/ Population	25.6	29.3	42.3	44.4	%					
Women workforce out of Gross Workforce	17.1	23.2	35.8	35.2	%					
Workforce according to the economic sectors	S:									
Agriculture	55.2	25.1	51.6	36.6	%					
Industry	10.6	11.3	11.2	20.5	%					
Other Activities	33.9	63.6	37.2	48.9	%					

1-1-3 Health Factors & Indicators:

It is noted that Lattakia Governorate occupies position no.5 if compared to the rest of Governorates in Syria with regard to the Number of Health Doctors, Pharmacists and Orthodontists in it. It also occupies position no.8 as for the number of technical assistants, and position no.6 for number of Licensed Midwives. However, all these indica-

tors drop sharply with regard to population coverage rate per each doctor. We can see that this coverage rate has taken position No.12 for doctor, orthodontists as well.

Table 7: Con	nparison o	f No. of Health	Profession	als in Syria & l	Lattakia Gov	ernorate(1999)-2004)	
	Health D	octors	s Orthodontists		Pharma-	Technical	Licensed	Nursing
Years	Count	Average of population per doctor	Count	Average of population per doctor	cists	Assistant	Midwives	Staff
1999	21393	753	10694	1506	8189	11233	4832	25680
2000	22408	728	11160	1462	8868	12030	4909	27164
2001	23784	703	12228	1267	9882	13339	5081	27913
2002	25073	683	14610	1172	10055	14057	5171	28325
2003	24473	717	14917	1176	10809	14798	5184	27o45
2004	25890	694	15312	1174	12724	16542	5443	28665
Lattakia	2126	426	1223	740	717	814	411	3508
Gover-								
norate								

Table No.8 shows that Lattakia Governorate Average population per hospital bed is lower in the classification compared to other Governorates in the country. It occupies (No.10) and it is lower even at the Overall level in the country. This therefore necessitates efforts to be exerted to increase hospitals & beds as well.

Table 8: Hosp	itals & Be	ds in Syria 8	k Lattakia G	overnorate			
Years	Public F	lospitals	Private Ho	spitals	Total		Average Popula-
	No.	Beds	No.	Beds	No.	Beds	tion per bed
1999	63	12202	312	5567	375	17772	842
2000	65	12518	325	5852	390	18370	830
2001	67	12418	336	6003	403	18421	848
2002	66	14311	343	6343	409	20654	829
2003	76	15227	364	6590	440	21817	804
2004	78	15487	376	6795	454	22282	807
Lattakia	4	1029	12	225	16	1254	722
Governorate							

Tables No. 9 to 14 show Medical Indicators and the level of Medical Services offered.

Table 9:Total Services by MoH in Lattakia Governorate in 2004										
Governorate	Health Centers	Hospitals	Emergency	Total						
Lattakia	1162895	980873	150765	2294533						
Total	25066201	14450391	3043440	45260032						

Table10: Health Centers: General & Specialised in Lattakia Governorate in 2004									
Year	General HCs	Specialised	Total	Health	Polyclinics				
		HCs		Points	-				
Lattakia	98	2	100	12	-				
Total	1175	43	1218	255	14				

	Table 11: Progress of work in Health Centers in Lattakia Governorate in 2004													
Gover- norate	Chil- dren Vac- cines	Teta- nus/Wo men	Preg nant Care	Fam- ily Plan- ning	Safe Child Clinic	Health Educa- tion	Healt h Moni- tor	Nutri- tion pro- gram	Ther- apy for Pa- tients	Den- tal Care	Labo- ratoy Ser- vice	Vac- cina- tion Cam paign	Poly- Clini c	Total
Lattakia	185796	1836	5890	3150 7	2449 4	28456	3997	71392	228269	1417 95	92132	7917 9	0	9010 70
Total	615548 9	487107	9824 2	6505 82	4348 83	253594	1069 98	704960	343434 6	1062 443	17699 98	1397 233	1237 157	1770 3036

Table 12 : Pa	Table 12: Patients Progress in MoH Hospitals in Lattakia Governorate in 2004									
Governorate Out Clin- Emergency Surgeries Laboratory Radiography Physiotherapy Endoscopies Dialysis Services										
Lattakia	230761	150765	18271	577451	120858	1817	22252	9553		
Total	2145161	3043440	425357	9556798	1646361	172185	370112	129848		

Table 13: Patients Progress in Private Hospitals in Lattakia Governorate in 2004										
Governorate	Out Clin- ics	Emergency out patient	Surgeries	Laboratory Services	Radiography	Dialysis	Physiotherapy	Endoscopies & Graghies		
Lattakia	6085	19	8938	2015	2239	-	-	-		
Total	233165	254999	116606	800685	181218	3854	2087	18938		

Table 14: Patients of Mol	H 1999-2004.		
Year	Total In patients	Total Out patients	Average stay days
1999	1653531	1680823	2.572
2000	1672139	1675694	2.48
2001	1912939	1653980	2.37
2002	1983883	1737268	2.36
2003	2038552	1736252	2.29
2004	2244386	1776178	2.201
Lattakia Governorate	169042	138536	2.85

1-1-4 Syndicates & Aid Funds:

Table No. 15 shows the number of Syndicates members and the number of their laborers in Syria. Then we compare these numbers to the numbers of Lattakia Governorate. This Table shows us that Lattakia Governorate contains 8.8% of the Syndicates in Syria and 8.5 % of the Overall number of Syndicates members in Syria.

As for the rate of benefit from Aid Funds 10.8% compared to the rest of Governorates in the country. It is comes third in benefit of these Funds.

Table 15: Laborers Syndicates, Members &Aid Funds , Lattakia Governorate 1999-2004.					
Year	Syndicates	Members	Aid Funds		
1999	194	711527	187		
2000	194	738286	189		
2001	194	740739	188		
2002	194	752419	188		
2003	205	754380	207		
2004	204	783757	205		
Lattakia Governorate	18	76251	22		

1-2: Basic Information about Private Sector Pharmacies:

After initiating field studies about private sector pharmacies, we had a list of 9 pharmacies in Lattakia Governorate in cooperation with Lattakia, DoH. We agreed on the method of filling questionnaires then we started to implement the survey both in rural and city places.

Questionnaire forms specific to general indicators for pharmacies were filled and questionnaires specific to common types of medication consumption.

Table No.16 indicates distribution of pharmacies in rural places ad city in Lattakia Governorate with their codes.

Table 16: Distribution of Pharmacies				
Rural	City			
A 11	A 21			
A 12	A 22			
A 13	A 23			
A 14	A 24			
A 15				

1-2-1: Duration of Survey: Table No.17 indicates duration of surveys in pharmacies in rural and city (these are periods extending from 20/8/2006 to 11/9/2006 as deadline) together with number of days and average days.

Table No	18 shows	overall	number	οf	hours	in	pharmacies.
Table No.	10 3110 003	Ovciun	Hullibel	Οı	Hours	111	priarriacics.

Table 17: Duration of Surveys per Days Pharmacies					
Pharmacies	Duration	Pharmacies	Duration/Day		
A 21	10	A 11	10		
A 22	17	A 12	10		
A 23	8	A 13	10		
A 24	10	A 14	10		
		A 15	10		
Total/ Days	45	Total/ Days	50		
Average/ Days	11.25	Average/ Days	10		

Table 18: Duration of Surveys per Hours Pharmacies					
Pharmacies	Duration	Pharmacies	Duration/Hours		
A 21	120	A 11	10		
A 22	68	A 12	10		
A 23	96	A 13	10		
A 24	110	A 14	10		
		A 15	10		
Total/ Hours	394	Total/ Hours	411		
Average/ Hours	98	Average/ Hours	82		
Total per Hours		8	8.5		
Averaç	ge Rate	90.35			

We notice that study lasted for /10.6/ days average in both rural & city areas, and /8.5/ hours on average of /90/ hours for each pharmacy.

1-2-3: Demand on Private Sector Pharmacies according to Areas:

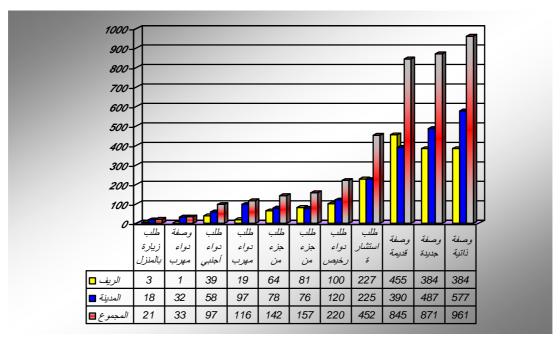
Table 19: Demand Distribution and Percentages				
Type of Demand	Total Number	Percentage		
Pharmacist to visit a patient's house	21	2.17		
Prescription for smuggled medication	33	3.42		
Demand for a foreign medication	97	10.04		
Demand for smuggled medication	116	12.01		
Demand for parts of a prescription(Price)	142	14.70		
Demand for parts of a prescription	157	16.25		
Demand for cheap medications	220	22.77		
Demand for consultation & advice	452	46.79		
Old prescription	845	87.47		
New prescription	871	90.17		
Self-prescribed medications	961	99.45		
Total (references)	966	100		

1-2-3: Demand Distribution on Pharmacies according to Areas:

Table No.20 indicates demand on pharmacies in both rural places and city with percentage were we found that 'self-prescribed medication' indicator owned the highest percentage in city for 26% and in overall rate for 24.5% too. In rural places 'old prescription' indicator was the highest for 26%.

Total	Vis	itors				
	City	Rural				
21	18	3	Number	Pharmacist to visit a patient's	Type of	
0.5%	0.8%	0.17%	visit a patient's house	house	Demand	
33	32	1	Number	Prescription for smuggled medica-		
0.8%	1.5%	0.06%	Prescription/ smuggled	tion		
			medication			
97	58	39	Number	Demand for a foreign medication		
2.5%	2.7%	2.22%	Demand/ foreign medication			
116	97	19	Number	Demand for smuggled medication		
3%	4.5%	1.08%	Demand/ parts of Drugs/			
			Price			
142	78	64	Number	Demand for parts of a medication		
3.7%	3.6%	3.94%	Demand /smuggled medica-			
			tion			
157	76	81	Number	Demand for parts of a prescription		
4%	3.5%	4.91%	Part of prescription/ Price	(Price)		
220	120	100	Number	Demand for cheap medications		
5.6%	5.6%	5.6%	Demand for cheap medica-			
			tions			
452	225	227	Number	Demand for consultation& advice		
11.6%	10.4	12.9%	Demand for consultation&			
	%		advice			
845	390	455	Number	Old prescription		
21.6%	18.1	25.9%	Old prescription			
	%					
871	487	384	Number	New prescription		
22.2%	22.2	21.89	New prescription			
	%	%				
961	577	384	Number	Self-prescribed medications		
24.5%	26.7	21.89	Self-prescribed medications			
	%	%			Total	
3915	2158	1757	Number			
100%	100%	100%	Type o	of Demand %		

Figure No.1 shows indicator rates in rural and city places together with total where we put percentages for these indicators on basis f demand.



Leaend:

Colours	Yellow stands for 'Rural'	Blue stands for 'City'	Purple stands for 'Total'
---------	---------------------------	------------------------	---------------------------

Bottom Indicators left to right: Pharmacist to visit a patient's house, Prescription for smuggled medication, Demand for a foreign medication, Demand for parts of a medication-Price, Demand for parts of a prescription, Demand for cheap medications, Demand for consultation& advice, Old prescription, New prescription, and Self-prescribed medications.

We noticed from figure No. 1 and Table No.20 indicates that the highest rate of overall total belonged to 'self-prescribed medication' indicator for /24%/ second is 'new prescribed medication' for /2.2%/ third is 'old prescriptions' for /21.6%/ and last was 'consultation from pharmacist' for /11.6%/.

In rural places, we see that 'old prescriptions' was the highest /25.9%/ second is 'old and new prescription' for /21.86%/ next is advice and consultation for /12.9%/. As for city, the highest percentage is / 26.7%/ for 'self-prescription' comes next /22.6%/ for demand on 'new prescriptions'.

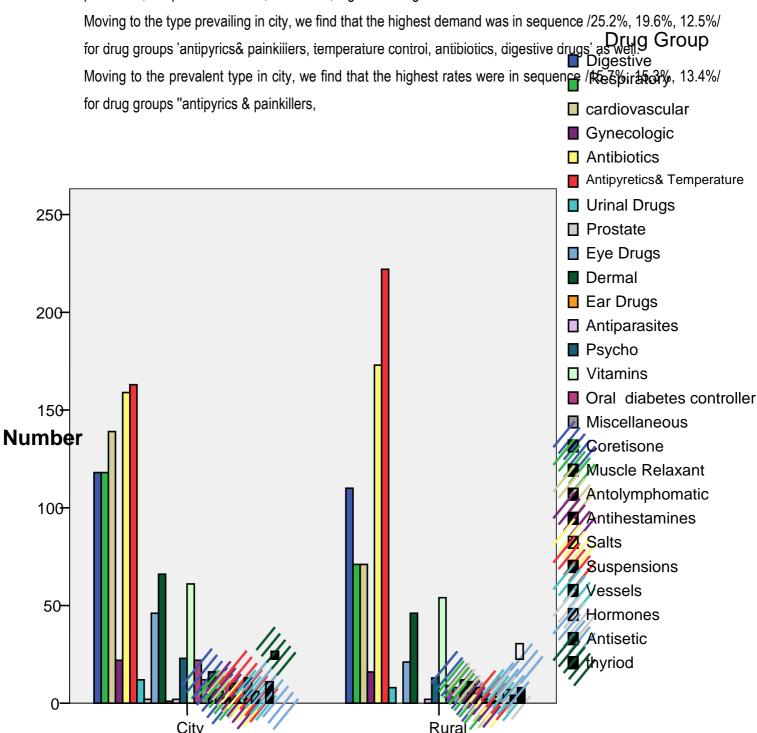
We noticed that 'pharmacist visit to a house' is /0.5%/ is considered to be the lowest in from overall total, and 'prescription of smuggled medications' is /0.8%/.

For rural places we find the minimal rates /0.06%/ belonging to 'demand for prescriptions of smuggled medication', and before it 'pharmacist visit to patient's house' for/0.017%/.

As for city, we found that minimum was 'pharmacist visit to patient's house' for /0.08%/, just before it comes 'demand for prescriptions of smuggled medication' for /1.5%/.

1-2-4 Distribution of Medication Groups according to Areas:

Table No.21 below indicates the condition of "Demand on different Drug Groups". We find clearly that in the case of overall total, we have the highest percentage as /20.01%, 17.3%, 11.9%/ in sequence 'antipyrics& painkillers, temperature control, antibiotics, digestive drugs'.



Area

Mis-	Diabe-	Vi-	Psy-	Para-	Ear	Der	Eye	Pr	Uri	Te	Anti		Cardio	Res	Di-	ut of Total		
cella- neous	tes Con- troller	tami ns	cho Drugs	site Drugs	Dru gs	mal	Drug s	os tat e	na ry	mp era- tur e	biot	Gyne- colog y	vascu- lar	pira- tory	ges- tive	Drug Gro	oup	
22	22	61	23	2	1	66	46	2	12	16 3	159	22	139	118	118	Number	С	A R
1.2%	2.1%	5.9 %	2.2%	2%	1%	6.4 %	4.4%	2%	1.2 %	15. 7%	15.3 %	2.1%	13.4%	11.4 %	11.4 %	In Area%	T	Е
60	%	%	%	%	%	%	%	%	%	%	%	%	%	62.4 %	51.8 %	In Group	Υ	Α
6%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	6.1 %	From Total		
8	9	54	13	2	0	46	21	0	8	22 2	173	16	71	71	110	Number	R U	
9%	1%	6.1 %	1.5%	2%	0%	5.2 %	2.4%	0 %	9 %	25. 2%	19.6 %	1.8%	8%	8%	12.5 %	In Area%	R A	
40%	29%	47 %	36.1%	50%	0%	41.1 %	31.3 %	0 %	40 %	57. 7%	52.1 %	42.1%	33.8%	37.6 %	48.2 %	Group	L	
4%	5%	2.8	7%	1%	0%	2.4	1.1%	0 %	4 %	11. 6%	9%	8%	3.7%	3.7 %	5.7 %	From Total		
20	31	115	36	4	1	112	67	2	20	38 5	332	38	210	189	228	Gross Nu	mber	u .
1%	1.6%	6%	1.9%	2%	1%	5.8 %	3.5%	1 %	1 %	20. 1%	17.3 %	2%	10.9%	9.8 %	11.9 %	In Area%		
100%	100%	100 %	100%	100%	100 %	100 %	100 %	10 0%	10 0%	10 0%	100 %	100%	100%	100 %	100 %	In Group%		
1%	1.6%	6%	1.9%	2%	1%	5.8	3.5%	1 %	1 %	20. 1%	17.3	2%	10.9%	9.8	11.9	From Total		

Total	Thyroid Drugs	Anti- septics	Hor- mone	Vessel Drugs	Sus- pen- sions	Salts	Anti- histamines	Anti- lym- phom	Muscle relax- ants	Corti- sone			
1 27	4	44	_	0	40	_	40	a	_	40	NI: mala an		Λ
1.37	4	11	0	9	13	2	10	3	9	19	Number	С	Α
100%	0.4%	1.1%	0%	0.9%	1.3%	0.2%	1%	0.3	0.9%	1.5%	In Area%		R
54%	100%	57.9%	0%	49.2%	72.2%	99.7%	83.3%	27.3%	35.3%	57.1%	Group	Τ	Е
54%	0.2%	0.6%	0%	0.3%	0.7%	0.2%	0.3%	0.8%	0.3%	0.8%	FromTotal	Υ	Α
882	0	8	4	7	5	1	2	8	11	12	Number	R	
100%	0%	0.9%	0.5%	0.8%	0.9%	0.1%	0.2%	0.9%	1.2%	1.4%	In Area%	Ü	
49%	0%	42.1%	100%	53.8%	27.8 %	33.3%	19.7%	72.7%	94.7%	42.9%	Group	R A	
49%	0%	0.4%	0.2%	0.4%	0.3%	0.1%	0.1%	0.4%	0.9%	0.9%	FromTotal	L	
1919		19		13	18	3	12	11	17	28	Gross No	ımbe	er
100%	0.2%	1	0.2%	0.7%	0.9%	0.2%	0.9%	0.9%	0.9%	1.5%	In Area%		
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Group		
100%	0.2%	1%	0.2%	0.7%	0.9 %	0.2%	0.6%	0.6%	0.9%	1.5%	FromTotal		

Table 22: Overall Demand Rates on Drug Groups arranged in a Count Down								
Drug Group	Frequency or Number	Percentage						
Antipyretic & Temperature	385	20.1						
Anti-biotics	232	17.3						
Digestive Drugs	228	11.9						
Cardiovascular Drugs	210	10.9						
Respiratory Drugs	189	9.8						
Vitamins	115	6						
Dermal Drugs	112	5.8						
Eye Drugs	67	3.5						
Gynecologic Drugs	38	2						
Psycho Drugs	36	1.9						
Oral Diabetes Controllers	31	1.6						
Cortisone	28	1.5						
Miscellaneous	20	1						
Urinary Tract Drugs	20	1						
Antiseptics	19	1						
Suspensions	18	0.9						
Muscle relaxants	17	0.9						
Vessel Drugs	13	0.7						
Anti-histamines	12	0.6						
Anti-lymphomatic	11	0.6						
Thyroid Drugs	4	0.2						
Hormone Drugs	4	0.2						
Anti-parasite	4	0.2						
Salts	3	0.2						
Prostate Drugs	2	0.1						
Ear Drugs	1	0.1						
Total	100	100						

2- Study on Medication Demand in Daraa Governorate

Daraa Governorate Status:

2-1 Basic Information:

Darra Governorate id located /110 Km/ to the south of Damascus. Its land is fertile too.

Demographical Indicators:

1-2-5 Expenditure on Medication:

Daraa population is /858000/ so percentage of Daraa population out of total population is /4.7%/ and average growth in Daraa Governorate compared to total population number and growth in different periods of time.

Table 23: Percentage of Daraa Governorate & Annual Average of Population Growth AVPG: Results of Population Count (1981-1994)

AVPG: (1995-2000/ 2000-2005)

Governorate	AVPG per 1000			Governorate's Population Percentage to Overall Count of Population			
	1981-1994	1995-2000	2000-2005	1981	1994	2004	
Daraa	40.6	33.0	29.9	4.0	4.4	4.7	
Grand Total	33.0	27.0	24.5	100	100	100	

From Table above, we can see average population growth is /29.9 per thousand/ compared to overall average population growth which is /24.5 per thousand/ from 2000-2005.

We noticed that Daraa Governorate rate out of overall population has increased from 1981-2004 /0.7%/.

Table No. 24 shows us the rates of Gender & Demographical Density in Daraa Governorate:

Governorate		4: Rates of Ge				ensity of Da-		
	raa Gov	raa Governorate (1970-1981-1994-2004)						
		Males for per Females	Density per Sq.Km					
	1994	2004	1970	1981	1994	2004		
Daraa	101.8	103.0	62	241	324	383		
Grand Total	104.7	104.5	34	49	74	96		

Table No.25shows the Proportional Demographical constituents of Daraa Governorate according to Gender, Age Groups, Residence Place in Mid-2005.

· ·	Table 25: Proportional Demographical constituents of Lattakia Governorate according to Gender ,Age Groups,& Residence Place in Mid-2005.										
Governorate Urban Places Rural Places Total											
	Males	Females	Total	Males	Females	Total	Males	Females	Total		
Lattakia	Lattakia 230 225 455 220 216 436 451 440 819										
Grand Total	4977	4728	9705	4291	4142	8433	9288	8870	18138		

3-2 Workforce:

Table No.26 shows the No. of Proportional Distribution Unemployed Population in Lattakia Governorate.

Table 26 : Proportional Distribution Unemployed Population in Daraa Governorate according to Gender Total Population of Syria.										
Governorate Previously Unemployed Unemployed(No job before) Total										
	Males	Females	Total	Males	Females	Total	Males	Females	Total	
Daraa	3.9	6.2	4.2	9.9	17.3	12.1	9.5	17.0	11.7	
Grand Total	100	100	100	100	100	100	100	100	100	

Table No.27 shows distribution of work injuries in Daraa Governorate. The percentage appears as 12.7% out of the Total Work Injuries in Syria. It is considered to be second highest rate in the country compared to other Governorates.

Table 27 : Wor	Table 27 : Work Injuries according to the nature of work the injury was incurred in during 2004 in Lattakia Governorate									
Governorate	Machinery	Lift	Other	Hazardous	Surrounding	Other	Total			
		Equipment	Equipment	Material &	Of the Work	Types not				
				Radioactivity		mentioned				
Lattakia	328	271	94	-	1481	75	2249			
	2326	971	820	213	10613	2744	17687			

Table No.28 shows that work force in Daraa Governorate depends mainly on Agricultural Sector. It constitutes 30.6% of the Workforce of the Governorate.

Table 28: Distribution of Workforce in Daraa Governorate according to Gender & Economic Sectors.									
1970 1994 1999 2001									
Workforce percentage/ Population	25.6	29.3	42.3	44.4	%				
Women workforce out of Gross Workforce 17.1 23.2 35.8 35.2 %									
Workforce according to the economic sectors	S:								
Agriculture	55.2	25.1	51.6	36.6	%				
Industry	10.6	11.3	11.2	20.5	%				
Other Activities	33.9	63.6	37.2	48.9	%				

2-1-3 Health Factors & Indicators:

It is noted that Daraa Governorate occupies position No.9 if compared to the rest of Governorates in Syria with regard to the number of Health Doctors, position /12/ for Orthodontists in it. It also occupies position /No.8/ as for the number of Technical Assistants position No./9/ for Pharmacists, and position /No.10/ for number of Licensed Midwives. However, we can see that this coverage rate has taken position No.9 for doctor, orthodontists as well for average population to each doctor and orthodontist.

Table 29 : Co	omparison	of No. of Health Pi	ofessional	s in Syria & Da	raa Governorate(1	999-2004)		
	Health D	octors	Orthodon	itists	Pharmacists	Technical	Licensed	Nursing
Years	Count	Average of population per doctor	Count	Average of population per doctor		Assistant	Midwives	Staff
1999	21393	753	10694	1506	8189	11233	4832	25680
2000	22408	728	11160	1462	8868	12030	4909	27164
2001	23784	703	12228	1267	9882	13339	5081	27913
2002	25073	683	14610	1172	10055	14057	5171	28325
2003	24473	717	14917	1176	10809	14798	5184	27o45
2004	25890	694	15312	1174	12724	16542	5443	28665
Daraa Gover- norate	955	865	437	1890	475	961	286	1476

Table No.8 shows that Daraa Governorate Average population per hospital bed is lower in the classification compared to other Governorates in the country. It occupies position (No.11) and it is lower even at the Overall level in the country. This therefore necessitates efforts to be made to increase hospitals & beds as well.

Table 30): Hospitals	& Beds in S	Syria & Daraa	a Governorate			
Years	Public Ho	ospitals	Private Hos	spitals	Total		Average Popula-
	No.	Beds	No.	Beds	No.	Beds	tion per bed
1999	63	12202	312	5567	375	17772	842
2000	65	12518	325	5852	390	18370	830
2001	67	12418	336	6003	403	18421	848
2002	66	14311	343	6343	409	20654	829
2003	76	15227	364	6590	440	21817	804
2004	78	15487	376	6795	454	22282	807
Daraa	4	1029	12	225	16	1254	722
Gover-							
norate							

Tables No. 9 to 14 show Medical Indicators and the level of Medical Services offered.

Table 31:Total Services by MoH in Daraa Governorate in 2004								
Governorates Health Centers Hospitals Emergency Total								
Daraa	1162895	980873	150765	2294533				
Total 25066201 14450391 3043440 45260032								

Table 32:	Table 32: Health Centers: General & Specialised in Daraa Governorate in 2004							
Year	Year General HCs Specialized GrandTotal HealthPoints Polyclinics HCs							
Daraa	98	2	100	12	-			
Total	1175	43	1218	255	14			

	Table 33: Progress of work in Health Centers in Lattakia Governorate in 2004													
Gover- norate	Chil- dren Vac- cines	Teta- nus/Wo men	Preg nant Care	Fam- ily Plan- ning	Safe Child Clinic	Health Educa- tion	Healt h Moni- tor	Nutri- tion pro- gram	Ther- apy for Pa- tients	Den- tal Care	Labo- ratoy Ser- vice	Vac- cina- tion Cam paign	Poly- Clini c	Total
Daraa	185796	1836	5890	3150 7	2449 4	28456	3997	71392	228269	1417 95	92132	7917 9	0	9010 70
Total	615548 9	487107	9824 2	6505 82	4348 83	253594	1069 98	704960	343434 6	1062 443	17699 98	1397 233	1237 157	1770 3036

Table 34 : P	Table 34: Patients Progress in MoH Hospitals in Daraa Governorate in 2004									
Governorate	Out	Emergency	Surgeries	Laboratory	Radiography	Physiotherapy	Endoscopies	Dialysis		
	Clinics	out patient	_	Services						
Daraa	230761	150765	18271	577451	120858	1817	22252	9553		
Total	2145161	3043440	425357	9556798	1646361	172185	370112	129848		

Table 34 : Patients Progress in Private Hospitals in Daraa Governorate in 2004								
Governorate	Governorate Out Clin- Emergency Surgeries Laboratory Radiography Dialysis Physiotherapy Endoscopies & Graghies							
Daraa	6085	19	8938	2015	2239	-	-	-
Total	233165	254999	116606	800685	181218	3854	2087	18938

Table 36: Patients of MoH Hospitals 1999-2004.							
Year	Total In patients	Total Out patients	Average stay days				
1999	1653531	1680823	2.572				
2000	1672139	1675694	2.48				
2001	1912939	1653980	2.37				
2002	1983883	1737268	2.36				
2003	2038552	1736252	2.29				
2004	2244386	1776178	2.201				
Daraa Governorate	169042	138536	2.85				

2-1-4 Syndicates & Aid Funds:

Table No. 15 shows the number of Syndicates members and the number of their laborers in Syria. Then we compare these numbers to the numbers of Daraa Governorate. This Table shows us that Daraa Governorate contains 8.8% of the Syndicates in Syria and 9.5 % of the overall number of Syndicates members in Syria.

As for the rate of benefit from Aid Funds, it is 5.8% compared to the rest of Governorates in the country. It is comes third in benefit of these funds.

Table 37: Laborers Syndicates, Members & Aid Funds, Lattakia Governorate 1999-2004.									
•									
Year	Syndicates	Members	Aid Funds						
1999	194	711527	187						
2000	194	738286	189						
2001	194	740739	188						
2002	194	752419	188						
2003	205	754380	207						
2004	204	783757	205						
Daraa Governorate	18	76251	22						

2-2: Basic Information about Private Sector Pharmacies:

After initiating field studies about private sector pharmacies, we had a list of 8 pharmacies in Daraa Governorate in cooperation with Daraa, DoH team. We agreed on the method of filling questionnaires then we started to implement the survey both in rural and city places.

Questionnaire forms specific to general indicators for pharmacies were filled and questionnaires specific to common types of medication consumption.

Table No.39 indicates distribution of pharmacies in rural places ad city in Lattakia Governorate with their codes.

Table 38: Distribution of Pharmacies with Codes used					
Rural	City				
C 21	C11				
C 22	C12				
C 23	C13				
	C14				
	C15				

2-2-1: Duration of Survey:

Table No.40 indicates duration of surveys in pharmacies in rural and city (these are periods extending from 20/8/2006 to 11/9/2006 as deadline) together with number of days and average days. Also, Table No.41 shows total number of hours for each pharmacy and overall number of hours.

Table 39: Duration of Surveys per Days for Pharmacies							
Pharmacies	Duration /Day	Pharmacies	Duration /Day				
C 21	10	C11	11				
C 22	17	C12	11				
C 23	8	C13	13				
	10	C14	15				
		C15	16				
Total/ Days	45	Total/ Days	50				
Average/ Days	15	Average/ Days	13.5				

Table 40: Duration of Surveys per Hours for Pharmacies							
Pharmacies	Duration	Pharmacies	Duration/Hours				
C 21	75	A 11	138				
C 22	90	A 12	96				
C 23	195	A 13	180				
		A 14	130				
		A 15	208				
Total/ Hours	360	Total/ Hours	752				
Average/ Hours	120	Average/ Hours	150				
Total pe	er Hours	1112					
Averag	e Rate	139					

We notice that study lasted for /14.25/ days average in both rural & city areas, and /1112/ hours on average of /139/ hours for each pharmacy.

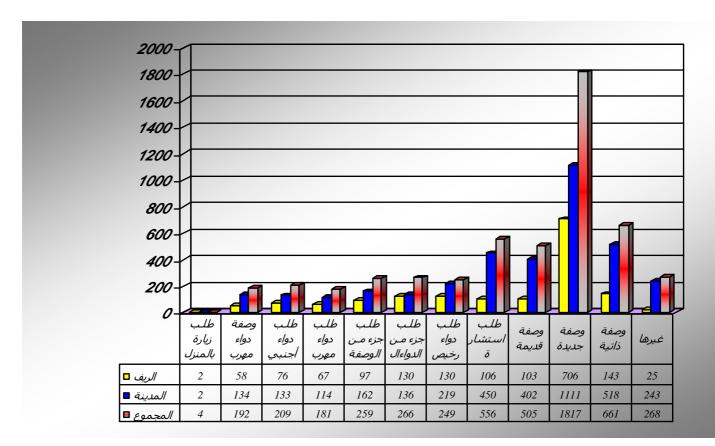
2-2-2: Demand on Private Sector Pharmacies:

Table 41: Demand Distribution and Percentage for all Pharmacies						
Type of Demand	Total Number	Percentage				
Pharmacist to visit a patient's house	4	0.08				
Prescription for smuggled medication	192	3.67				
Demand for a foreign medication	209	3.99				
Demand for smuggled medication	181	3.08				
Demand for parts of a prescription	259	4.95				
Demand for parts of a prescription (Price)	266	4.82				
Demand for cheap medications	349	6.67				
Demand for consultation & advice	556	10.62				
Old prescription	505	9.65				
New prescription	1817	34.72				
Self-prescribed medications	661	12.63				
Others	268	5.12				
Total (references)	5267	100				

2-2-3: Demand Distribution on Pharmacies according to Areas:

Table No.42 indicates demand on pharmacies in both rural places and city with percentage where we found that 'new prescription' owned the highest percentage in rural places; second is 'self-prescribed medication' indicator for 34% and 8.5%. Same is in city for 30.7% and 14.3%. As for overall rate, same indicators were 34.5% and12.5% too.

Total		itors	emand ad Percentages for Pha	madics in Rulaid Oity Flaces			
TOlai							
1	City	Rural	Nivershaar	Dhamas siat ta visit a maticalla	Type of		
4	2	2	Number				
0.1%	0.1%	0.1%	Visit a patient's house	house	Demand		
192	134	58	Number	Prescription for smuggled medica-			
3.6%	3.6%	3.5%	Prescription/ smuggled	tion			
			medication				
209	133	76	Number	Demand for a foreign medication			
4%	3.7%	4.6%	Demand/ foreign medication				
181	114	67	Number	Demand for smuggled medication			
3,4%	3.1%	4.6%	Smuggled medication				
259	162	97	Number	Demand for parts of a medication			
4.9%	4.5%	4.1%	Parts of Drugs				
266	136	130	Number	Demand for parts of a prescription			
5.1%	3.8%	5.9%	Part of prescription/ Price	(Price)			
349	219	130	Number	Demand for cheap medications			
6.6%	6%	7.9%	Cheap medications				
556	450	106	Number	Demand for consultation& advice			
10.6%	12.4%	6.5%	Consultation& advice				
505	402	103	Number	Old prescription			
9.6%	11.1%	6.3%	Old prescription				
1817	1111	706	Number	New prescription			
34.5%	30.7%	43%	New prescription				
661	518	143	Number	Self-prescribed medications			
12.5%	14.3%	8.7%	Self-prescribed medications				
268	342	25	Number	Others			
5.1%	6.7%	1.5%	Other Demands				
5267	3624	1643	Number				
100%	100%	100%	Type of Demand %				



Legend:

Colo	urs	Yellow stands for 'Rural'	Blue stands for 'City'	Purple stands for 'Total'

Bottom Indicators left to right: Pharmacist to visit a patient's house, Prescription for smuggled medication, Demand for a foreign medication, Demand for parts of a medication-Price, Demand for parts of a prescription, Demand for cheap medications, Demand for consultation& advice, Old prescription, New prescription, and Self-prescribed medications.

We noticed from figure No.3 and Table No.42 indicate that the lowest rate out of overall total belonged to 'pharmacist visit to patient house' indicator in rural places for /0.01%/ before it was 'prescription of smuggled medication' for /3.5%/. As for city, the lowest is 'pharmacist visit to patient house' for /0.01%/ and last was 'prescription of smuggled medication' for /30.1%/.

We noticed from overall total that the lowest rate belongs to 'pharmacist visit to patient house' for /0.8%/. Next is 'prescription of smuggled medications' for /3.4%/

2-2-4 Distribution of Medication Groups according to Areas:

Table No.43 below indicates the condition of "Demand on different Drug Groups". We find clearly that in the case of overall total, we have the highest percentage as /20.5%, 16.7%, 16.5%/ in sequence 'antipyretics& painkillers, temperature control, antibiotics, digestive drugs'.

Legend:

From bottom line: left to right: Rural Places, City Places

From the right side in coloured squares: bottom up: thyroid medications, antiseptics, vessel medication, hormones, salts, anti-histamines, anti-lymphoma, muscle relaxant, cortisone, miscellaneous, diabetic controllers, vitamins, psycho drugs, anti-parasites, eye drugs, temperature controllers & antipyretics, gynecologic, cardiovascular medication, digestive drugs respiratory tract drugs urinal tract drugs, dermal medications, prostate drugs antibiotics, suspensions,

Figure No.4: demand rates for drug groups distribution on areas.

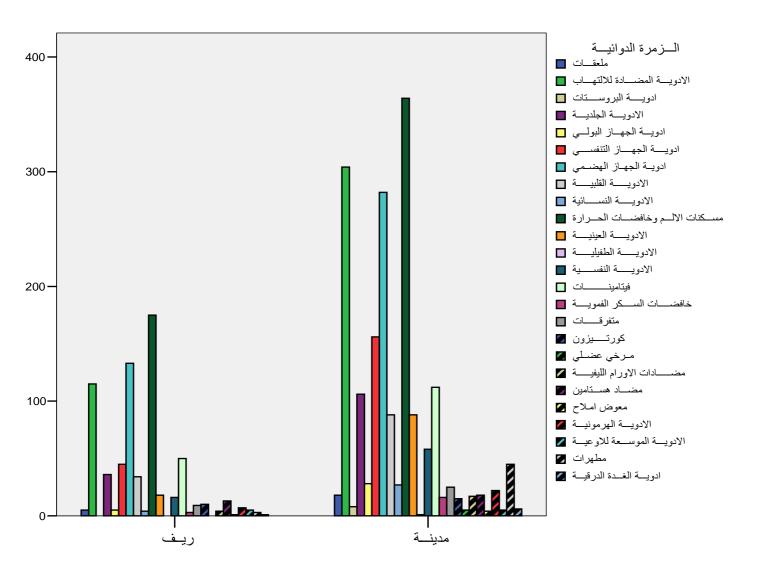


Table 43: Distribution rates on drug groups for areas with percentage within areas and groups out of total.

Mis- Cellane-	Diabe- tes	Vi- tami	UPS for an Psycho Drugs	Para- site	Der- mal	Ey e	pro sta	Uri nar	Ant i-	Anti- biotics	Gyne- cologic	Card io	Respi- ratory	Diges- tive		
bus	Controll er/oral	ns		Drugs		Dru gs	te	У	py- reti cs							
9	3	50	16	0	36	18	0	5	17 5	115	4	34	45	143	Number	
1.3%	0.4%	7.2 %	3.2%	0%	5.2 %	2.6 %	0 %	0. 7 %	25 .3 %	16.6 %	0.6%	6.5 %	4.9%	19.2 %	In Area	
26.5%	15.8 %	30. 9%	21.6%												In Group	
0.4%															FromTo- tal	
25	16	11 2	48	1	106	88	8	28	36 4	304	27	88	156	282	Number	
1.4%															In Area	
73.5 %															In Group	
1%															FromTo- tal	
34	19	162	74	1	142	10 6	8	33	53 9	419	31	12 2	201	415		

Total	Thyroid	Antiseptics	Hor- mones	Vessel Drugs	Suspen- sions	Salts	antihis- tamines	Antilym- phoma	Muscle Relaxant	Cortisone			
9				5	175	115	4	34	45	123	Number	City	Α
											In Group]	R
											In Area	Rural	E
											From Total		Α
											Number		
											In Area		
											In Group		
											From Total		
											Gross Numb	er	
											Number		
											In Area	1	
											In Group		
100%			1.9%	1.2%	0.4%	0.9%	1.2%	0.8%	0.2%	1%	From Total		

Table 45: Overall Demand Rate	es on Drug Groups arranged in a	a Count Down
Drug Group	Frequency or Number	Percentage
Antipyretic & Temperature	539	21.5
Anti-biotics	419	16.7
Digestive Drugs	415	16.5
Respiratory Drugs	201	8
Vitamins	162	6.5
Dermal Drugs	142	5.7
Cardiovascular Drugs	122	4.9
Eye Drugs	106	4.2
Psycho Drugs	74	2.9
Antiseptic	48	1.9
Miscellaneous	34	1.4
Urinary Tract Drugs	33	1.3
Gynecologic Drugs	31	1.2
Anti-histamines	31	1.2
Hormone Drugs	29	1.2
Coretisone	25	1
Suspensions	23	0.9
Anti-lymphomatic	21	0.8
Oral Diabetes Controllers	19	0.8
Vessel Drugs	10	0.4
Prostate	8	0.3
Thyroid Drugs	7	0.3
Muscle Relaxant	5	0.2
Salts	5	0.2
Anti-parasite	1	0
Total	2510	100

5- Annex No.1: **General Indicators for Pharmacies:**

Date:	Time to start Data Collection:				
	Total	Overall Total			
New prescription					
Old prescription					
Consultation and Advice					
Self-prescribed medications/ patient asking for Brand name of a medication					
Demand for Cheap medica- tion					
Part of medication/ Price re- lated					
Part of prescription					
Smuggled medication					
Visit a patient's house					
Demand of foreign Medica- tion					
Demand for smuggled medi- cation					
Prescription of smuggled Medication					
Others					
Date:		f data collection on:			
	Anney 2.				

Questionnaire on Prevalent Type of Demand in Drug Consumption: Under Supervision of HSMP/Funded by EU

Date: / / 2006	Time of Data Collection: from	n:to:
Pharmacy:	Location:	Data Collector:

Serial	Brand Name	Drug Group	Formula (Tablets,	Synthesis	Volume & Titer	Total Number	Price
1		· ·					
2							
3							
4							
5							
6							
7							
8							
9							

Study 9: Private outpatient clinics in Dara'a





-Study No.9-Case Study of Pattern of Demand for Private Outpatient Medical Care in Darra'

R6.A2.P2-1

Final Report

Date: August, 2006

Prepared by

Riad Sukkar, PhD **Allied Management Consultants**

Study about Services at Private Clinics, Daraa Governorate

Final Report

Project Title: Studies on Health Seeking Behaviours and Capacity To Pay

No.9

Project Number: R6.A2.P2-1

Country: Syria

Counterpart: EU- Syria – Health Modernization Programme

Beneficiaries: Ministry of Health
 Project start date: 28th May 2006
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Figure 9: Does a Patient need extra expenses other than Treatment.........29

1-EXECUTIVE SUMMARY:

Located in the southwest of Syria, Dara'a forms the southern gate of the country. Its area is 4,600 km² stretching from the border of Damascus in the north, to Jordan in the south, the Golan in the west and Djebal Al-Arab in the east. The region is known for its mineral water (Al-Yadudeh). The governorate is linked with other countries and governorates by international highways as well as the Hejaz railway, which passes through it¹.

The study intends to shed the light on the pattern of demand of patients for private providers (outpatient medical care) in the governorate of Dara'a through the evaluation of patients' examinations and treatment cost. The mission is a pilot case in the form of a survey, which assesses the services of private practices and willingness of patients to pay for medication.

The study followed the subsequent steps:

- 7. Studying the points, which have to be covered by the survey in order to meet the goals of the study.
- 8. Designing the template for the survey.
- 9. Gathering and filling 498 surveys.
- 10. Encoding and analysing data.
- 11. Analyzing processes and findings.
- 12. Presenting the findings of the study.

We can summarise the findings of the study in the following points:

- The population of Dara'a is 860,000 people equally divided between males and females. Half of the population is between the ages of 16 and 46 (the working section of the population).
- Most of the people live in rural areas.
- The workforce of Dara'a revolves around construction activities. This activity comes in first place for the employment of males whereas teaching takes the first place in the employment of females.
- The unemployment rate in Dara'a is 7.7% and is considered reasonable. The unemployment rate for females is 15.2% and only 6.8% for males.
- The average number of people for each medical center is 8958 and for each hospital bed in private hospitals is 8350. Those numbers are high if it compared with other governorates of Syria.
- This governorate contains a large number of gynecologists and internists and general surgeons. There are only 3 doctors specialized in rheumatism, 4 cardiologists, and one dissection doctor. Those numbers are very low.
- 86% of the patients are new clients in the rural areas where this number is less in the cities which comes up to 54% only. At the governorate level the percentage comes up to 71%.
- The study showed that the most common diseases are: 24% digestive, 13% entereologic, and 10% genital.

- 7% of the patients at rural areas have been referred to specialised doctors, where it is only 2% at the city, which might mean that certain specialisation is not exist at the rural areas.
- 47% of the patients need to buy medicines after the treatment and 15% needs to have an X-ray.
- 60% of the patients need extra treatment outside the clinic at rural areas where it is only 13% at the city, which that might mean the clinics at the cities are better equipped.
- The expenses of the medical treatment at the city is higher than the cost at the rural. The average cost at the city is 400 SYPs where it is around 250 Syrian pounds at the rural.
- The other treatment expenses such as x-ray are much higher at the city since it is not existed at the rural. So most of the people at the rural need to go the city for this kind of treatment.
- Doctors felt that 25% of the patients were unable to pay the visit fee at the city these numbers show that the cost of treatment in private practices is high compared to the purchasing power of individuals in Dara'a. It was only 5% at the rural area. This is might due the high cost of treatment at the city and also due to limited income for the people at the cities if it is compared with the people at the rural since they have different type of income such as land investment.
- 85% of the rural are patients has to visit the doctor one more time while it is only 55% of the city patients has to do this.
- 86% of the rural area patients need more expenses other than the cost of the visit, and only 54% of the city patients, due to long distance between the medical centers in the rural area and the patient's residences.
- The average time a doctor devotes to a patient is 12 minutes and it is reasonable.

Given all the above, we suggest the following:

- The medical insurance system should be prepared and implemented as soon as possible to decrees the burden on the patients and especially limited income people.
- Creating new medical centres to meet the needs of the increasing population.
- Support the private clinics and medical centres at the rural area in order to provide proper services which reflect on reducing the cost of the treatment.
- Bring more rheumatism, heart, and dissection doctors to the governorate.
- Increase the number if beds at the private hospital in order to reduce the treatment cost.

Create new outpatient clinics at the hospitals as well as creating new sections such as emergency, physiotherapy, endoscope surgery, and artificial kidney dialysis

2- Purpose:

This study is an experiment to monitor the continuous demand to establish extensive HI Scheme especially for workers with the Government. These requirements are repeated continually by Government and the purposes of 10th Five-year Plan together these requirements of limited incomes categories who need to secure cures & treatment for them and their families too. These demands come up here in light of implementing HI Scheme is to carefully assess private clinics contracted with.

This study intends to have a leading experiment to assess services of private clinics with regard for checks & expenses in Daraa Governorate. A questionnaire was designed to assess these clinics & capacity of patients to afford expenses of treatment.

3- Methods for Conducting this Study:

The following stages were adopted in this study:

- 1- Research on the points that are to be put into the questionnaire with view to achieving the targets of this study.
- 2- Designing formats for questionnaire applying to both Town & countryside.
- 3- Collect & fill up 498 forms.
- 4- Encodement & analysis of data.
- 5- Analysis of Procedures & findings.
- 6- presentation of this study findings.

Summary of the activities in this study:

3-1 Questionnaire Form:

An integrated work team was formed up to fulfill this mission in cooperation with HSMP. Questionnaires were prepared in coordination with MoH, Syria in order to make sure about the quality of these questionnaires, we prior to starting, have trained people in charge of executing the mission. This aimed at fulfilling these forms and checking accuracy & quality in doing this study.

3-2: Method:

The team traveled with Consultancy Office Staff to Daraa Governorate to start distribution of questionnaires to patients in clinics through the doctors there. The team divided into two groups. One was responsible for city and the other was responsible for countryside. 498 questionnaires forms were filled in two weeks time which was the time of the project. Under supervision of a specialist who was there for responding to any queries or problem might arise while carrying the survey out.

3-3 Data Collection:

After filling the questionnaires, Consultancy Office assigned a number of employees for Data entry to computer using a special computer programme, another employee was there to supervise, check for the quality of data entry & to secure an extent of truthfulness in doing data entry.

3-4 Release of Report:

After all, preparation for wording of the report by Consultancy Office by a specialised team in order to discuss the report with HSMP representatives.

3-5 Names of Doctors who were interviewed:

we visited 7 private clinics of different specialties, the following table shows the names of doctors who were helped us to fulfill our mission in Daraa. Taking into consideration that 3 clinics were selected in Daraa City and 4 in different areas in the countryside of Daraa Governorate.

Table 1: Names of Doctors at Surveyed Private clinics:

	Name of Doctor	Specialty	Town	No. of Days	Actual No. of Forms	Average No. of Forms per Month
1	Yasser Ammur	Interiology	Khebet Gazale	7	34	146
2	Khalaf Bader	Interiology	Daraa	4	41	308
3	Bashar Miqdad	gynecology	Daraa	5	34	204
4	Yahia Jihani	Otolaryngology	Nawa	10	29	87
5	Awad Zuaabi	General Health	Izra	10	55	165
6	Issa Ajaj	General Surgery	Daraa	12	155	388

7	Farid Akeh	Public Health	Sanameen	8	150	563
Ttl					498	1859

Source: AMC study + Questionnaires

4-Status of Daraa Governorate:

4-1 Introduction:

Daraa is located to southwest of Syria. This Governorate. It also considered as the south gate to the country. Territory of Daraa Governorate is /4600 km²/. It shares borders with Damascus Countryside to the north extending south to Syrian-Jordanian Border line, it is to the east of Golan Heights and to the west of Jabal al-Arab. Daraa Governorate is famous for its mineral water spas. It became a strategic linking point to other countries & governorates via a grid of paved ways and Hijazi Railway.

4-2 Population Status & Demographical indicators:

Population in Daraa Governorate are /860.000/ divide equally 50% males 50% females. Half of Daraa population belong to (16-50) age group considered as working category distributed:

Table 2: Distribution of Population (Gender) as follows in 2005.

Age Group	Males	Females	Total
Less than 1 year old	12.870	13.728	26.598
1-5 Years old	57.057	56.199	113.256
5-15 Years old	17.975	117.117	235.092
16-49 Years old	207.207	208.065	415.272
50-60 Years old	16.302	15.873	32.175
Above 60 Years old	18.018	18.876	36.894
Total	429.429	429.858	859.287

Source: Study on HI Scheme at Daraa Governorate.

We notice that Population of Daraa Governorate are at rural places mostly.

Table 4: Population Estimate currently resident in Daraa on 1/7/2005 according to Gender & residence place (in thousands)

Record	City/ Town		Countryside		е	
	Males	Females	Total	Males	Females	Total
Daraa Governorate	202	192	394	234	230	464

Source: Statistical Group ,Daraa Governorate Page:71.2005

3-4: HR & Workforce Status in Daraa Governorate:

Workforce in is centered Daraa Governorate on construction & building activities for males. Daraa Governorate females work in education activities comes fist (44.3%). This table shows distribution of workers and employees according to activity & gender

Table 4: Proportional distribution of Workers above 15 Years according to Gender (%)

Activity	Males	Females	Total
Farming, forestation & Hunt	14.9	16.8	15.1
Stone & Metal Industry	0.1	0.1	0.1
Transformation Industry	8.3	5.3	8
Electricity, Gas & Water	1.2	0.7	1.1
Building & Construction	30.4	6.8	28

¹⁻ http://www.made-in-syria.com/Darra.htm

Activity	Males	Females	Total
Wholesale	11.9	0.3	11
Transport, Storage& Telecom	8	1.5	7.3
Financial Brokers	0.1	0.3	0.1
Real-estate Broker & Lease	1	0.4	1
Public administration& Defense	14.3	12.7	14.1
Education	4.7	44.3	8.7
Social Affairs& Health	0	0.1	0
Social Service	2.5	2	2.4
Domestic Services	0.2	0.2	0.2
International Organisations	2.5	4.8	2.7
Total	100	100	100

Source: Gross Population & Habitat Count: Primary Findings in 2004 Page: 54

Unemployment Rate in Daraa Governorate is 7.7 % which is moderate where Females have most of it 15.2% of them are unemployed. Whereas, Unemployment Rate for Males is 6.8%.

Table 5: Unemployment rate above15 Years old / gender (September 2004):

Workforce	Males	Females	Total
Employed	93.2	84.8	92.3
Unemployed	6.8	15.2	7.7
Total	100%	100%	100%

Source: Primary findings of count of population and habitat Page: 63 (2004)

Health Status at Daraa Governorate:

The table below indicates types of Healthcare services at Daraa Governorate for population /859.800/ & number of population for each bed at private hospitals is /8350/ which is a high if compared to services at other governorates.

Table 6: basic Physical Indicators of Healthcare Sector in 2005:

Indicators	Unit	Available	Average Population per Unit
No. of Health Centers & Specialised Units	Centers	96	8.958
Public Hospitals	Hospital	5	
Public Hospitals Beds	Bed	600	1.433
Private Hospitals	Hospital	5	
Private Hospitals Beds	Bed	103	8350
No. of Doctors	Doctor	455	1890

Source: Study on HI Scheme at Daraa & Lattakia Governorates + Daraa Doctors Syndicate+ AMC

Table below shows that distribution of doctors now at Daraa Governorate, we found that No. of gynecologists & entereologists. In the third place are paediatricians & General Surgeons. There are only 3 rheumatoid doctors, 4 cardiologists, 1 for anatomy. Number of doctors specialised in these is very low.

Table 7: Distribution of doctors according to specialty:

Specialisation	No	Specialisation	No
Interiology	60	Forensics	3
Gynecology	62	Otolaryngology	32
Cardiology	4	Thoracic	7
General Surgery	44	Radiology	20
Nephrology 2		Anesthesiology	23

Specialisation	No	Specialisation	No
Family	4	Emergency	7
Endocrinology	4	Neurology	17
Dermatology	18	Gastrology	7
Ophthalmology	18	Pediatrics	57
Laboratory	30	Anatomy	1
Nephrology	23	Public Health	7
Physiotherapy	2	Rheumatism	3

Source: Daraa Doctors Syndicate.

As showed in the map page:10, number of Ambulance cars is /10/ distributed proportionately all over the Governorate. We can see from table below that the mostly demanded services are 'vaccination, nutrition programmes, curative treatment'

Tables 8: Progress of Action at Healthcare Centres in 2004:

Children Vaccination	312.773
Women Tetanus	29.772
Pregnant Care	6.910
Family Planning	37.339
Safe Child Clinic	19.486
Health Education	8.260
Health Monitoring	8.242
Nutrition Programmes	165.054
Curative Services	133.565
Dental Care Services	51.899
Laboratory Services	168.833
Poly-clinics	51.087
Total	1.046.746

Source: Statistical Group,2005. page:446+447

We notice in the table below that rush upon private hospitals is very weak, but for laboratory services, surgical operations it is fairly acceptable. Because number of beds in public hospitals is lager than those in private ones (600:103 in sequence). Add that there are some departments not available at private hospitals such as outpatient clinics, emergency, physiotherapy, endoscopy, artificial dialysis. Taking into account that numbers of private & public hospitals are the same (5 each). Low rush upon radiology section in private hospitals is ascribable to high prices & fees if compared to those at public hospitals.

The most active patient progress departments were Laboratory & Emergency.

Table 9: Patient Progress at Private Hospitals in 2004:

Department	Public Hospitals	Private Hospitals
Outpatient Clinics	164.118	0
Emergency visitors	237.687	0
Surgical Operations	28.733	1.612
Laboratory Services	420.386	7.174
Radiography	115.339	72
Physiotherapy	5.849	0
Endoscopy	19.875	0
Artificial dialysis	6.617	0

Source: Statistical Group,2005. page:448+449

The following tables shows that daily expenses of a bed according to specialisation are for artificial kidney dialysis, ICU comes second.

Table 10: Daily Expense of a Hospital Bed according to Specialisation:

Department	Expenses (SYP)
Surgery	1.556
Obstetrics & Gynecology	1.684
Pediatrics	486
Interiology	1.001
ICU	2.037
Artificial Dialysis	4.787
Urinal Surgery	1.520
Ophthalmology	1.662
Burns	1.474
Otolaryngology	1.694
Cardiology	868
Orthopeodology	1.704
Neuro-Surgery	1.393

Source: HI scheme Study at Daraa Governorate

5- General Assessment of Findings:

The Research Team has prepared this study in cooperation with 7 doctors from Daraa Governorate. Questionnaire Form in order to get data about patients visiting their clinics. Table below shows the names of doctors and their specialisation with the area of clinics and number of patients present at the time of survey.

Table 11: Names of doctors & No. of patients:

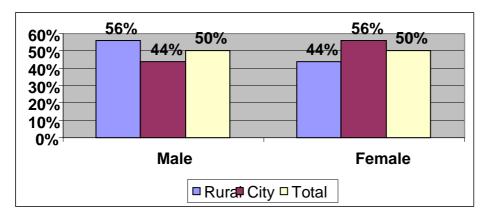
	Name of Doctor	Specialty	Town	No. of Sur- veyed Pa- tients
1	Yasser Ammur	Interiology	Khebet Gazale	34
2	Khalaf Bader	Interiology	Daraa	41
3	Bashar Miqdad	Gynecology	Daraa	34
4	Yahia Jihani	Otolaryngology	Nawa	29
5	Awad Zuaabi	General Health	Izra	55
6	Issa Ajaj	General Surgery	Daraa	155
7	Farid Akeh	Public Health	Sanameen	150
Ttl				498

Source: Questionnaire Forms+ Tabulation of AMC

We also noted that hospitals in 'Daraa, Izra and Nawa' cut number of visitors to private clinics down. While having no hospital in Sanameen increases numbers of patients visiting them to (150 patient a day).

The Questionnaires covered all age groups. Average is 28 years old. Findings show that 56% of countryside clinics patients are "Males" while 56 % of city clinics patients are "Females" may be because of having specialised clinics in city particularly Obstetrics & Gynecology.

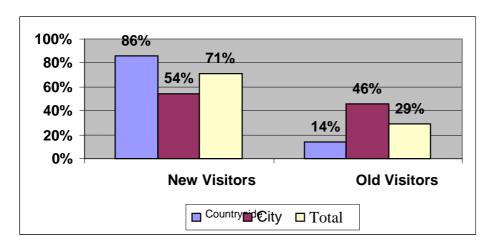
Figure 1: Gender of Patients:



Source: Questionnaire Forms+ Tabulation of AMC

Findings showed that 86% of rural clinics patients are new visitors (first time), whereas 54% of city clinics patients are new visitors only. In general, new visitors rate is 71% in Daraa Governorate.

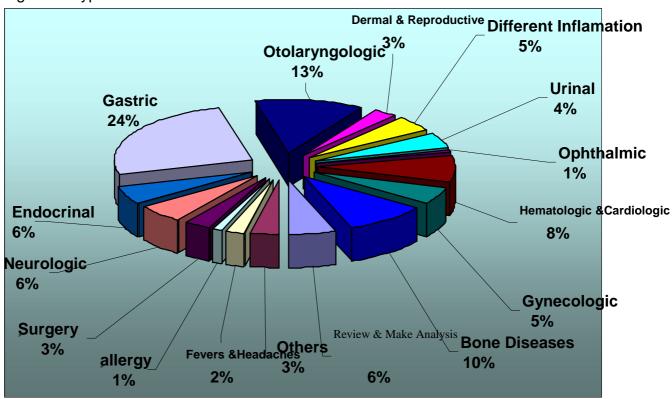
Figure 2: Clinics New\ Old Visitors Rate:



Source: Questionnaire Forms+ Tabulation of AMC

After questioning doctors about their diagnosis for their patients, we found that gastric diseases are most common 24%, otolaryngeal diseases are in the second place 13%, gynecologic diseases 10% and ophthalmic 1%, allergic ones 1% as in the following pie.

Figure 3: Types of Diseases:



Source: Questionnaire Forms+ Tabulation of AMC

The team of AMC has collected & encoded all diseases listed in the questionnaire. Basically 14 diseases & another cell for checking & analysis.

Table 12: Classification of Diseases surveyed in this study:

Gastric	Endocrinal	Neurological	Surgery	Allergy	Fever & Headache	Others	Check
enteritis	Diabetes	arthritis	Check follow a surgery	Allergy	Sun hit	Over- weight+ hypo- activity	Check
enteritis	Diabetes	Epileptic Symptoms	Check follow a surgery for a mass	Allergy	Fatigue	Lumbago	Check
enteritis	Diabetes	Lower limbs inflammation	A forearm mass	Allergy	Hay Fever	Migrating Mamma	Check
enteritis	Diabetes	Ache in joints	Saccule	DrugAl- lergy	Arthritic Fever	Obesity	Check
Aphtha	Glands	Intense	A forearm mass	DrugAl- lergy	Fever	Wound Stitch	Check
enteritis	Glands	arthritis	Armpit mass		Headache	Neck wound	Check
enteritis	Thyroid	menopause	Fat Mass		High Tem- perature		Check
Hepatitis	Postopera- tive Check for thyroid	Anxillary nerve inflammation	Fat Mass		Nausea	Sting	Check
Enterio infection	Postopera- tive Check for thyroid	arthritis	Fat Mass		Sun hit Symptoms	Hydrocele	Check

Gastric	Endocrinal	Neurological	Surgery	Allergy	Fever & Headache	Others	Check
Colitis	Thyroid	Parkinsonism Symptoms	Mass in palm		Fatigue	Pain in lower thorax	Check
Ulcer	Thyroid	arthritis	Fat Mass		High Tem- perature	Tinea	Check
Colitis	Diabetes	Epilepsy	Mass			Grippe	Check
Appendi- tis	Diabetes	Rheumatism	Villous cyst			Grippe	Check
Hepatitis	Diabetes	Rheumatism	Villous cyst			Tinea	Check
Colon Spasm	Diabetes	Migraine	Follow up a surgery			Schizo- phrenia	Check
enteritis	Diabetes	Migraine				Meno- pause	Check
enteritis	Diabetes	Migraine				Meno- pause	Check
Colitis	Diabetes	Vertebral in- jury					Check
enteritis	Mammal Gland in- flammed	Muscular pain					Check
enteritis	Diabetic foot	Muscular pain					Check
enteritis	Diabetic foot	Muscular pain					Check
enteritis	Diabetic foot	Muscular pain					Check
enteritis	Check for Diabetic foot	Muscular pain					Check
Gastritis	Diabetic foot	Psychosis					Check
Colitis	Lymphatic nodes	Psychosis					Check
Ulcer syn- drome	Lymphatic nodes	Aging teeth					Check
Ulcer syn- drome	Lymphatic nodes	backache					Check
Ulcer syn- drome	Lymphatic nodes	backache					Check
Ulcer syn- drome	Lymphatic nodes	backache					Check
Ulcer syn- drome	Lymphatic nodes enlarged						Check analysis
enteritis							Check analysis
enteritis							Check analysis
ERCP							Check analysis
Dysen- tery En- teritis							Check analysis

Gastric	Endocrinal	Neurological	Surgery	Allergy	Fever & Headache	Others	Check
Dysen-							
tery En-							
teritis							
Postop-							
erative							
check /							
Anal Hia-							
tus							
Postop-							
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Hernia,							
Hiatus							
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ERCP							
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ERCP							
Postop-							
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check /							
Anal Hia-							
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Postop-							
erative							
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Prepare							
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Gall							
Bladder							
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Gastric	Endocrinal	Neurological	Surgery	Allergy	Fever & Headache	Others	Check
Anal							
Hernia							
Anal							
Hernia							
Anal Hia-							
tus Swollen							
Colon							
Anal Hia-						+	
tus							
Postop-							
erative							
check /							
Anal Hia-							
tus							
Anal Hia-							
tus							
Gall							
Bladder							
Gall							
Bladder							
Anal							
Hernia							
Peri-anal							
abscess							
Peri-anal							
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Peri-anal							
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Anal Hia-							
tus							
Anal							
Hernia							
Gall							
Bladder							
Anal Hia-							
tus							
Inguinal	1					1	
Hernia							
Peri-anal						1	
masses							
Anal Hia-	1					1	
tus							
Drawing	1					1	
thread							
post							
Appdec-							
tomy							
Inguinal							
Hernia							
Hellila	I				_1		

Gastric	Endocrinal	Neurological	Surgery	Allergy	Fever & Headache	Others	Check
ERCP							
Inguinal							
Hernia							
Gall							
Bladder							
Anal Hia-	Inguinal						
tus	Hernia						
Weable							
Proce-							
dure							
Check							
Anal Hia-							
tus							
Anal Hia-							
tus							
Inguinal							
Hernia							
Gall							
Bladder							
Check							
Inguinal							
Hernia							
Anal Hia-							
tus							
Enteritis							
Enteritis							
Gastritis							
Gastritis							
Enteritis							-
Gastritis							-
Anal Hia-							-
tus							
Diarrhea							
Diarrhea							
Broma-							
toxism							
Broma-							
toxism							
Spasmo							
Colitis							
Enteritis							
Diarrhea		1	+		+		+
Colitis							
Broma-		1	+		+	+	+
toxism							
Diar-							
rhea+							
Vomiting							
Broma-		1	+		+	+	+
toxism							
Enteritis		1	+		+	+	+
Gastritis							
Symp-							
toms		1	+		1		
Broma-							
toxism		1	+		1		
Ulcer		<u> </u>					<u>L</u>

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Gastric	Endocrinal	Neurological	Surgery	Allergy	Fever & Headache	Others	Check
Diar-							
rhea+							
Vomiting							
Diar-							
rhea+							
Vomiting							
Colitis							
Enteritis							
Gastritis							
Appendi-							
titis							
Diar-							
rhea+							
Vomiting							
Diar-							
rhea+							
Vomiting							
Ulcer							
Broma-							
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Right							
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Signs							
Dehydra-							
tion							
Dehydra-							
tion							
Dehydra-							
tion							
Signs							

Gynecologic	Orthopedic	Cardiac + Hematologic	Ophthalmologic	Urinologic	Different Inflammation	Dermatogenital	Otolaryngology
Expectant mother	discus	Cardiac	conjunctivitis	cystitis	inflammation	Dermatitis	Tonsillitis
Pregnancy	Fracture contusion	Hypertension	conjunctivitis	Nephritis	inflammation	Plantar wart	Tonsillitis
Secondary infertility	Coccyx fistula	Hypertension	Posterior cor- nea	kidney	inflammation	Dermatitis	Tonsillitis
Infertility	Coccyx fistula	Cardiac	Tear canal obstruction	Cystitis	inflammation	Skin allergy	Tonsillitis
	Coccyx fistula	Cardiac		Cystitis	inflammation	Fungus	Tonsillitis
4 month pregnancy	Coccyx fistula	Cardiac		Cystitis	inflammation	Skin allergy	Ototitis
Diseased Fetus skull	Coccyx fistula	Cardiac+ Blood pres- sure		Cystitis	inflammation	Eczema	Inflammation+ Cold
Late maturity	Coccyx fistula	Cardiac+ Hypertension		Urinary tract infection	inflammation	impotency	Pneumonia
Hysterectomy	Coccyx fistula	Cardiac		nephrospasm	inflammation	Genital contu- sion	Tonsillitis
Hysterectomy	Coccyx fistula	Cardiac		nephrospasm	inflammation	Prostate	Thoracic pain
Minor infertility	Coccyx fistula	Cardiac		Urinary tract infection	inflammation	smallpox	Lung fever
Pregnancy	Coccyx	Thoracic		Urinary tract	inflammation	smallpox	Thoracic pain

Gynecologic	Orthopedic	Cardiac + Hematologic	Ophthalmologic	Urinologic	Different Inflammation	Dermatogenital	Otolaryngology
	fistula	palpitation		infection			
Ovariocystosis	Coccyx fistula	Thoracic pain palpitation		Stress incon- sistence	inflammation	smallpox	Thoracic pain
Minor infertility	Coccyx fistula	Thoracic palpitation		Urinary tract infection	inflammation		Bronchitis
Dysmenoria	Coccyx fistula	Palpitation		Nephrospasm	inflammation		Bronchitis
Menischesis two weeks	Coccyx fistula	Palpitation		Stress incon- sistence	inflammation		Asthma
Hysterotitis	Coccyx fistula	Cardiac		Nephrospasm	inflammation		Thoracic pain
Follow up fetus status	Coccyx fistula	cardio reten- tion		Urinary tract infection	inflammation		Thoracic pain
Follow up fetus status	Coccyx fistula	cardio reten- tion		Stress incon- sistence	inflammation		Hearing impairment
Follow up fetus status	Coccyx fistula	cardio reten-		Urinary burn	inflammation		Otoblennoria
Follow up fetus status	Coccyx fistula	Heart failure		Cystitis	inflammation		Abscess
Follow up a surgery	Coccyx	cardio reten-		Urinary tract infection	inflammation		Epitasis
Infertility Treatment	Coccyx fistula	hypertension		Intection	inflammation		Hearing loss
Endoscope ligation	Coccyx fistula	Sclerosis			inflammation		Nausea
Hot fits	Extra toes &fingers	Throbbing thoracic pain					Tonsillitis
Mamillitis	ago.o	anemia					Otoblennoria
5 month preg- nancy		anemia					Hearing loss
Inflammation		anemia					Ceruminal blockage
Omphalitis		anemia					Nose contusion
Mammatitis		anemia					Epitasis
Genital hemor- rhage		anemia					Laryngitis
Embryotocia		Perinatal pan cytolysis					Inflammation
Fetus moni- toring		anemia					Otoblennoria
Fetus moni- toring		anemia					Otoblennoria
Circumcision		anemia					Strange object in ear
per mastitis		Postoperative Check (vari- cose)					Bronchitis
Circumcision		Varicose					Laryngitis
Left mammal		Postoperative Check (vari- cose)					Tonsillitis
Circumcision		Leg Varicose					Cochlear Nau- sea
Check for ma- mectomy		Leg Varicose					Laryngitis
Circumcision		Hyperlipeds					Laryngitis
Pregnancy							Tonsillitis
Pregnancy							Laryngitis
Pregnancy							Otoblennoria
Mammal mass							Tonsillitis
Pregnancy Signs							Tonsillitis
Pregnancy Signs							Tonsillitis
Inhaled placen- tal liquid							Bronchitis

Gynecologic	Orthopedic	Cardiac + Hematologic	Ophthalmologic	Urinologic	Different Inflammation	Dermatogenital	Otolaryngology
Inhaled placen- tal liquid							Bronchitis
							Bronchitis
							Lung symptoms
							Tonsillitis
							Bronchitis
							Cold
							Cold
							Otitic Media
							Cochlear Nau- sea Symptoms
							Bronchial Allergy
							Bronchial Allergy
							Asthma Symp- toms
							Asthma Symp- toms

Source: AMC Tables + Questionnaires

study showed that 7% patients of rural clinics needed a referral to a specialised doctor in rural polyclinics while 2% of city clinics patients only needed this. This means that there are some specialisations that are not available in the countryside. 47% of patients needed to pay for drugs, 15% needed analysis & radiography, and it decreases to 13% for additional treatment cures.

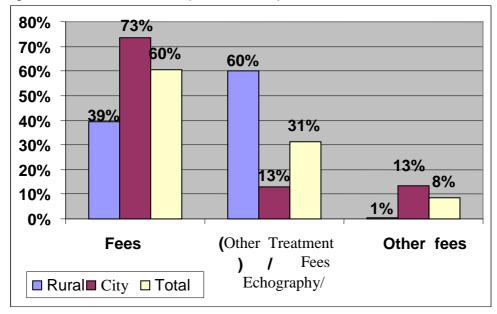
60% 51% 47% 50% 43% 40% 27% 30% 20% 18% 15% 20% 13% 11% 5% 10% 1% 0% Medical Prescription others Referral to advice Additional another ■ Rural City total analysis

Figure 4: Treatment needed for patients in Daraa Governorate:

Source: AMC Statistics& Questionnaires

Study also showed that 60% of clinic patients in rural places needed fees for checks & other treatment outside the clinic such as echography, 13% of city patients needed fees as such which is added to the fees of checks. This may be ascribable to having equipment in the city clinics.

Figure 5: Distribution of expenditure in private clinics:

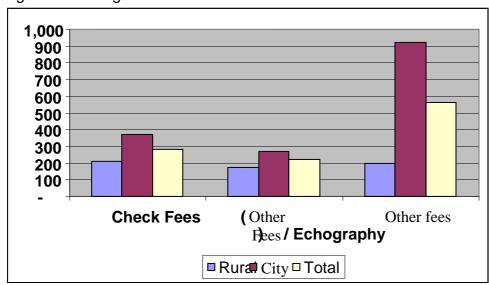


Source: AMC Sta-

tistics& Questionnaires

Study showed that expenditure in the city is higher than in rural places, therefore average check fee is /400 SYP/ whereas it was /250 SYP/ in countryside. The difference in fees appears in other fees for treatment thus the majority of these treatments are not available except in city (e.g. radiography, laboratory services, physiotherapy, or surgery...)

Figure 6: Average Healthcare fees:



Source: AMC Statistics& Questionnaires

Study indicates the average of medical check fees to be /350 SYP/ which is higher than countryside ones /225 SYP/, and average expenses of medical check is /338/ in Daraa Governorate.

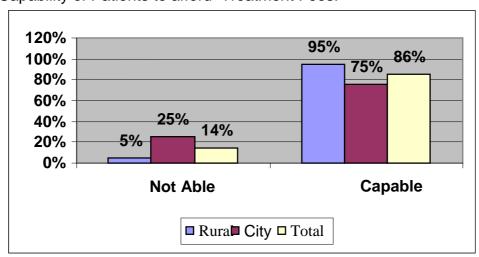
Table 13: Fees in Surveyed Clinics

AREA	Average Check Fees (SYP)
Izra	200
Nawa	250
Daraa	400
Daraa	400
Daraa	300
Kherbet Gazaleh	200
Sanameen	250

Source: AMC Statistics& Questionnaires

25% of patients in clinics made their doctors feel that they are not able to afford check fees while this rate in rural areas was only 5%. This might be ascribed to high fees in city compared to countryside or because city inhabitants are of limited income compared to income in rural areas due to investment in land and selling crops out .

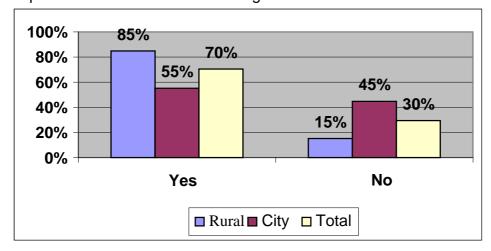
Figure 7: Capability of Patients to afford Treatment Fees:



Source: AMC Statistics& Questionnaires

Study showed that 85% of rural places clinic patients need to have at least another check whereas 55% only in city need to. In total 75 % of patients need to see the doctor again.

Figure 8: Do patients need to visit a doctor again:

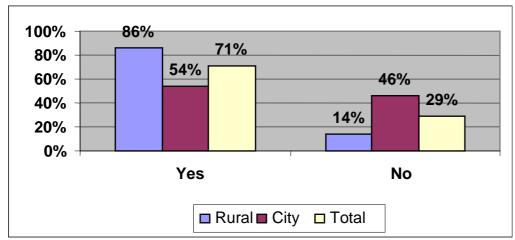


Source: AMC Statistics& Questionnaires

Study indicated that 86% of rural clinics patients are in need for other expenses added to treatment expenditure whereas 54% of city clinic patients need such extra expenses perhaps due to having faraway healthcare centres or being distant from their houses in rural areas.

Source: AMC Statistics& Questionnaires

Figure 9: Do patients need to pay extra expenses other treatment ones:



Source: AMC

Statistics& Questionnaire

Study also showed that average time for patient examination is /12 minutes/ which is moderate.

6- Findings & Outcome:

- Population of Daraa Governorate are /860.000/ half of them males, half females & 50% belong to age group /16-49/ constituting workforce in its community.
- Majority of population id in rural places in this Governorate
- workforce in Daraa Governorate work in building & construction to be first for males while education is first for females for 44.3%.
 Governorate.
- Unemployment rate is 7.7% a moderate rate females are mostly included in this percentage for 15.2% and it drops foe males 6.8%.
- Population per healthcare centre is /8958/ same as for beds in private hospitals /8950/ which is a good rate compared to other governorate such as Ragga.
- Study showed that there is a large number of gynecologists, second entereologists in this governorate, third are surgeons. Rheumatism specialists are very few 3 or 4 cardiologists and an anatomist.
- first time clinic visitors are 86% in rural areas ,54% for city clinics, total average rate is 71% in Daraa Governorate.
- Gastric disorders are mostly common ones 24% then otolaryngitis 13%, gyne-cology 10% not much for ophthalmology or allergy diseases 1% only.
- 47% of patients needed to buy drugs for treatment while 15% needed other examination outside a clinic such as echography whereas it dropped to 13% who needed extra treatment.

- 60% of rural clinic patients needed other fees as echography outside the clinic while only 13% in city needed such fees. This might be ascribed to having equipment there.
- Study indicates the average of medical expenditure in city to be /400 SYP/ which
 is higher than countryside ones /250 SYP/, and such difference is apparent due
 to other fees for treatment, the majority of services are not available except in
 city (e.g. X-ray, laboratory services, surgery or physiotherapy)
- Study showed that 25% of patients in clinics made their doctors feel that they
 are not able to afford check fees while this rate in rural areas was only 5%. This
 might be ascribed to high fees in city compared to countryside or because city
 inhabitants are of limited income compared to income in rural areas due to investment in land and selling crops.
- Study showed that 85% of rural places clinic patients need to have at least another check whereas 55% only in city need to. In total 75 % of patients need to see a doctor again.
- Study indicated that 86% of rural clinics patients need other expenses added to treatment expenditure whereas 54% of city clinic patients need such extra expenses perhaps due to having distances among healthcare centres or being distant from their houses in rural areas
- Study showed that average time for patient examination is /12 minutes/ which is moderate.

7-Recommendations:

We recommend the following according to the outcome of study:

- Speed up preparations for HI Scheme in a gradual manner so that we can decrease agony of citizens especially those of limited incomes.
- Initiate new Healthcare Centres to include higher numbers of population.
- Encourage initiation of private clinics particularly for specialties not available.
- Support private clinics & Healthcare Centres in rural places so as to provide suitable services for countryside population to make them able to avoid traveling to city or to another governorate.
- Increase number of beds in private hospitals to cover rising number of population &cut down costs of treatment in them.
- Establish out-clinics, emergency. Physiotherapy, endoscopy, artificial kidney departments.

Sources:

- -Statistical Group, Central Statistics Office, Syrian Prime Ministry, 2005.
- -Primary Findings, Houses & Population Count, Central Statistics Office, Syrian Prime Ministry, 2004
- www.made-in-syria.com/ragga.htm
- Study about HI Scheme in Daraa, Daraa Directorate of health, MoH, Syria.

Format of Questionnaire:

Questionnaire No.:
Clinic Type :
Clinic Address:

Date of visit	
Patient Age	
Gender	Male Female
New Patient or old Client	New I Old I
Patient Residing in the Area	Yes I NoI
Diagnosis & Remarks	
Therapy & Treatment	- Medical Advice ()
	- Prescription ()
	- Additional Analysis or graphies ()
	- Referral to another Doctor, Specialty ()
	- Others, please indicate ()
OL I. F	()Adminstration for a
Check Fees	()Admission fees SYP () Different treatment fees(Graphy) SYP
	() Others
Did you feel patient not capa-	Yes I NoI
ble of affording the fees?	1001
Does he/she need rechecking?	Yes I NoI
Patient needed other ex-	Yes I NoI
penses (Drug, analysis,)	
Duration of check (minutes)	
Other Information	
<u> </u>	1

Study 10: Private outpatient clinics in Lattakia

SYRIAN MINISTRY OF HEALTH EU-Syria





Health Sector Modernisation Programme

HSMP

Existing Demand for outpatient care in urban and rural areas in Lattakia governorate

Study No. 10

Final Report -November 2006

Prepared by: MCI International



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Executive Summary

The scope of this study is identifying the demand of outpatient private clinics in urban and rural areas of Lattakia governorate to determine the funding processes and integrate them in health insurance schemes, in addition, this study will be considered as a pilot study in other governorates.

This study has been implemented as follows:

Identifying ten clinics in Lattakia governorate.

Identifying five clinics in the urban and five clinics in the rural.

Identifying basic properties of the related questionnaire with cooperation of the ministry of health experts

Conducting staff training about obtaining information and the ways of filling out the questionnaires

Encoding and validation the authenticity of the information.

Analyzing data obtained through "SPSS Ver.13 program"

Submitting the final report about this study results.

This study gives a fundamental idea about the demand of outpatient private clinics in Lattakia governorate and identifies the frequency, and visit duration through out the therapy; It also gives an idea about the fees and usage medical devices in those clinics.

The following points have been studied during the survey:

Physician's Specialty Age of the patient

Gender of the patient

Diagnoses or Signs and symptoms

Treatment

Fees for visit

Duration of visit

This study results could be summarized as follows:

In most clinics, the demands of outpatient private clinics were very different between urban and rural areas, due to the diversity of population between urban and rural areas. There were also convergent percentage of demand between both males and females.

It is also notable that the most frequent age category visiting clinics was (21-30 years) age category which represent 27% of total patients, then (31-40 years) age category about 19%.

this high frequency gave these two age categories, the highest percentage of medical prescriptions and the highest percentage in using medical devices.

In referral to other parties we suggest that similar study should be repeated on specialized clinics having the same financial and professional level; so that the characteristics of "age categories" demand of outpatient private clinics could be identified.

With regard to fees related to demand of outpatient private clinics, "physician's direct fees" took the highest percentage then different fees and then fees of using medical equipments.

For the thereby session duration, it was found that (15 min) was the most frequent ones in all covered clinics, while, the duration (20 min) was the second ones.

Finally, as this kind of studies plays a major role in health care household expenditures and in forming health insurance schemes, we suggest similar studies to be implemented. It should be considered all specialties of clinics and popularization of the studies to cover all governorates.

1- Scope and Purpose:

Scope of this Study is to have a selected group of 10 private clinics in Lattakia Governorate (5 in rural places, 5 in city).

Purpose of this study is to achieve:

Agree on types of demand on private clinics in Lattakia Governorate both in rural, city places.

Data collect and analysis about basic characteristics of demand on private clinics.

2- Methodology:

Three basic stages were used:

2-1 Stage 1:

We called it 'Preparing Stage'. In it workshops were held in MCI International or with HSMP Experts with Directorate of Planning at MoH to agree on questionnaire forms with view to reaching into the most appropriate format to fit the scope and purpose of this study.

2-2 Stage 2:

This is supposed to be 'training and planning stage' in the project, so experts of MCI International on how to deal with outcome questionnaires from stage 1. physical resources required for launching this study particularly computer programmes used for such studies. The following programmes are chosen:

SSPS Statistics, Ver. 13.0 for Windows

3-2 Stage 3:

Implementation of study is in this stage when data is collected taking basic questionnaires t be fed to the above mentioned computer programmes then moving further into analysis and arranging the results.

These questionnaires were filled under supervision and full coordination with specialised staff in Directorate of Health, Lattakia.

We were aided in this study all through its stages by statistics issued by Central Statistics Office, especially Statistic Group, 2005 Version which is the latest version available right now.

3- Essential Information about Lattakia Governorate:

Located to northwestern side of Syria, 320 Km far from Damascus. It has a major seaport in it on Syrian coast. It is considered to be a major tourist attraction place.

3-1 Population & Demographical Indicators of Lattakia Governorate

Population of Lattakia toll up to /891.000/ so the portion of Lattakia population from overall Syrian population is /4.91 %/ as I Table No.1 together with population growth average during past years and recent times.

<u>Table 1</u> : Percentage of Lattakia Governorate & Annual Average of Population Growth AVPG: Results of Population Count (1981-1994) AVPG: (1995-2000/ 2000-2005)									
Governorate	AVPG per 10	000		Governorate's Population Percentage to Overall Count of Population					
	1981-1994	1995-2000	2000-2005	1981	1994	2004			
Lattakia	22.6	19.3	17.5	6.1	5.4	9.4			
Grand Total	33.0	27.0	24.5	100	100	100			

We can see from the table that a drop in the Growth at this Governorate (0.0017.5) compared to the Average of Population Growth in Syria (0.0024.5) during (2000-2005). The total Population No. of Lattakia Governorate out of Overall Population has dropped during (1981-2004) by 1.2%.

The source of Tables 1-15 is Statistical group/ E- version issued by Statistics Office-Damascus/ 2005.

Table 2 shows us the rates of Gender & Demographical Density in Lattakia Governorate:

Governorate		<u>Table2:</u> Rates of Gender & Demographical Density of Lattakia Governorate (1970-1981-1994-2004)							
	No. of	No. of Males for Density per Sq.Km							
	per 10	per 100 Females							
	1994	2004	1970	1981	1994	2004			
Lattakia	104.8	102.0	169	241	324	383			
Grand Total	104.7	104.5	34	49	74	96			

Table 3 shows the Proportional Demographical constituents of Lattakia Governorate according to Gender ,Age Groups, Residence Place in Mid-2005.

Table 3: Proportional Demographical constituents of Lattakia Governorate according to Gender ,Age										
Groups,& Residence Place in Mid-2005.										
Governorate	ate Urban Places Rural Places Total									
	Males	Females	Total	Males	Females	Total	Males	Females	Total	
Lattakia	230	225	455	220	216	436	451	440	819	
Grand Total	4977	4728	9705	4291	4142	8433	9288	8870	18138	

3-2 Workforce:

this Table shows the No. of Proportional Distribution Unemployed Population in Lattakia Governorate.

<u>Table 4</u> : Proportional Distribution Unemployed Population in Lattakia Governorate according to										
Gender Total Population of Syria.										
Governorate Previously Unemployed Unemployed(No job be- Total										
		T = .		fore)	· - ·			T		
	Males	Females	Total	Males	Females	Total	Males	Females	Total	
Lattakia	a 3.9 6.2 4.2 9.9 17.3 12.1 9.5 17.0 11.7									
Grand Total	100	100	100	100	100	100	100	100	100	

Table 5 shows distribution of work injuries in Lattakia Governorate. The percentage appears as 12.7% out of the Total Work Injuries in Syria. It is considered to be second highest rate in the country compared to other Governorates.

Table 5 : Work Injuries in Syria according to the nature of work the injury was incurred in during 2004 in										
Lattakia Gover	Lattakia Governorate									
Governorate Machinery Lift Equipment Equipment Content Equipment Equipment Content Equipment Content Equipment Content Equipment Content Equipment Content Con										
Lattakia	328	271	94	-	1481	75	2249			
	2326	971	820	213	10613	2744	17687			

Table 6 shows that work force in Lattakia Governorate depends mainly on Agricultural Sector. It constitutes 30.6% of the Workforce of the Governorate.

Table 6 : Distribution of Workforce in Lattakia Governorate according to Gender & Economic Sectors.								
	1970	1994	1999	2001				
Workforce percentage/ Population	25.6	29.3	42.3	44.4	%			
Women workforce out of Gross Workforce	17.1	23.2	35.8	35.2	%			
Workforce according to the economic	sectors):						
Agriculture	55.2	25.1	51.6	36.6	%			
Industry	10.6	11.3	11.2	20.5	%			
Other Activities	33.9	63.6	37.2	48.9	%			

3-3 Health Factors & Indicators:

It is noted that Lattakia Governorate occupies position no.5 if compared to the rest of Governorates in Syria with regard to the Number of Health Doctors, Pharmacists and Orthodontists in it. It also occupies position no.8 as for the number of Technical Assistants, and position no.6 for number of Licensed Midwives. However, all these indicators drop sharply with regard to population coverage rate per each doctor. We can see that this coverage rate has taken position no.12 for doctor, orthodontists as well.

Table 7:	Table 7 : Comparison of No. of Health Professionals in Syria & Lattakia Governorate(1999-2004)									
	Health	Health Doctors		ontists	Pharma-	Technical	Licensed	Nursing		
Years	Count	Average of population per doctor	Count	Average of population per doctor	cists	Assistant	Midwives	Staff		
1999	21393	753	10694	1506	8189	11233	4832	25680		
2000	22408	728	11160	1462	8868	12030	4909	27164		
2001	23784	703	12228	1267	9882	13339	5081	27913		
2002	25073	683	14610	1172	10055	14057	5171	28325		
2003	24473	717	14917	1176	10809	14798	5184	27045		
2004	25890	694	15312	1174	12724	16542	5443	28665		
Lattakia Gover- norate	2126	426	1223	740	717	814	411	3508		

Table 8 shows that Lattakia Governorate Average population per hospital bed is lower in the classification compared to other Governorates in the country. It occupies (No.10) and it is lower even at the Overall level in the country. This therefore necessitates efforts to be exerted to increase hospitals & beds as well.

Table 8: He	Table 8: Hospitals & Beds in Syria & Lattakia Governorate									
Years	Public F	lospitals	Private H	ospitals	Total		Average Popu-			
	No.	Beds	No.	Beds	No.	Beds	lation per bed			
1999	63	12202	312	5567	375	17772	842			
2000	65	12518	325	5852	390	18370	830			
2001	67	12418	336	6003	403	18421	848			
2002	66	14311	343	6343	409	20654	829			
2003	76	15227	364	6590	440	21817	804			
2004	78	15487	376	6795	454	22282	807			
Lattakia Governorate	4	1029	12	225	16	1254	722			

Tables 9 to14 show Medical Indicators and the level of Medical Services offered.

Table 9:Total Services by MoH in Lattakia Governorate in 2004							
Governorates Health Centers Hospitals Emergency Total							
Lattakia	Lattakia 1162895 980873 150765 2294533						
Total	25066201	14450391	3043440	45260032			

Table 10: Health Centers: General & Specialized in Lattakia Governorate in 2004								
Year	General HCs Specialized GrandTotal HealthPoints Polyclinics HCs							
Lattakia	Lattakia 98 2 100 12 -							
Total 1175 43 1218 255 14								

	Table 11: Progress of work in Health Centers in Lattakia Governorate in 2004													
Gover- norate	Children Vac- cines	Teta- nus/Wo men	Preg- nant Care	Fam- ily Plan- ning	Safe Child Clinic	Health Educa- tion	Healt h Moni- tor	Nutrition program	Therapy for Pa- tients	Den- tal Care	Labo- ratoy Ser- vice	Vac- cina- tion Cam- paign	Poly- Clinic	Total
Lattakia	185796	1836	5890	31507	24494	28456	3997	71392	228269	14179 5	92132	79179	0	90107 0
Total	615548 9	487107	98242	65058 2	43488 3	253594	10699 8	704960	343434 6	10624 43	17699 98	13972 33	1237 157	17703 036

Table 12 : P	Table 12: Patients Progress in MoH Hospitals in Lattakia Governorate in 2004									
Governorate Out Clin- Emergency out patient Surgeries Laboratory Services Radiography Physiotherapy Endoscopies Dialysis										
Lattakia	230761	150765	18271	577451	120858	1817	22252	9553		
Total	2145161	3043440	425357	9556798	1646361	172185	370112	129848		

Table 13 : P	Table 13: Patients Progress in Private Hospitals in Lattakia Governorate in 2004									
Governorate	Out Clin-	Emergency	Surgeries	Laboratory	Radiography	Dialysis	Physiotherapy	Endoscopies		
	ics	out patient		Services		-		& Graghies		
Lattakia	6085	19	8938	2015	2239	-	-	-		
Total	233165	254999	116606	800685	181218	3854	2087	18938		

Table 14: Patients of MoH 1999-2004.								
Year	Total In patients	Total Out pa-	Average stay					
		tients	days					
1999	1653531	1680823	2.572					
2000	1672139	1675694	2.48					
2001	1912939	1653980	2.37					
2002	1983883	1737268	2.36					
2003	2038552	1736252	2.29					
2004	2244386	1776178	2.201					
Lattakia Gover-	169042	138536	2.85					
norate								

3-4 Syndicates & Aid Funds:

Table No. 15 shows the number of Syndicates members and the number of their laborers in Syria. Then we compare these numbers to the numbers of Lattakia Governorate. This Table shows us that Lattakia Governorate contains 8.8% of the Syndicates in Syria and 8.5% of the Overall number of Syndicates members in Syria.

As for the rate of benefit from Aid Funds 10.8% compared to the rest of Governorates in the country. It is comes third in benefit of these Funds.

Table 15 : Laborers Syndicates, Members & Aid Funds, Lattakia Governorate 1999-2004.									
Year	Syndicates	Members	Aid Funds						
1999	194	711527	187						
2000	194	738286	189						
2001	194	740739	188						
2002	194	752419	188						
2003	205	754380	207						
2004	204	783757	205						
Lattakia Governorate	18	76251	22						

4-Essential Data about Private Clinics:

Having completed field studies about 11 private clinics in Lattakia Governorate, those applying sorts of HI schemes, the contents and how to fill in the information of this study was passed over to these clinics in cooperation with Directorate of Health (DoH), Lattakia. The survey appeared to be promptly done in both rural and city on equal level.

Table No.16: shows the names of clinics that are studied together with encodement:

Table 16: Names of Institution/Establishment & the Overall No. of Employees							
	Rural Area	City					
Code	Specialty	Code	Specialty				
B21	General Medicine	B11	General Internology				
B22	Family Medicine	B12	General Medicine				
B23	Gynecology	B13	Internology				
B25	Emergency Medicine	B14	Dermatology				
B26	General Medicine	B15	Gynecology & Obstet-				
			rics				

5- Time required for Surveying:

Table No.17 indicates the duration of surveying for rural & city clinics: periods lasting from 20th of August till 11th of September 2006 as deadline with count of days and average number of days.

Table 17: Duration of Survey.								
Rural	Area	City						
Code	Duration	Code	Duration					
B21	11	B11	20					
B22	10	B12	8					
B23	10	B13	12					
B25	11	B14	12					
B26	15	B15	17					
Average	11.4	Average 13.8						

6-Distribution of Clinic Visitors:

Table 1	Table 18: Distribution of Clinics and Visitors:							
	Rural Area			City				
Code	Specialty	Visitors (Fre- quency)	Code	Specialty	Visitors (Fre- quency)			
B21	General Medicine	98	B11	General Internology	104			
B22	Family Medicine	27	B12	General Medicine	99			
B23	Gynecology	22	B13	Internology	100			
B25	Emergency Medi- cine	100	B14	Dermatology	92			
B26	General Medicine	43	B15	Gynecology & Ob- stetrics	100			
	Average	58		Average	99			

Table No.18 indicates that distribution of visitors for each clinic in rural and city areas. We can notice that number of visitors in rural areas is much smaller than same number in city. This is ascribable to the increase in city population numbers.

7- Age Groups Distribution on Clinics:

Table No. 19 indicates distribution of age groups and their percentage:

Table 19: Distribution of Age Groups:						
Age Groups per years	Percentage	Cumulative Percentage				
Less than 1 year	2.9	2.9				
1-10 year	10.8	13.8				
11-20 year	11.7	25.5				
21-30 year	26.6	52.1				
31-40 year	18.7	70.8				
41-50 year	13.5	84.3				
51-60 year	8.2	92.5				
Over 61 years	7.5	100				
Total	100					

Table No. 19 indicates distribution of age groups to clinics, figure -1- indicates age groups distributions:

Table	Table 20: Distribution of Age Groups to Clinics									
		<1	1-10	11- 20	21- 30	31- 40	41- 50	51- 60	61<	Total
Clinic	B11	0	1	-	12	20	24	18	22	104
Code	B25	3	13	16	20	16	22	6	4	100
	B26	8	11	1	10	4	3	1	5	43
	B12	4	19	11	21	16	10	6	12	99
	B13	0	1	10	23	22	24	17	3	100
	B14	3	16	17	27	17	9	2	1	92
	B15	0	0	9	64	23	2	2	0	100
	B21	5	20	10	14	22	7	11	9	98
	B22	0	4	8	5	2	4	1	3	27
	B23	0	0	3	13	5	1	0	0	22
Tot	tal	23	85	92	209	147	106	64	59	785

Figure No.1 Not Available in this Text, the original Arabic Text contains it.

We noticed from Table No.21 that age group (21-30) is most frequently visit clinics for 27% then comes in the second place age group (31-40) for 19% accumulative rate up to 71%.

Table 21: Distribution of Age Groups in percentage and Frequency of visits:						
Age Groups per	Number	Percentage	Cumulative Percent-			
years			age			
Less than 1 year	23	2.9	2.9			
1-10 year	85	10.8	13.8			
11-20 year	92	11.7	25.5			
21-30 year	209	26.6	52.1			
31-40 year	147	18.7	70.8			
41-50 year	106	13.5	84.3			
51-60 year	64	8.2	92.5			
Over 61 years	59	7.5	100			
Total	785	100				

8- Distribution of Visitors to Clinics according to Gender:

Figure No.2 shows the distribution of visitors to clinics and

Graph 2:



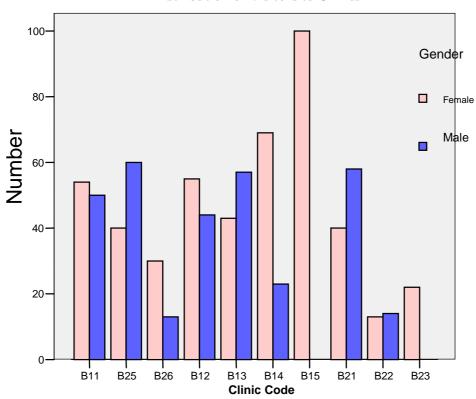


Table 22: Distribution of Visitors to Clinics:							
	Number Percentage Percentage						
Female	466	59.4	59.4				
Male	319	40.6	100				
Total	785	100	-				

9- Diagnosis, Symptoms & Features:

These indicators were not focused on in this study due to difference between the scope of this study and these indicators.

10- Indicators of Treatment:

This indicator is sub-divided indicators into:

- 10-1 Physician's consultation.
- 10-2 Medical Prescription.
- 10-3 Medical Equipment used.
- 10-4 Medical Referral to another institution.
- 10-5 Others.

We are to study each of these sub-indicators separately:

Table	23: Distributi	ion of visitors	to clinics:	
		Yes	No	Total
Clinic	B11	4	100	104
Code	B25	77	23	100
	B26	40	3	43
	B12	91	8	99
	B13	88	12	100
	B14	74	18	92
	B15	93	7	100
	B21	16	82	98
	B22	9	18	27
	B23	11	11	22
	Total	503	282	785
	Percentage	64.1	35.9	

We can notice from Table No. 23 that medical advice was 36% of total questionnaire which were studied.

Table No. 24 indicates relation of patient gender with "medical advice indicator" where medical advice occupied 65% of females had obtained medical advice whereas 36% of males did.

Table 24: G	Table 24: Gender of Patients Relations to Medical Advice Indicator.							
Total	Treatment:	Medical Ad-						
	vi	ce						
	No	Yes						
466	138	328	Number	Female	Gender			
59.4%	48.9%	65.2%	Medical Ad- vice%					
319	144	175	Number	Male				
40.4%	51%	34.8%	Medical Ad- vice%					
785	282	503	Number		Total			
100%	100%	100%	Treatment: Medical Advice%					

We notice that age group (21-30) has obtained medical advice in most cases. This can be ascribed to high frequency of this group to clinics. Table No. 25 and figure 3 demonstrate these indicators.

Graph 3: Not available for copying from source:

Table 25: Medical Advice Relations to Age Group & Percentage:							
Total	_	Medical Ad- ce					
	No	Yes					
23	5	18	Number	1>	Age Group		
2.9%	1.8%	3.6%	Medical Ad- vice%		Group		
85	28	57	Number	1-10			

Table 25: N	Table 25: Medical Advice Relations to Age Group & Percentage:							
Total	Treatment: Medical Ad- vice							
	No	Yes						
10.8%	9.9%	11.3%	Medical Ad- vice%					
92	38	54	Number	11-20				
11.7%	13.5%	10.7%	Medical Ad- vice%					
209	51	158	Number	21-30				
26.6%	18.1%	31.4%	Medical Ad- vice%					
147	50	97	Number	31-40				
18.7%	17.7%	19.3%	Medical Ad- vice%					
106	41	65	Number	41-50				
13.5%	14.5%	12.9%	Medical Ad- vice%					
64	33	31	Number	51-60				
8.2%	11.7%	6.2%	Medical Ad- vice%					
59	36	23	Number	Above 61				
7.5%	12.8%	4. 6%	Medical Ad- vice%					
785	282	503	Number		Total			
100%	100%	100%	Treatment: Medical Advice%					

10-2: We noticed from Table No.26 that the highest age group which obtained medical prescription was (21-30) years then (31-40) years.

Table 26: M	edical prescri	ption Relation	ns to Age Gro	up & Percenta	age:
Total		Medical Pre- otion			
	No	Yes			
23	7	16	Number	1>	Age
2.9%	6.7%	2.3%	Medical pre- scription%		Group
85	14	71	Number	1-10	
10.8%	11.5%	10.4%	Medical pre- scription %		
92	12	80	Number	11-20	
11.7%	13.5%	11.7%	Medical pre- scription %		
209	27	182	Number	21-30	
26.6%	26%	26.7%	Medical pre- scription %		
147	15	132	Number	31-40	
18.7%	14.4%	19.4%	Medical pre- scription %		
106	10	96	Number	41-50	
13.5%	6.9%	14.1%	Medical pre- scription %		
64	12	52	Number	51-60	
8.2%	11.7%	7.6 %	Medical pre- scription %		
59	7	52	Number	Above 61	
%7.5	6.7 %	7.6%	Medical A%		

681	104	785	Number	Total
100%	100%	100%	Treatment: Medical Prescription%	

Table 27: Gender of Patients Relations to Medical Prescription Indicator.							
Total	Treatment: Medical Advice						
	No	Yes					
466	54	412	Number	Female	Gender		
59.4%	51.9%	65.5%	Prescription %				
319	50	269	Number	Male			
40.6%	48.1%	39.5%	Prescription %				
785	104	681	Number		Total		
100%	100%	100%	Treatment: Medical Prescription%				

Table No. 27 indicates that 61% of female patients obtained medical prescription while 39% of males did.

Table No.28 shows that physical distribution of clinics is linked to the prescriptions given to patients ad percentage as well:

Table	28 : [Distribution		al Prescription	to clinics & Per-		
centa	ge:	1					
		Total		:Medical Pre-			
				ription			
<u> </u>			Yes	No			
Clini	B11	104	103	1	Number		
С		13.2%	15.1%	0.1%	Prescription %		
Cod	B25	100	93	7	Number		
е		12.7%	13.7%	6.7%	Prescription %		
	B26	43	38	5	Number		
		5.5%	5.6%	4.8%	Prescription %		
	B12	99	86	13	Number		
		12.5%	12.6%	12.5%	Prescription %		
	B13	100	83	17	Number		
		12.7%	12.2%	16.3%	Prescription %		
	B14	92	12	80	Number		
		11.7%	11.7	11.5%	Prescription %		
	B15	100	94	6	Number		
		12.7%	13.8%	5.8%	Prescription %		
	B21	98	66	32	Number		
		12.5%	9.7%	30.8%	Prescription %		
	B22	27	21	6	Number		
		3.4%	3.1%	5.8%	Prescription %		
	B23	22	17	5	Number		
		2.8%	2.5%	4.8%	Prescription %		
	То-	785	681	104	Number		
	tal						
	Perc	entage	100%	100%	Prescription %		

10-3: Using Medical Equipment:

Table No.29 indicates the link between using medical equipment and age group. We can see that age group (21-30) comes first in using these equipment.

Table 29 : M			elations to Age	Group & Perc	entage:					
Total	Treatment Equip									
	No	Yes								
23	21	2	Number	1>	Age					
2.9%	3.5%	2.3%	Medical Equip- ment%		Group					
85	73	12	Number	1-10						
10.8%	12.1%	6.6%	Medical Equip- ment%							
92	75	17	Number	11-20						
11.7%	13.4%	6.6%	Medical Equip- ment%							
209	156	53	Number	21-30						
26.6%	25.8%	29.3%	Medical Equip- ment%							
147	118	29	Number	31-40						
18.7%	14.4%	19.4%	Medical Equip- ment%							
106	75	31	Number	41-50						
13.5%	12.4%	17.1%	Medical Equip- ment%							
64	48	16	Number	51-60						
8.2%	7.9%	8.8 %	Medical Equip- ment%							
59	38	21	Number	Above 61						
%7.5	%7.5 6.3% 11		Medical Equip- ment%							
181	604	785	Num	ber	Total					
100%	100%	100%	Treatment: Med %		· Jtai					

Table No.30 shows that Clinics B23, B11 in sequence have had the highest rates of using medical equipment ranged from using "oto-endoscope to echography". This is when ratios of visitors were separately calculated not to total as whole.

Table	30: U	se of Me	dical Equipn	nent to clinics &	& Percentage:		
		Total		ent :Medical uipment			
			No	Yes			
Clini	B11	104	26	78	Number		
С		13.2%	4.3%	43.1%	Equipment %		
Cod		75					
е	B25	100	92	8	Number		
		12.7%	15.2%	4.4%	Equipment%		
		8					
	B26	43	42	1	Number		
		5.5%	7.0%	6%	Equipment %		
		2.3					
	B12	99	95	1	Number		

Table 30:	Use of Me	dical Equipr	nent to clinics &	& Percentage:				
	Total		ent :Medical					
			uipment					
		No	Yes					
	12.6%	15.7%	2.2%	Equipment %				
	4.1							
B1	3 100	98	2	Number				
	12.7%	1.1%	16.2%	Equipment %				
	2							
B1	4 92	3	89	Number				
	12.7%	1.7%	14.7%	Equipment %				
B1	5 100	34	66	Number				
	12.7%	18.8%	10.9%	Equipment %				
	34							
B2	1 98	25	73	Number				
	12.7%	13.8%	12.1%	Equipment %				
	25.5							
B2	2 27	21	6	Number				
	3.4%	5.0%	3.0%	Equipment %				
	33.3							
B2	3 22	17	5	Number				
	2.8%	9.4%	8%	Equipment %				
	77.3							
To	- 785	181	608	Number				
ta								
P	ercentage	100%	100%	Equipment %				

Figure No.4: indicates relation of using medical equipment to age groups: Figure not moved from original Arabic Text into English text:

Table 31 : G	ender of Patie	ents Relations	to Using Med	dical Equipm	ent Indicator.
Total	_	Medical Ad- ce			
	No	Yes			
466	356	358	Number	Female	Gender
59.4%	60.8%	58.9%	Medical Equipment%		
319	71	248	Number	Male	
40.6%	39.2%	41.1% Medical Equipments			
785	181	604	Nun	nber	Total
100%	100%	100%	Treatmen Equipr		

10-4 Referral to another institution:

Table No.32 indicates that both age groups (51-60) & (Above 60) are having referrals in most cases 39.1% & 37.3% in sequence with reference to the number of cases not to total number.

Table 32: Medical Referrals Relations to Age Group & Percentage:							
Total	Treatment: Medical Ad-						
1 0 00	vice						

	No	Yes							
23	18	5	Number	1>	Age				
2.9%	3.0%	2.7%	Medical Refer- ral%		Group				
21.8%			rai%						
85	78	7	Number	1-10					
10.8%	13.0%	3.8%	Medical Refer- ral%						
8.2%			14176						
92	78	14	Number	11-20					
11.7%	13.0%	7.6%	Medical Refer- ral%						
15.2%			rai%						
209	170	39	Number	21-30					
26.6%	28.3%	21.2%	Medical Refer- ral%						
18.7%			rai%						
147	108	39	Number	Number 31-40					
18.7%	18.0%	21.2%	Medical Refer- ral%						
26.5%			rai%						
106	73	33	Number	41-50					
13.5%	12.1%	17.9%	Medical Refer- ral%						
31.1%			rai%						
64	39	25	Number	51-60					
8.2%	6.5%	13.6%	Medical Refer- ral%						
39.1%			rai%						
59	37	22	Number	Above 61					
7.5%	6.2%	12.0%	Medical Refer- ral%]					
37.3%			Ta170						
785	601	184	Nun	nber	Total				
100%	100%	100%	Treatment: M	ledical Refer-]				
			ra						

Table	Table 33: Distribution of Medical Referral to another Institution with Clinics										
& Per	centag	e:									
		Total	Treatment:	Medical Re-							
			fer	ral							
			No	Yes							
Clini	B11	104	64	.40	Number						
C		13.2%	10.6%	21.7%	Referral to another institution within same Clinic%						
Cod	B25	100	92	8	Number						
е		12.7%	15.3%	4.3%	Referral to another institution within same Clinic%						
	B26	43	33	10	Number						
		5.5%	5.5%	5.4%	Referral to another institution within same Clinic%						
	B12	99	66	33	Number						
		12.6%	11.0%	17.9%	Referral to another institution within same Clinic%						
	B13	100	40	60	Number						
		12.7%	32.6%	32.6%	Referral to another institution within same Clinic%						
	B14	92	90	2	Number						
		11.7%	15.0%	1.1%	Referral to another institution within same Clinic%						

Table 33: Distribution of Medical Referral to another Institution with Clinics & Percentage: Treatment: Medical Re-Total ferral No Yes **B15** 100 14 86 Number Referral to another institution within 12.5% 14.3% 6.7% same Clinic% **B21** 98 86 12 Number Referral to another institution within 12.5% 14.3% 6.5% same Clinic%

Referral to another institution within 3.4% 3.8% 2.2% same Clinic% 22 21 **B23** 1 Number Referral to another institution within 2.8% 3.5% 0.5% same Clinic% To-785 601 184 Number tal

4

Number

Percentage 100% 100% Use of Medical Equipment%

Table 34 : G	ender of Patie	ents Relations	to Using Med	dical Referral	Indicator.
Total	_	Medical Ad- ce			
	No	Yes			
466	368	98	Number	Female	Gender
59.4%	61.2%	53.3%	Medical Refer- ral%		
319	233	86	Number	Male	
40.6%	38.8%	46.7%	Medical Refer- ral%		
785	601	184	Nun	Total	
100%	100%	100%	Treatment: M		

10-5-Others:

There is a number of other treatments such as "Acupuncture, Serum Injection, Stitching or Bandaging". However, these can not be considered as having statistical indication view to being mixed up in majority with other indicators such as using technical medical equipment or referral to other institutions.

11- Expenses & Costs of Treatment:

This indicator is sub-divided into 3 as follows:

- Doctors wages & fees.

B22

27

23

- Different fees.
- Fees of using medical equipment.

Table 35: Expenses & Cost of Treatment											
	Mean	SYP	SUM	Max	Min	Number					
				SYP	SYP						
	Std Er-	Statistic	Statistic	Statistic	Statistic	Statistic					
	ror										
Doctors Fees	5.896	267.65	208500	2000	0	779					
Different Fees 11.264 214.81 5800 400 100 2											

Use	of	Medical	7.645	174.19	5400	250	100	31
Equip	ment							

We notice from Table No.35 that average doctors fees is /268 SYP/ and average fee of using medical equipment is /175 SYP/ and there are different fees of /215 SYP/. We notice that maximum doctors fees was /2000 SYP/ for attending delivery or for minor surgeries in clinics. Minimum fee is /0 SYP/ (but actually next minimum after zero is /50 SYP/).

Table No. 36 indicated expenses of doctors fees detailed with percentage for each sum of money that was paid. This also shows us that the range of doctors fees is (200-300 SYP) which reach up to 68% of all the sums paid.

Table	35: Tre	eatm	ent F	ees													
	Doctors Fees																
	Fee	0	50	100	150	200	250	300	350	400	500	600	700	750	1000	2000	Total
Clinic	B 11	0	0	0	0	0	0	0	0	0	96	0	0	7	1	0	104
Code	B 25	0	0	1	48	41	7	3	0	0	0	0	0	0	0	0	100
Couc	B 26	0	0	0	0	43	0	0	0	0	0	0	0	0	0	0	43
	B 12	20	0	0	0	79	0	0	0	0	0	0	0	0	0	0	99
	B 13	0	0	0	0	51	49	0	0	0	0	0	0	0	0	0	100
	B 14	7	0	6	3	0	7	61	0	0	2	0	0	0	1	0	87
	B 15	13	0	0	0	1	0	84	0	0	2	0	0	0	0	0	100
	B 21	0	1	0	4	35	36	9	0	5	3	1	2	0	1	0	97
	B 22	0	0	0	3	17	0	3	2	1	1	0	0	0	0	0	27
	B 23	0	0	0	15	4	0	0	0	0	1	0	0	0	0	0	22
	Total	40	1	7	73	271	99	160	2	6	105	1	2	7	3	2	779
% out o	f total	5.1	0.1	0.9	9.4	34.8	12.7	20.5	0.3	8.0	13.5	0.1	0.3	0.9	0.4	0.3	100%

Table No.37 as well shows that expenses of using medical equipment were limited to about 55% at /150 SYP/ out of the total for using these equipments while visiting the clinic.

Table 37: Expenses of Using Medical Equipment in Clinics & Percentage							
Total	Sums p	oaid for	using M	edical			
	Equipn	nent					
	100	150	200	250			Clinic
9	0	1	3	5	Number	В	Code
29.0	0%	3.2%	9.7%	16.1%	Percentage out of Total	21	
%							
6	2	1	3	0	Number	В]
19.4	6.5%	3.2%	9.7%	0%	Percentage out of Total	22	
%							
16	0	1	15	0	Number	В	
51.6	0%	3.2%	48.4	0%	Percentage out of Total	23	
%			%				
31	5	17	7	2	Number	•	Total
100	16.1%	54.8%	22.6	6.5%	Percentage out of Total		
%			%				

Table No.38 indicates that other various expenses in clinics together with percentage.

		uration of Visits				ime Rar	nge in N	linutes			
			5-10	11-15	16-20	21-25	30	30-60	61- 180	181- 240	Total
Clinic	В	Number	0	0	8	63	26	7	0	0	104
Code	11	Percentage in Clinic	0%	0%	7.7%	60.6%	25%	6.8%	0%	0%	100%
		Percentage out of Total	0%	0%	1%	8.2%	3.4%	0.9%	0%	0%	13.6%
	В	Number	50	30%	15	63	3	0	0	0	100
	25	Percentage in Clinic	50%	30%	15%	60.6%	3%	0%	0%	0%	100%
		Percentage out of Total	6.6%	3.9%	2%	8.2%	4%	0%	0%	0%	13%
	В	Number	13	30	15	2	2	3	0	0	43
	26	Percentage in Clinic	30.2%	23.3%	15%	2%	2%	3%	0%	0%	100%
		Percentage out of Total	1.7%	1.3%	2%	3%	3%	4%	0%	0%	5.6%
	В	Number	25	26	31	0	11	2	0	0	95
	12	Percentage in Clinic	26.3%	27.4%	32.6%	0%	11.6%	2.2%	0%	0%	100%
		Percentage out of Total	3.4%	3.3%	4%	0%	1.4%	0.2%	0%	0%	12.4%
	В	Number	12	50	33	3	0	0	0	0	100
	13	Percentage in Clinic	12%	50%	33%	3%	0%	0%	0%	0%	100%
		Percentage out of Total	1.5%	6.5%	4.6%	4%	0%	0%	0%	0%	13%
	В	Number	55%	35	0	0	1	0	0	0	91
	14	Percentage in Clinic	60.4%	38.5%	0%	0%	1.1%	0%	0%	0%	100%
		Percentage out of Total	7.2%	4.6%	0%	0%	1%	0%	0%	0%	11.9%
	В	Number	0	27	69	1	3	0	0	0	100
	15	Percentage in Clinic	0%	27%	69%	1%	3%	0%	0%	0%	100%
		Percentage out of Total	0%	3.5%	9%	1%	4%	0%	0%	0%	13%
	В	Number	11	37	11	5	5	16	0	0	85
	21	Percentage in Clinic	13%	43.5%	12.9%	5.9%	5.9%	18.9%	0%	0%	100%
		Percentage out of Total	1.4%	4.8%	1.4%	7%	7%	2%	0%	0%	11.1%
	В	Number	10	8	7	0	1	1	0	0	27
	22	Percentage in Clinic	37%	29.6%	25.9%	0%	3.7%	3.7%	0%	0%	100%
		Percentage out of Total	1.3%	1%	9%	0%	.1%	0.1%	0%	0%	3.5%

	В	Number	0	2	7	8	2	1	1	1	22
	23	Percentage	0%	9.1%	31.8%	36.4%	9.1%	4.5%	4.5%	4.5%	100%
		in Clinic									
		Percentage	0%	3%	9%	1%	3%	0.1%	0.1%	1%	2.9%
		out of Total									
Total		Number	176	225	192	83	59	30	1	1	767
		Percentage out of Total	23%	29.4%	26%	10.8%	7.7%	3.9%	1%	1%	100%

Total	Sums- Different Expenses								
	100	150	200	250	30 0	400			Clinic
5	0	1	0	3	0	1	Number	В	1
18.5	0%	3.7%	0%	11.1%	0	3.7	Percentage out of	12	
%					%	%	Total		
1	0	1	8	9	2	1	Number	В	1
3.7%	0%	0.0%	3.7%	0%	0	0%	Percentage out of	15	
					%		Total		
21	0	2	9	8	0	1	Number	В	1
77.8	3.7%	7.4%	33.3%	26.6%	0	3.7	Percentage out of	21	
%					%	%	Total		
31	2	2	13	8	1	1	Number		Total
100%	7.4%	7.4%	48.1%	29.6%	3.	3.7	Percentage out of To	otal	7
					7	%			
					%				

12- Duration of Visits:

Table No. 39 indicates relation of visit duration for each clinic separately with percentage of time range for visits together with time ranges for each clinic. Percentage of time for the rest of clinics is indicated to. This table shows that time range is (11-15 minutes) which is most frequent for 29% then time range (16-20 minutes) for 25% which means that time range (11-20 minutes) constitutes 54% of overall duration.

Table No.40 shows that time ranges according to frequency for each one of ranges. Hence, we see that duration (15 minutes) is representing the highest percentage for frequency for 23.6%. Second is time for treatment (20 minutes) for 23.2%.

Table 40	Table 40: Duration of Visits, Frequency & Percentage							
Time	No of Times/ Fre-	Percentage	Cumulative Per-					
per	quency		centage					
Minutes								
0:05	9	1.2	1.2					
0:07	9	1.2	2.3					
0:08	7	9	3.3					
0:09	1	1	3.4					
0:10	150	19.6	22.9					
0:11	1	1	23.1					
0:12	23	0.3	26.1					
0:13	15	2	28					
0:14	5	7	28.7					

Table 40	Table 40: Duration of Visits, Frequency & Percentage						
Time	No of Times/ Fre-	Percentage	Cumulative Pe	er-			
per	quency		centage				
Minutes							
0:15	181	23.6	52.3				
0:16	1	1	52.4				
0:17	82	1.3	53.7				
0:18	59	7	53.1				
0:20	8	23.6	77.3				
0:22	10	1	77.4				
0:25	4	10.7	88.1				
0:30	59	7.7	95.8				
0:35	8	1	96.9				
0:40	10	1.3	98.2				
0:45	4	5	98.7				
0:50	2	3	99				
0:55	1	1	99.1				
1:00	5	7	99.7				
3:00	1	1	99.9				
4:00	1	1	100				
Total	767	100					

13- Conclusion:

This study is considered to be a main study which is to be basis for further studies of more relevance and depth. Among these further studies we can find study on family healthcare expenditure and study on insurace systems.

We again emphasise that this is initial study that covers an overall objective about demand on private out-clinics in Lattakia Governorate both in city and rural places.

We would like to thank everybody who participated and cooperated with us to make this study complete. Special thanks to Planning Team, Ministry of Health, and the team in Lattakia

Annex 1 Questionnaire about Prevalent Type at Out-patient Clinics Under supervision of HSMP in cooperation with EU

Date	
Age of Patient	
Gender	[] Female [] Male
Diagnosis & Signs	
Treatment & Ther-	[] Medical Advice
ару	[] Medical Prescription
	[] Medical Equipment:
	Medical Referral:
	[] Others: please specify
Cost & Expenses	[] Doctor Fees: Sum// SYP
of Visit	[] Medical Equipment: Sum// SYP
	[] Others: Yes [] Sum// SYP, No []
Duration of Visit	Per Minutes:
Other Information	

Study 11: Private and public hospitals in Al Raqqa



Allied Management Consultants



Studies on provider payment, user iees and fair financing

-Study No.11-Availability and Quality of Secondary and Tertiary Hospital Care in Raqqa

R6.A3.P2-2

Final Report

Date: July 2006

Prepared by: Riad Sukkar, PhD

Project Title: Studies on Health Seeking Behaviours and Capacity To Pay

No.11

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Availability and Quality of Secondary and Tertiary Hospital Care in Raqqa

Final Report

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1-EXECUTIVE SUMMARY:

Al-Raqqa governorate is situated in the North-East of Syria and includes two oasis. Two rivers pass through it (Al-Fourat and Al-Bleikh) as well as Al-Assad Lake, which is shared with the governorate of Aleppo. Being a crossroad of Al-Fourat basin and situated on the northern border of Syria, Al-Raqqa became a strategic center for agriculture, exchange of commercial goods, and export.

This study aims at comparing private and public hospitals in Al-Raqqa governorate through the evaluation of their medical equipments, quality of the services provided, assessment of human resources, and patients' satisfaction. The mission is a pilot case in the form of two surveys which measure the readiness of hospitals and the quality of their services. The first survey concentrates on the actual state of hospitals in Al-Raqqa governorate whereas the second focuses on the level of patients' satisfaction with the services provided. Hospitals have been selected in coordination with the head of the Health Directorate in Al-Raqqa taking into consideration whether they are general or specialized hospitals. Four hospitals were chosen: 2 from the private sector (Al-Muwasat and Al-Tib Al-Hadith) and 2 from the public sector (Al-Tawlid and Al-Watani).

The study followed the subsequent steps:

- 13. Studying the points which have to be covered by the surveys in order to meet the goals of the study.
- 14. Designing templates for the two surveys: "currents state of hospitals" and "patient satisfaction".
- 15. Gathering and filling 4 hospitals surveys (one for each chosen hospital).
- 16. Gathering and filling 40 surveys for patient satisfaction.
- 17. Encoding and analyzing data.
- 18. Analyzing processes and results.
- 19. Presentation of results.

We can summarize the findings of the study in the following points:

Al-Ragga Governorate:

- Al-Raqqa contains 4.5% of the population of Syria although its area reaches 11% of that of the country. This governorate is not densely populated.
- Most of its population resides in the rural areas of the governorate.
- The workforce of this governorate revolves around agricultural activities given the presences of the rivers and lake which increase the fertility of the land.
- Unemployment in Al-Raqqa is high (10.3%). 14% of women are unemployed whereas this percentage goes down to 9.5% for men.
- The number of medical centres, doctors, hospital beds is low compared to the number of people residing in this governorate.
- Hospitals in the public sector are difficult to evaluate since they don't have a proper system.
- The most highly demanded medical services are immunization, general treatment services, and paediatric clinics.

- People go to public hospitals more frequently than private ones. This is due to the number of hospital beds which is nearly twice that of private hospitals, although the number of private hospitals (7) is more than double that of public ones (3).
- The most frequented sections in public hospitals are medical laboratories, emergency whereas private hospitals depend on external clinics and laboratories (in second place).

Surveyed hospitals:

- The number of patients per room in the internal section of public hospitals is rather high (7 in the intensive care department, 10 in the cardiology department, 6 in the "kidney cleansing" department), knowing that patients in this section need a high level of care.
- The sections which are nonexistent in the surveyed hospitals are:
 - o In all the sampled hospitals: heart surgery, blood banks, and dental clinics.
 - In the private hospitals surveyed: intensive care, kidney cleansing, head and neck care, nutrition, sterilization, external clinics, refrigerators, burns treatment,X- Ray
- The largest department in the surveyed hospitals (81 rooms and 188 patients) is the OB-GYN department. But these numbers are skewed given that we have a public hospital specialized in OB-GYN. We can observe that in public hospitals, there are 3 patients per room whereas in private ones, there's only one patient per room.
- Public hospitals' capacity and number of rooms is much larger than that of private hospitals especially when it comes to the internal and surgery departments, not to mention of course departments which are absent in private hospitals (head and neck care, and external clinics).

The number of patients in surveyed hospitals:

- The highest number of patients in the OBGYN department is in the natural birth section in private hospitals (40%) and in the gynaecology section in public hospitals (43%).
- Caesarean sections have a higher percentage in private hospitals (7%) than in public ones (4%). The reason is that better care is given in private hospitals.
- Cases of premature births are taken to private hospitals only for the same reason given above.
- The proportion of abortions among pregnancies is high (9%).
- The highest number of patients in the radiology department is in the simple x-ray section for public hospitals (66%) and the echo section in private hospitals (56%) followed by simple x-ray section (40%). The high percentage of echo in private hospitals is due to the routine procedures including analysis and echo incurred prior to doctors' diagnosis and surgery. Mammograms and multi layer x-ray are not available in private hospitals.
- There is no demand for televised and resonant radiography.
- 100% of patients in the internal department of private hospitals are in the diagnosis and treatment of internal diseases section. This is because intensive care, kidney cleansing, and cardiology sections do not exist in these hospitals. 44% of internal department patients in public hospitals are in the diagnosis and treatment section and 26% are in the cardiology section.
- Nervous, digestive, blood, and gland diseases are relatively absent in Al-Raqqa governorate.

- The highest number of patients in the surgery department for both private and public hospitals is in the general and aesthetic surgery section (57% and 39% consecutively). There were no child surgeries and eye and ear surgeries in private hospitals. The proportions of patients for these sections in public hospitals are 29% and 21% consecutively.
- Demand for microscope surgery is non existent in Al-Raqqa.

Human resources in surveyed hospitals:

- The highest academic degrees in the administrative department of public hospitals is a university degree, whereas in private hospitals it a dentistry degree. The highest salary in this department in private hospitals is S.P. 75,000 whereas it is only S.P.12,000 in public hospitals. This difference explains the gap in the level of administration of public hospitals. All employees of this department in public hospitals have more than 10 years experience whereas only half of these employees have this experience in private hospitals. The other half has 6-10 year of experience. The experience of employees in the administrative department of public hospitals is higher than that of employees in private hospitals.
- Salaries of doctors range from S.P. 8.5-13 thousand in public hospitals and S.P. 55-65 thousand in private hospitals. Public hospitals do have doctors who hold a masters or doctorate. 67% of doctors in public hospitals have less than 5 years experience whereas 47% in private hospitals have more than 10 years experience. Higher salaries in private hospitals attract doctors with higher academic credentials and better experience.
- The salary of nurses in public hospitals is S.P. 9000 regardless of academic credentials. This salary goes down to S.P. 5000 in private hospitals. There are no midwives in private hospitals. The percentage of nurses with more than 10 years experience is 25% in public hospitals and only 6% in public ones.
- Salaries of employees in the technical department of public hospitals range between S.P. 7-11 thousand. They go down to S.P. 5000 in private hospitals. There are no technicians with a university degree in private hospitals and that explains the low salaries. Employees in this department in public hospitals have less than 5 years experience and those of private hospitals have 6-10 years experience.
- The average salary of employees in the services department of public hospitals is S.P. 8000 and only S.P. 4000 in private hospitals. There are no recipients of middle school degrees in this department. 90% of those employees in private hospitals have less than 5 years experience whereas 71% of them have more than 10 years experience in public hospitals.
- Salaries of employees in support departments range between S.P. 7-11 thousand in public hospitals and S.P. 5-8 thousand in private ones. All these employees in private hospitals have 6-10 years experience and 47% of them in public hospitals have more than 10 years of experience.
- The highest salaries in sampled hospitals are given in the administrative department.
- There is a positive correlation between the salary of hospital staff members and their educational level and experience.
- Public hospitals did not provide us with the cost of treatment, we were therefore unable to compare them with those of private hospitals. Furthermore, private hospitals only provided us with the cost of treatment in some sections.

Patients' satisfaction about services provided in sampled hospitals:

In public hospitals, 65% of the sampled patients thought the followed processes at the reception were good, 5% thought they were very good, whereas in private hospitals, 50% thought they were very good and 35% thought they were good. We can conclude that the processes followed at the reception are good.

- In public hospitals, 70% of the patients thought the professionalism of employees at the reception was good, and none thought it was very good, whereas in private hospitals, 55% thought it was very good and 35% thought it was good. We can conclude that the professionalism of employees at the reception is good.
- 70% of the patients in public hospitals thought the level of cleanliness at the reception was good, 5% thought they were very good, whereas in private hospitals, 95% thought it was very good. We can conclude that the level of cleanliness at the reception is good.
- 50% of the patients in public hospitals thought the instructions given by employees at the reception were good, 35% thought they were acceptable and 15% thought they were unsatisfactory, whereas in private hospitals, 90% thought they were very good, and 10% thought they were good. We can conclude that whereas instructions given by employees at the reception in private hospitals are deemed very good, those given in public ones are only deemed acceptable.
- 65% of the patients in public hospitals thought the location of the reception was good, 5% thought it was very good, whereas in private hospitals, 80% thought it was very good and 15% thought it was good. We can conclude that the location of the reception is good.
- 65% of the patients in public hospitals thought the processes followed in the treatment section were good, none thought they were very good, whereas in private hospitals, 40% thought they were very good and 55% thought they were good. We can conclude that the processes followed in the treatment section are good.
- 50% of the patients in public hospitals thought the way doctors treated them was good, 10% thought it was very good, whereas in private hospitals, 90% thought it was very good and 5% thought it was good. We can conclude that the way doctors treated their patients is good.
- 50% of the patients in public hospitals thought the way doctors treated them was good, 10% thought it was very good, whereas in private hospitals, 90% thought it was very good and 5% thought it was good. We can conclude that the way doctors treated their patients is good.
- 70% of the patients in public hospitals thought the way nurses treated them was good, 15% thought it was acceptable; no one thought it was very good. Whereas in private hospitals, 25% thought it was very good and 15% thought it was good. Since the nurses at the public hospital gets higher salary and secure job positions.
- 35% of the patients in public hospitals thought that cleanliness in the treatment section was good, 55% thought it was acceptable, no one thought it was very good. Whereas in private hospitals, 95% thought it was very good and 15% thought it was good. While cleanliness in the treatment section is considered very well in private hospitals, it is only considered acceptable in public ones.
- 50% of the patients in public hospitals thought that performance in the treatment section was good, 35% thought it was acceptable, and no one thought it was very good. In private hospitals, 90% thought it was very good and 5% thought it was good. We can conclude that performance in the treatment section is good.
- 30% of the patients in public hospitals thought that equipments in the treatment section were good, 45% thought they were acceptable, and 20% thought they were very good. In private hospitals, 75% thought they were very good and 20% thought they were good. While equipments in the treatment section are considered very good in private hospitals, they are only considered acceptable in public ones.

- 65% of the patients in public hospitals thought that services rendered in the radiology department were good, 15% thought they were very good. In private hospitals, 40% thought they were very good and 55% thought they were good. We can conclude that services in the radiology department are good.
- 70% of the patients in public hospitals thought that services rendered in the laboratories were good, 5% thought they were very good. In private hospitals, 40% thought they were very good and 55% thought they were good. We can conclude that services in the laboratories are good.
- 40% of the patients in public hospitals thought that services rendered in the pharmacies were good, 15% thought they were very good. In private hospitals, 40% thought they were very good and 60% thought they were good. We can conclude that services in the pharmacies are good.
- 40% of the patients in public hospitals thought that the food served was acceptable, 25% thought it was good, no one thought it was very good. All patients in private hospitals did not know how the food served was. We can conclude that the food served in public hospitals was only acceptable.
- 45% of the patients in public hospitals thought that the rooms were acceptable, 35% thought they were good, no one thought they were very good. 80% of the patients in private hospitals thought they were very good and 20% thought they were good. While rooms in private hospitals are considered very good, they are only considered acceptable in public ones.
- 55% of the patients in public hospitals thought that the services rendered in the rooms were acceptable, 20% thought they were good, no one thought they were very good. 85% of the patients in private hospitals thought they were very good and 15% thought they were good. While the services in the rooms in private hospitals are considered very good, they are only considered acceptable in public ones.
- 50% of the patients in public hospitals thought that these hospitals were good, 25% thought they were acceptable, no one thought they were very good. 60% of the patients in private hospitals thought they were very good and 40% thought they were good. While private hospitals are considered very good, public ones are only considered good.
- The services that satisfied the patients most in both public and private hospitals are doctors' treatment and cleanliness.
- The things that dissatisfied the patients in public hospitals are the treatment of nurses and the presence of insects, whereas in private hospitals patients were dissatisfied with the high cost of treatment and the treatment of nurses (in second place). We can conclude that the treatment of nurses needs to be improved in both types of hospitals and public hospitals need to work on their cleanliness, which is a critical issue when it comes to health.
- From our assessment of patients' satisfaction, we find that the level of rendered services in private hospitals is generally better than that of public hospitals.

Given all the above, we suggest the following:

- Increasing the number of medical centres and hospitals proportionally with the population
- Creating an automated system in public hospitals and improving their equipments to the level of private hospitals.

- Establishing a new management system in the public sector, so the centres will be turned into an independent cost centre, so they will be able to provide paid services in order to be able to increase the level of the provided services.
- Developing the management skills in the public hospital in order to be able to develop its skills in strategic planning away from the central planning system.
- Increase the number of private, specialized, and medium size medical centres, and should be distributed in all over the governates. This will encourage the patients to take a proper medical treatment and reduce the cost of the transportation.
- Develop the nurses skills by provide new training courses specialized for nurses concentrating on the customer satisfactions. The ministry has to put new procedures in nurses hiring at the private sector hospital. The government should encourage the private training centre to provide such courses.
- Implement international standards for the sterilization and cleanness in the hospitals.
- Reduce the number of patients per room in the internal section of public hospitals in order for them to get the proper care.
- Create new departments which they are not exist in the private sector hospitals.
- Increase the salaries of administrative employees and doctors in public hospitals to attract more highly qualified staff.
- Increase the salaries of nurses, technical employees and support staff in private hospitals to attract more highly qualified staff with better experience.
- Improving
 - processes, professionalism, cleanliness and location of the reception department.
 - o processes, doctors' treatment and performance in the treatment department
 - o services rendered in the radiology, laboratories, and pharmacy departments

Which are considered good in public hospitals to their level in private hospitals which is considered very good.

- Improving the level of instructions at the reception, cleanliness and equipments in the treatment department, rooms and services in the rooms, which are considered acceptable in public hospitals to their level in private hospitals, which is considered very good.
- Improving the food served in public hospitals
- Introducing training courses for nurses in all hospitals about patients' treatment and adding these courses to the nursing curriculum.
- Improving the level of cleanliness and sterilization in public hospitals.
- Decreasing the cost of treatment in private hospitals. We believe that health insurance will significantly participate in reaching this goal.
- It was not possible for private hospitals to give out enough information concerning the cost system.

2- Purpose of this Study:

This study aims at establishing an experiment due to the continuous need to establish extensive HI Scheme especially for workers with the Government. These requirements are repeated continually by Government and the purposes of 10th Five-year Plan together with requirements of Popular Work Organisations. All these requirements are result of limited incomes categories need to secure cures & treatment for them and their families too. A pre-requisite for identifying HI Scheme is willingness & ability to pay the expenses by citizens.

This study intends to have a leading experiment to assess coverage of HI Scheme expenses in Raqqa Governorate. A first questionnaire was designed to cover issues about hospital status another questionnaires covered patient satisfaction. Questionnaires were chosen in cooperation

with Director of Health, Raqqa taking into consideration whether hospitals were specialized or general ones.

3- Methods for Conducting this Study:

The following stages were adopted in this study:

- 1- Research on the points that are to be put into the questionnaire with view to achieving the targets.
- 2- Designing models for questionnaire applying to both hospitals & patients' satisfaction.
- 3- Collect & fill up 4 questionnaire forms: 2 about private hospitals 2 about public ones.
- 4-. Collect & fill up 40 questionnaires about patients' satisfaction.
- 5- Encodement & analysis of data.
- 6- Analysis of procedures & results.
- 7- Presentation of this study results.

Summary of the activities in this study:

3-1 QUESTIONNAIRE Form:

An integrated work team was formed up to fulfill this mission in cooperation with HSMP. Questionnaires were prepared in coordination with MoH, Syria in order to make sure about the quality of these questionnaires prior to circulating them, and to check for the capacity of the people in charge for the mission to execute it in order to get the highest possible quality. We trained responsible staff on filling these forms to secure accuracy & quality in doing this study.

3-2 The team cooperated with Consultancy Office Staff to travel to Raqqa Governorate to start distribution of questionnaires (44) to hospitals and patients there. The team worked in two weeks under supervision of a specialist who was there for responding to any queries or problem might arise while doing this survey.

3-3 Data Collection:

After filling the questionnaires, Consultancy Office assigned number employee for Data entry to computer using a special computer programme, another employee was there to supervise, check for the quality of data entry & to secure an extent of truthfulness and quality in doing this work.

3-4 Release of Report:

After all preparations for writing & issuance of this report by Consultancy Office through a specialised team. Preparation to discuss the report with HSMP & MoH representatives were done.

4-Status of Ragga Governorate:

4-1 Introduction:

Raqqa is located to Northeast of Syria, including two deserts, River Euphrates & its tributary River Baliekh pass through this Governorate. It also shares a large part of Assad Lake with Aleppo Governorate. Due to being located in the corner of two rivers then extending north to the Syrian-Turkish Border line, Raqqa Governorate became a strategic linking point for all crops, exchange of products for export.

Among the most remarkable places in Raqqa is al-Baath Dam which was achieved in 1990 upon which this Governorate depends. The storage capacity of this Dam is up to 90 million m³.

Table 1: Information about al-Baath Dam:

Storage Capacity	Water Basin Per	Maximum Height	Length (m)
Per 1000 m ³	1000 m ²	(m)	
90000	27150	12	2650

Information source: Statistical Group Page 49.

Table 2: Territory per Square Acres:

Brown Agronomy Soil	90
Desert Soil	273
White Soil	2596
Black Soil	248
Soil formed up fromground water sources	
Total	3306

Source: Statistical Group- land Survey department.

4-2 Population Status & Demographical indicators:

Population in Raqqa Governorate are distributed as follows:

Table 3: Distribution of Population according to Civil Registration Records (Gender) on 1/7/2005.

Record	Gender	(Per 1000 people) Percentage from No. of Males			
	Males	Females	Total	Total Population of Syria	100 Females (Gender Rate)
Raqqa Governorate	413	398	811	4.5 %	96

Source: Study on HI Scheme at Ragga Governorate Page: 2.

We notice of what was mentioned above that Population Rate of Raqqa Governorate is 4.5 % of the Total Population of Syria. It is a very little percentage compared to the territory of land which is 11% of Syrian Territory.

Table 4: Population Estimate currently resident in Raqqa on 1/7/2005 according to Gender & Lifestyle(in thousands)

Record	City/ Town		Countryside		Grand Total		
	Males	Females	Total	Males	Females	Total	811
Raqqa Governorate	155	149	304	258	249	507	

Source: Study on HI Scheme at Raqqa Governorate Page: 3.

We notice that the majority of Ragga inhabitants are in countryside.

3-4: HR Manpower & Workforce Status in Ragga Governorate:

Workforce in is centered Raqqa Governorate on Agronomy & Farming activities due to having two rivers and a lake in which makes land more fertile than ever. Raqqa Governorate comes in the first place as for employment of workforce both Males & Females. Building & Construction activities comes in the second place for Males. Education activities comes second for Females.

Table 5: Proportional distribution of Workers above 15 Years according to Gender (%)

Activity	Males	Females	Total
Farming, forestation & Hunt	41.1	70.1	46.1
Fishing	0.2	-	0.2
Stone & Metal Industry	0.3	-	0.2
Transformation Industry	6.2	3.5	5.7
Electricity, Gas & Water	1.6	0.3	1.4
Building & Construction	20.4	3.3	17.4
Wholesale	8.4	1.0	7.1
Transport, Storage& Telecom	5.5	0.5	4.6
Financial Brokers	0.1	-	0.1

Real-estate Broker & Lease	0.6	0.1	0.5
Public administration& Defense	8.3	3.8	7.6
Education	3.9	14.8	5.8
Social Services	1.6	0.4	1.4
Domestic Services	0.1	0.3	0.1
International Organisations	1.6	2.0	1.7

Source: Gross Population& Habitat Count: Primary Results in 2004 Page: 54

Unemployment Rate in Raqqa Governorate is 10.3 % which is high where Females have most of it 14% of them are unemployed. Whereas, Unemployment Rate for Males is 9.5%.

Table 6: Employees Count above 19 Years old:

Males	Females	Total
198810	192330	391140

Source: Study on HI Scheme at Ragga Governorate Page: 8

Table 7: Unemployment Rate above 15 Years according to Gender: (Percentage)

Workforce	Males	Females	Total
Employed	90.5%	86.0%	89.7%
Unemployed	9.5%	14.0%	10.3%
Total	100%	100%	100%

Source: Gross Population & Habitat Count: Primary Results in 2004 Page: 53

Health Status at Ragga Governorate:

The table below indicates all sorts of Healthcare services at Raqqa Governorate. Though these services are not sufficient for population, it comes as follows:

Table 8: basic Physical Indicators of Healthcare Sector in 2005:

Indicator	S	Unit	Available	Average Population per Unit
No. of Healt	h Centers &	Centers	48	16000
Specialised	Units			
Public Ho		Hospital	3	
Public Hosp	itals Beds	Bed	400	2052
Private Ho	ospitals	Hospital	7	
Private Hos	pitals Beds	Bed	161	6000
No. of	Public	Doctors	367	1150
Doctors	Private	Doctors	347	
No. of	Public	Dentist	63	3284
Dentists	Private	Dentist	187	
No. of Ph	armacists	Pharmacist	304	2700
No. of Nurses		Nurse	557	
No. of Midwives		Midwife	178	
No. of Pa	ramedics	Technician	201	
		me at Pagga Cove	_	7

Source: Study on HI Scheme at Raqqa Governorate Page: 6+7

We see in the table to follow that services mostly required are vaccination, immunization campaigns for children then pediatric clinics:

Table 9: Progress of Health Centres in 2004:

Children vaccine	411.284
Women Tetanus	48.817
Pregnant Care	6.922
Family Planning	14.336

Health Education	39.841 1.881
Health Audit	1.746
Nutrition Programmes	2.717
Therapeutical Services	53.486
Dental Services	25.807
Laboratory Services	19.612
Vaccination Campaigns	114.928
Polyclinics	-
Total	741.379

Source: Statistical Group 2005, page 448+449.

We notice from table below that use of pubic hospitals is much larger than private ones due to large number of beds in them (Double number of beds in private hospitals) as stated above. Although toll of private hospitals is two times larger than public ones.(3-7)

We can notice that departments of higher patient progress in public hospitals are laboratory & emergency while in private hospitals are polyclinics & laboratory.

Table 10: Patient Progress in Hospitals in 2004:

Governorate	Public Hospitals	Private Hospital
Out-clinics	41.739	8.829
Emergency Check	192.223	78
Surgery	16.200	4.021
Laboratory Service	260.269	7.813
Radiology	46.510	1.185
Endoscopy	321	
Artificial Kidney	8.306	520

Having analysed some of the figures related to HI Scheme implemented now at Raqqa Governorate, we found that Total No. of employees at Public Sector who are beneficiaries of HI Scheme was as follows:

- Employees at Public Sector are /32810/ who are still incumbents holding their posts till now.
- Pensioners at Public Sector are /3000/ distributed in belongingness to Social Security Establishment & Pension and Insurance.
- No. of Unemployed who are registered at Employment Office are /39125/-2

Study about HI in Raqqa page:8

5- General Assessment of Results:

5-1 Study of information about Ragga Hospitals:

1- Infrastructure Status:

The following table shows infrastructure status and equipment with regard to capacity, number of rooms, average patient toll per room in private & public hospitals, for each specialised wards and basic services departments ,

Table 11: Infrastructure of Hospitals:

Depart-	Maximum	Capacity		Number	of Rooms		No. of	Patients/N	No. of
ment							Rooms		
	Private	Public	Total	Private	Public	Total	Private	Public	Total
	Hospitals	Hospitals		Hospi-	Hospitals		Hospitals	Hospitals	
				tals					
			Ho	spital Infr	astructure				
		(Synecolo	gy & Obs	tetric Depart	tment			
Labour	8	11	19	5	4	9	2	32	2
Gyneco-	2	2	4	2	2	4	1	1	1
logic Sur-									
gical									
Rooms									
Incubators	9	12	21	3	1	4	3	12	5
Inpatient	20	124	144	17	47	64	1	3	2
Rooms									
Total	39	149	188	27	54	81	1	3	2
				Interno	ology				
ICU	-	7	7	-	1	1	-	7	7
Cardiac	5	10	15	2	1	3	3	10	5
Care									
Dialysis	-	12	12	-	2	2	-	6	6
Section									
Cardiac	-	-	-	-	-	-	-	-	
Catheter									
Total	5	29	34	2	4	6	3	7	6

Department	Maximum Capacity			Number of Rooms			No. of Patients/No. of Rooms		
	Private	Public	Total	Private	Public	Total	Private	Public	Total
	Hospitals	Hospitals		Hospitals	Hospitals		Hospitals	Hospitals	
				Clinics					
Cardiology	-	1	1	-	1	1	1	1	1
Gastro endocri-	-	1	1	-	1	1	1	1	1
nal ortho, Hema-									
tology									
Thoracic/ Neu-	-	1	1	-	1	1	-	1	1
ralgic									
Sur-	-	1	1	-	1	1	-	1	1
gery/General,ort									
ho, urinal, neu-									
rology, cardio-									
logic									
Obstetric clinic	-	1	1	-	1	1	-	1	1
Pediatric clinic	-	1	1	-	1	1	-	1	1
Eyes clinic	-	2	2	-	-	-	-	-	-
Dermal clinic	-	1	1	-	1	1	-	1	1
Emergency	-	1	1	-	1	1	-	1	1
otolaryngologic	-	1	1	-	1	1	1	1	1
Dental Clinic	-	-	-	-	-	-	1	-	-
	Surgery								
General Surgeries	4	7	11	4	7	11	1	1	1
Cardiac Surger- ies	-		-		-	-	-	-	-
Burns Surgeries	-	10	10	-	3	3	1	3	3
Total	4	17	21	4	10	14	1	2	2

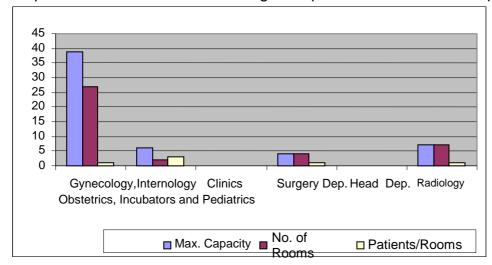
Department	Maximum	Capacity		Number o	f Rooms		No. of	Patients/No	o. of
							Rooms		
	Private	Public	Total	Private	Public	Total	Private	Public	Total
	Hospitals	Hospitals		Hospitals	Hospitals		Hospitals	Hospitals	
Head Department	Head Department								
Eye Disease	-	6	6	-	2	2	-	3	3
Section									
Ear& Nose Sec-	-	6	6	-	2	2	-	3	3
tion									
Jaw Section	-	6	6	-	2	2	-	3	3
Physiotherapy	-	12	12	-	2	2	-	6	6
Placemia	-	5	5	-	1	1	-	5	5
Total	-	35	35	-	9	9	-	4	4

Department	Maximum Capacity			Number	of Roon	ns	No. of Patients/No. of Rooms		
•	Private Hospitals	Public Hospitals	Total	Private Hospitals	Public Hospitals	Total	Private Hospitals	Public Hospitals	Total
	Supporting Services								
Radiography									
Simple Radi- ography	3	8	11	3	8	11	1	1	1
Televised Ra- diography	-	8	11	-	1	1	-	1	1
CT Scan Unit	-	1	1	-	1	1	-	1	1
Ultrasonic Unit	4	2	6	4	2	6	1	1	1
Mammography Unit	-	2	2	-	2	2	-	1	1
MIRNAN Unit	-	1	1	-	1	1	-	1	1
Total	7	15	22	7	15	22	1	1	1
			Otl	her Depart	ments		l	I.	l
Blood Bank	-	-	-	-	-	-	-	-	-
Laboratory	11	98	109	2	4	6	6	25	18
ICU	3	-	3	1	2	3	3	-	1
Emergency	5	12	17	3	6	9	2	2	2
Nutrition	-	450	450	-	2	2	-	225	225
Sterilisation	-	100	100	2	2	4	-	50	25
Pharmacy	300	600	900	2	2	4	150	300	225
Fridges	-	12	12	-	1	1	-	12	12
Inpatient Department	40	365	405	24	131	155	2	3	3
Total	359	1.637	1.996	34	150	184	11	11	11

Source: Questionnaire Forms+ Tabulation of AMC

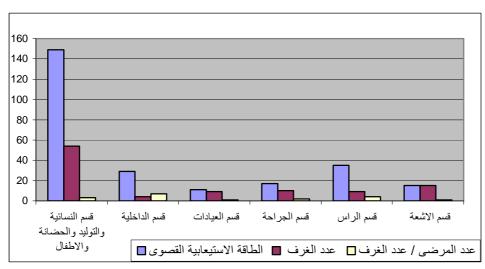
Figures below show that maximum capacity is in gynecology department (188 patients for public & private hospitals). The largest number of rooms in such a department is (81 rooms). However, this rate is biased since there is a specialised hospital (Obstetrics Hospital) which is a public hospital. In general, average occupancy of rooms in public hospitals is 3 patients per room while in private hospitals, it is 1 patient per room.

Graph No.1: Infrastructure according to Departments in Private Hospitals.



Source: Questionnaire + AMC Tabulation:

Graph No.2: Infrastructure according to Departments in Pubic Hospitals:



Source: AMC Statistics& Questionnaires.

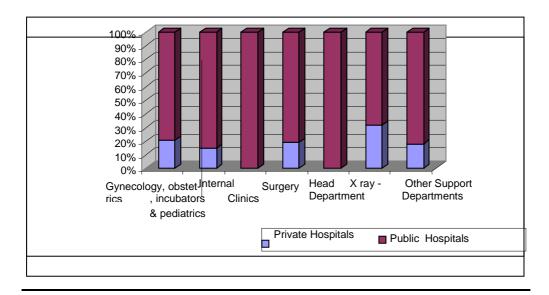
<u>Legend:</u> Please note the following points in figure No.2 above:

Columns from left to right: (gynecology, obstetrics, incubators and pediatrics/Internology/ clinics 'No columns'/ surgery/ head department 'No columns'/ radiology department). From the bottom in coloured boxes left to right.

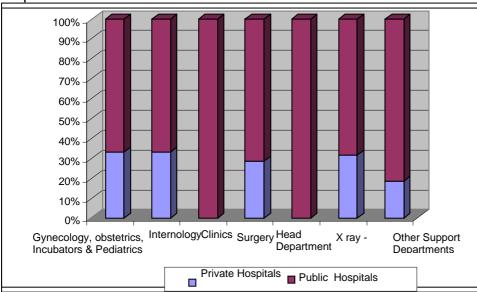
Maximum Capacity	No. of Rooms	No. of Patients/ Rooms
------------------	--------------	------------------------

We notice from graphs below that capacity in public hospitals is remarkably larger than that of private hospitals particularly in Internology and surgery departments excluding departments not available in private hospitals (head care and clinics).

Graph No.3: Availability of services in Pubic & Private Hospitals:







Source: AMC Statistics& Questionnaires.

2- Types of Services accessible & Number of Patients:

In what comes after is analysis of services available in different departments in hospitals such as in obstetrics, radiography, Internology and surgery departments together with number of patients in each one of these departments.

We noticed that these departments don't have out-patients (those not in need for admission) and all patients are in-patients.

Table below indicates that use of public hospitals is larger than private ones while in the case of surgery departments use was same for private ad public ones. This use of public hospitals is ascribable to the fact that beds available in these hospitals is fairly larger and some of existing departments in them are not available at private hospitals.

100% 80% 49% 77% 79% 60% 96% 40% 51% 20% 33% 21% 0% Obstetrics Internology Surgery X-ray Private Hospital Public Hospitals

Graph No.5: Patient Rates in Departments:

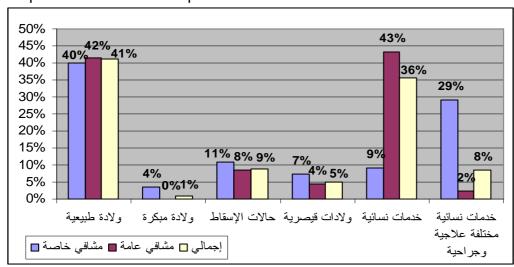
Source: AMC Statistics& Questionnaires.

Obstetric Department:

Figure below shows that normal birthgiving is basically the largest number of patients in this department in both private and public hospitals 40% and 42% in sequence. Gynecologic service comes second in public hospitals with regard to number of patients in obstetric department for 43%, whereas surgical and therapeutical obstetric service comes in the second place in private hospitals in 29%.

We noticed that Cesarean Section rates in private hospitals is 7% which is higher than public hospitals 4% due to the fact that care at private hospitals is much better. Graph below shows that premature baby birth do not go straight to public hospitals and they go to private hospitals due to same reason mentioned earlier.

We notice that gross average of miscarriage is relatively high 9%. Graph No. 6: Obstetric Department:



SourSource:

AMC Statistics& Questionnaires.

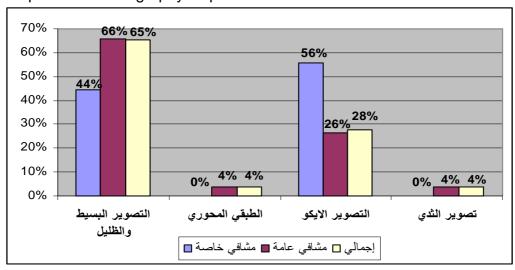
<u>Legend</u>: From left to right columns say (normal delivery, premature delivery, caesarian section, Gynecologic services, miscellaneous gynecologic services)

Blue refer to Private hospitals Purple refer to Public hospitals White refer to Total

Radiography (X-ray) Department:

We noticed from the following graph that the highest rate of patients in radiography department is simple and opaque X-ray imaging in public hospitals for 66% because of their low cost compared to their cost in private hospitals which use echography in their radiography departments for 56% then simple and opaque X-ray imaging for 40%. This might be ascribed to routine regulations necessitates all tests and imaging before a doctor diagnoses the case or before a surgery. We notice that mammography and CT scan imaging aren't available in private hospital.

We noticed that there is no demand on televised scanning and MIRNAN. Graph No.7: Radiography Department:



Source: AMC statistics + Questionnaires

<u>Legend</u>: From left to right columns say (Simple & opaque X-ray, CT scan, echography, mammography)

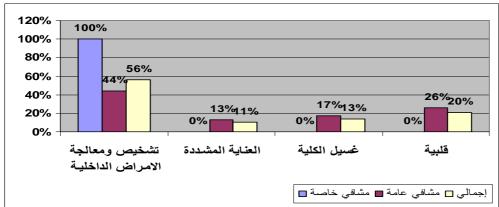
Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

Internology Department:

We conclude from the graph to follow that 100% of private hospitals in- patients in Internology departments are in diagnosis and therapy sections. This is because no ICU, artificial dialysis and cardiac in them. While in public hospitals only 44% are in internal diagnosis and therapy sections and 26% are in cardiac section.

Figure below indicates that services for neurological, gastric, thoracic, hematological, endocrinal diseases are not available in Raqqa Governorate.

Graph No.8: Internology Department



Source: AMC statistics + Questionnaires

<u>Legend</u>: From left to right columns say (Diagnosis& treatment of internal diseases, ICU,

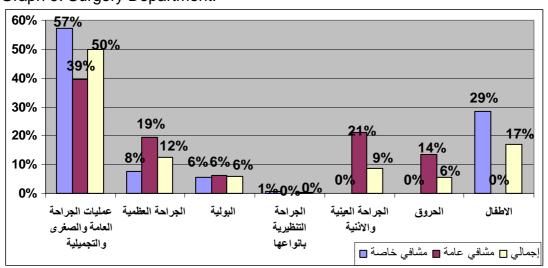
artificial dialysis, cardiology)

Blue refer to Private hospitals	<u>Purple</u> refer to Public hospitals	White refer to Total

Surgery Department:

We can see from the following graph that the highest rate of patients in surgery departments is in general, minor and plastic surgery in private and public hospitals 57%, 39% in sequence whereas pediatric surgery is 29% in private hospitals and 0% in public hospitals. As for ophthalmic, ear surgery is 21% in public hospitals and 0% in private hospitals. Demand on endoscope surgery is very little.

Graph 9: Surgery Department:



Source: AMC Statistics& Questionnaires

<u>Legend</u>: From left to right columns say (General, minor & plastic surgical operations, bone surgery, urinal surgery, endoscope surgery, ophthalmic & ear surgery, burns, pediatric)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

HR Level:

This study shows that expertise in private and public hospitals as average of their scientific qualifications, average salary, years of experience in each department.

Administrative Department:

We can see from figure below that the highest scientific degree in administrative departments in public hospital is university degree while in private hospitals it was is for dentists. The highest salary in administrative department in private hospitals is /75.000 SYP/ compared to /12.000 SYP/. This contrast can cause real differences in management of both private and public hospitals.

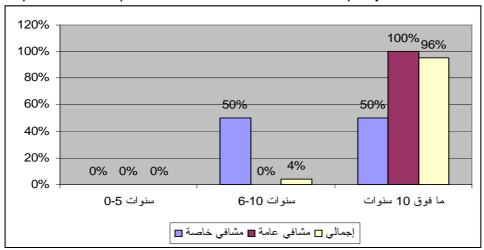
So far, we found that all administrative staff in public hospitals possess experience of more than 10 years while in private hospitals half of administrative staff possess more-than-10 years experience, the other half possess experience ranging from 6-10 years.

Graph 10: Salaries of Administrative Staff: Not Valid link!

Source: AMC Statistics& Questionnaires

In the graph to follow, we see that all administrative staff in public hospitals possess experience of more than 10 years while in private hospitals 50% of administrative staff possess more-than-10 years experience, the other 50% possess experience ranging from 6-10 years.

Graph No. 11: Experience of Administrative Staff per years :



Source: AMC Statistics& Questionnaires

<u>Legend</u>: From left to right columns say (0-5 years old, 6-10 years old, above 10 years old)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

Medical Doctors Department:

In the figure below, we can see salaries of doctors mostly ranging from /8.500 SYP-13.000 SYP/ in public hospitals while they range from 55.000 SYP-60.000 SYP/ in private hospitals. We noticed that there were no doctors, PH. MD. Holders or M MD holders in public hospitals.

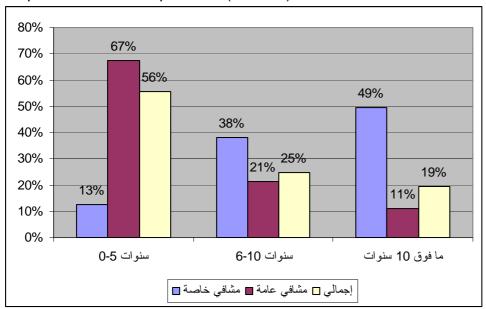
Graphs 12: Salaries in Doctors Department:

Not valid link!

Source: AMC Statistics& Questionnaires

Figure below indicates that 67% of doctors in public hospitals possess experience not exceeding 5 years while in private hospitals 49% possess more-than-10 years experience.

Graph 13: Years of Experience (Doctors):



Source: AMC Statistics& Questionnaires

<u>Legend</u>: From left to right columns say (0-5 years old, 6-10 years old, above 10 years old)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

Higher salaries in private hospitals are attractive to doctors of higher qualification and experience as in figure above.

Nurses and Midwives Department:

From the following figure we can see that salaries of nurses is /9.000 SYP/ in public hospitals regardless to scientific qualification, and in private hospitals it is /5.000 SYP/, we noticed that there are no midwives employed in private hospitals.

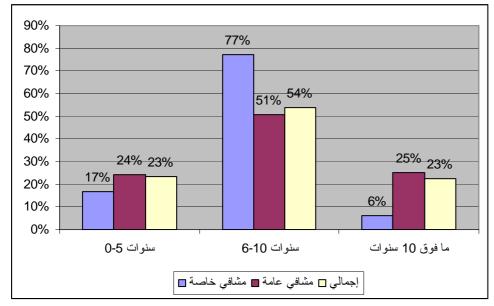
Figure 14: Nurses Salaries:

No valid link!

Source: AMC Statistics& Questionnaires

From figure below, we see that 71%, 51% of nurses in private & public hospitals in sequence having experience ranging 6-10 years. We noticed that rates of nurses possessing experience of 10 years in public hospitals is 25% while same rate in private hospitals what explains higher rates in public hospitals.

Figure 15: Years of Experience for Nurses:



Source: AMC Statistics& Questionnaires

<u>Legend</u>: From left to right columns say (0-5 years old, 6-10 years old, above 10 years old)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

Technical Department:

From figure below, we notice that salaries of employees in technical department in public hospitals range from /7-11 SYP/. It is /5.000 SYP/ in private hospitals. We notice absence of technicians who are university degree and industrial Education Certificate holders in private hospitals which is why salaries are lower.

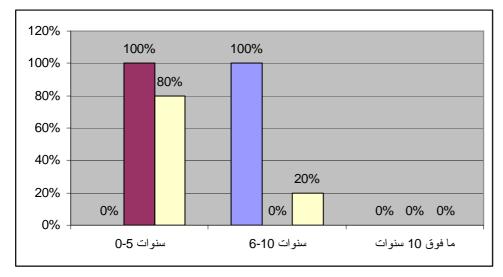
Graph No.16: Salaries of Technical Department Staff:

No valid link!

Source: AMC Statistics& Questionnaires

We notice from figure below that technical department staff in public hospitals possessing less than 5 years experience while in private hospitals we see technicians possessing 6-10 years experience. No employees of more than 10 years experience.

Graph No.17: Experience per year for Technical Staff:



Source: AMC Statistics& Questionnaires

<u>Legend</u>: From left to right columns say (0-5 years old, 6-10 years old, above 10 years

old)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

Service Department Staff:

We can see from figure below that average salaries for service department staff is /8.000 SYP/ in public hospitals and /4.000 SYP/ in private hospitals without recruiting preparatory certificate holders into these departments.

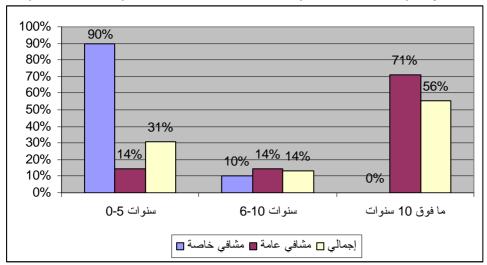
Graph No.18: Salaries of Technical Department Staff:

No valid Link

Source: AMC Statistics& Questionnaire

The figure below shows that 90% of employees in technical departments in private hospitals holding experience not exceeding 5 years. 71% of them possess experience of more than 10 years in public hospitals which explains high salaries in them.

Graph No.19: Experience of Technical Department Staff per years:



Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (0-5 years old, 6-10 years old, above 10 years old)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

Support Departments:

We see from figure below that salaries of support departments staff such as technical assistants in X-ray or Laboratory ranging from /7.000-11.000 SYP/ in public hospitals and /5.000-8.000 SYP/ in private hospitals.

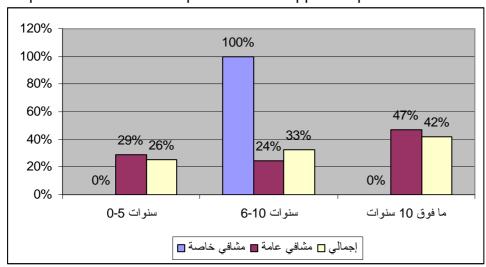
Graph No.20: Salaries of Support Department Staff:

Not valid Link!

Source: AMC Statistics& Questionnaire

From figure below, we see that support departments staff in private hospitals possess experience ranging from 6-10 years. 47% f them having experience of more than 10 years.

Graph No.21: Years of Experience for Support Departments Staff:



Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (0-5 years old, 6-10 years old, above 10 years old)

Blue refer to Private hospitals	Purple refer to Public hospitals	White refer to Total

In general, experience of staff in public hospitals is larger than private ones.

4-Cost and Fees:

As mentioned earlier, this study covered public & private sector hospitals. Table below shows average cost in some departments in private hospitals. Because public hospitals did not indicate any cost of treatment so we can not make ay comparison

Table 12: Average Cost in some departments in private hospitals:

Department	Cost
Obstetric Surgery	5.285 SYP
X-ray imaging and analysis	475 SYP
Internal Surgery	33.00 SYP

Source: AMC Statistics& Questionnaire

<u>5-2 Study of Patient Satisfaction about Hospital Performance in Raqqa Governorate:</u>

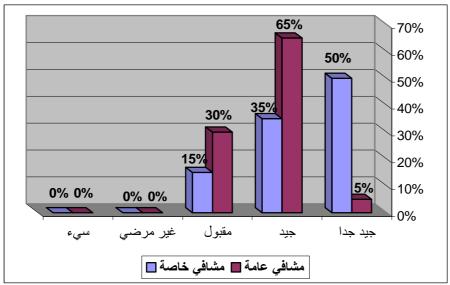
We polled opinions of 40 patients who visited the following hospitals in Raqqa: Modern Medicine Hospital, National Hospital, and Obstetric Hospital I order to assess their performance with regard to reception staff, levels of basic services.

<u>1- Patient Satisfaction about Reception Department in Surveyed Raqqa Governorate Hospitals:</u>

Procedures in Reception Department:

Figure below indicates that 65% of patients in public hospitals consider procedures and regulations in reception to be "Good", only 5% of them consider it to be "Very Good" while this same rate is higher in private hospitals up to 50% and 35% consider it to be "Good". We conclude that procedures in reception are good in general.

Graph No.22: Procedures in Reception Department:



Source: AMC Statistics& Questionnaire

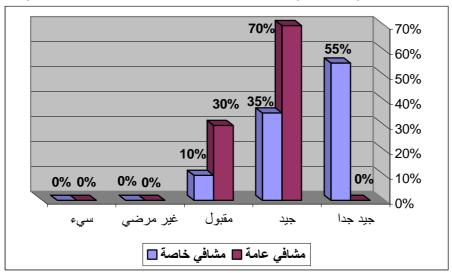
<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

r to Public hospitals

Professional Level of Reception Department:

Figure below indicates that 70% of patients in public hospital consider that professionalism of Reception Staff to be "Very Good" while in private hospitals people find it "Very Good" is 55% and 35% find it "Good". In general, we see professionalism of reception staff is good.

Graph No. 23: Professional Level of Reception Department:



Source: AMC Statistics& Questionnaire

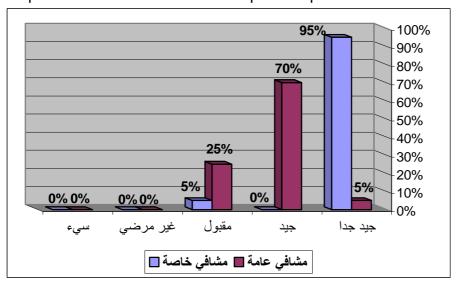
<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

Blue refer to Private hospitals Purple refer to Public hospitals

Cleanliness of Reception Department

Figure below shows that 70% of patients consider cleanliness of reception departments to be "Good", 5% considered it to be "Very Good" whereas it is 95% in private hospitals. We conclude that cleanliness in reception is very good in general.

Graph No. 24: Cleanliness of Reception Department:



Source: AMC Statistics& Questionnaire

Blue refer to Private hospitals	Purple refer to Public hospitals	
' 	<u> </u>	

Recommendation and Guidance from Reception Staff:

50% of public hospitals patients consider guidance of reception staff to be "Good" and 35% of them consider it to be acceptable, 15% consider it to be "Unsatisfactory" while in private hospitals, 90% patients considered guidance to be "Very Good", 10% considered it to be "Good".

Levels of guidance vary from public to private hospitals while level is considered to be "Very Good" in private hospitals, guidance in public hospitals to be considered "Acceptable".

90% 100% 80% 50% 60% 35% 40% 10% 20% 0% 0% 0% 0% 0% مقبول جيد جدا جيد

مشافى عامة 🔳 مشافى خاصة 🔲

Graph No.25: Guidance offered by Reception Staff:

Source: AMC Statistics& Questionnaire

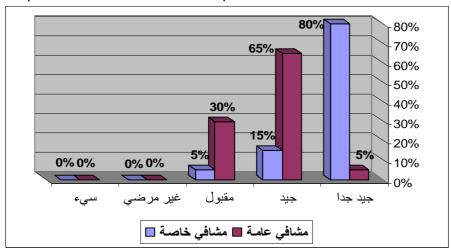
<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

	Blue refer to Private hospitals	Purple refer to Public hospitals	
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Location of Reception Department:

65% of patients in public hospitals consider the place of reception t be "Good", while 5% consider it to be "Very Good". This rate increases in private hospitals to be 80% considering it "Very God" and 15% consider it "Good". In general, we conclude that place of reception is good.

Graph No.26: Location of Reception:



Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

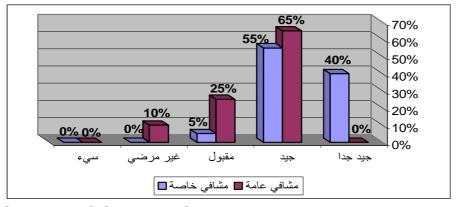
Blue refer to Private hospitals Purple refer to Public hospitals
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<u>2- Patient Satisfaction about Basic Services (Therapeutical) in surveyed Raqqa Hospitals :</u>

Procedures in Therapy Departments:

We notice from figure below that 65% of patients in public hospitals consider procedures in therapeutical departments to be "Good" but none considered it to be "Very Good". In private hospitals, 40% of patients considered it to be "Very Good" and 55% considered it to be "Good", so we consider it to be good in general.

Graph No.27: Procedures in Therapy Departments:



Source: AMC Statistics& Questionnaire

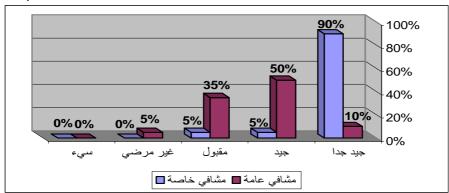
<u>Purple</u> refer to Public hospitals	
	<u>Purple</u> refer to Public hospitals

Doctors Treatment with Patients:

50% of patients in public hospitals consider doctors behavior (treatment) with the to be "Good", 10% consider it to be "Very Good". These rates are higher in private hospitals 90% consider it to be "Good" and 5% consider it to be "Very Good".

We conclude from figure below that doctors treatment with patients in private hospitals in general is better than in public hospitals.

Graph No.28: Doctors treatment with Patients:

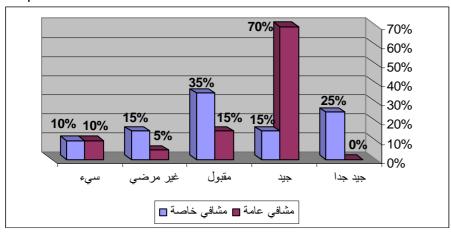


Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

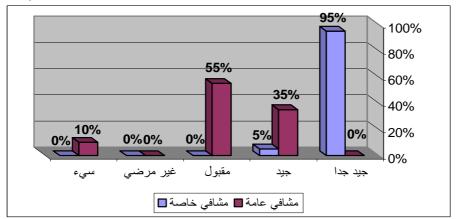
Blue refer to Private hospitals Purple refer to Public hospitals

Nurses Behaviour (Treatment) with Patients: Graph No.29.



Source: AMC Statistics& Questionnaire Cleanliness in Therapy Department:

Graph No.30.

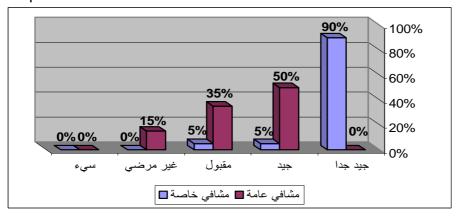


Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

Blue refer to Private hospitals	Purple refer to Public hospitals	

<u>Performance level at Therapy Department:</u> Graph No.31

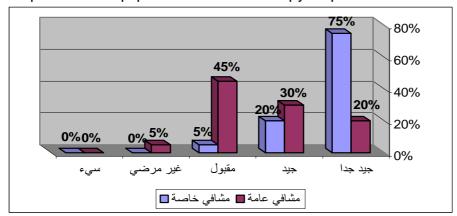


Source: AMC Statistics& Questionnaire

Blue refer to Private hospitals	Purple refer to Public hospitals	
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Equipment Level at Therapy Department:

Graph No.32: Equipment Level at Therapy Department:



Source: AMC Statistics& Questionnaire

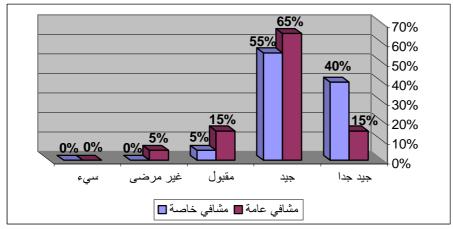
<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

Blue refer to Private hospitals Purple refer to Public hospitals

<u>Patient Satisfaction about levels of other Services in Surveyed Raqqa Governorate Hospitals:</u>

X-ray and Radiography:

Graph No.33:Services in Radiography

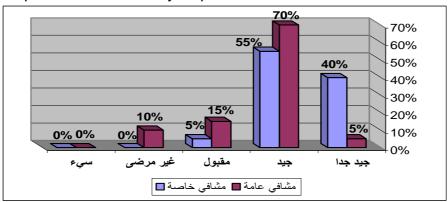


Source: AMC Statistics& Questionnaire

Blue refer to Private hospitals	Purple refer to Public hospitals	

Laboratory Department:

Graph No.34: Laboratory Department Services:



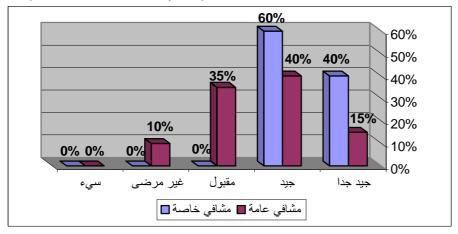
Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

Blue refer to Private hospitals Purple refer to Public hospitals

Pharmacy Department:

Graph No.35: Pharmacy Department Services:

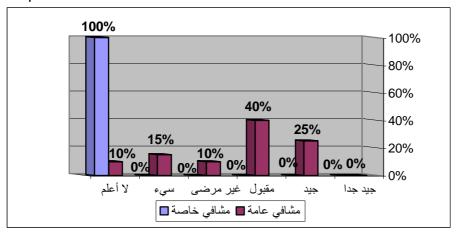


Source: AMC Statistics& Questionnaire

Blue refer to Private hospitals	Purple refer to Public hospitals	

Catering Level:

Graph No.36:



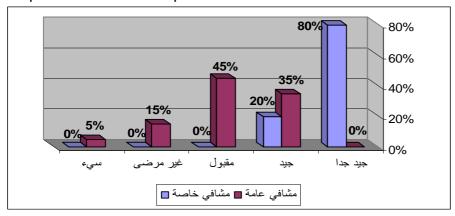
Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

Blue refer to Private hospitals	Purple refer to Public hospitals	
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Inpatient Rooms Level:

Graph No.37:Level of Inpatient Rooms:

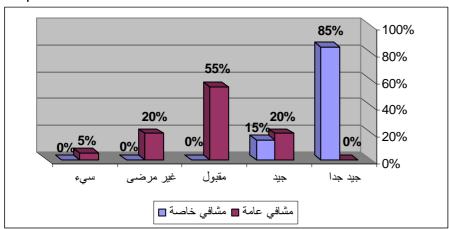


Source: AMC Statistics& Questionnaire

Blue refer to Private hospitals	Purple refer to Public hospitals	
Dide refer to 1 fivate flospitals	Tarpic refer to rabile nospitals	

Room Services Levels:

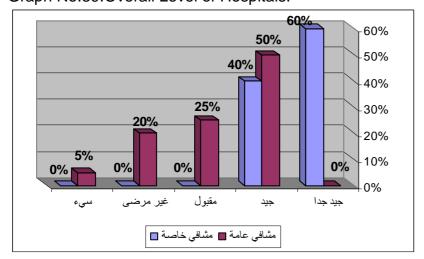
Graph No.38: Level of Room Service:



Source: AMC Statistics& Questionnaire

<u>Legend</u>: From left to right columns say (Bad, Not Satisfactory, Acceptable, Good, Very Good)

<u>4- Patient Satisfaction about Overall level of Surveyed Hospitals in Raqqa:</u> Graph No.39:Overall Level of Hospitals:



Source: AMC Statistics& Questionnaire

Blue refer to Private hospitals	Purple refer to Public hospitals	
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6- Recommendations:

Based on the outcome above stated, we recommend the following:

- Establish extra healthcare centres fit for population size.
- Initiate a computerised system for public hospitals in addition to raising the level of equipment to match levels of private hospitals
- Convert public hospitals into independent cost centres to be able to give out charged/paid services to help them in promoting the level of their work in delivering services.
- Developing management staff cadre working in Public hospital in order to allow them to put forward strategic and development plans special for their hospitals apart from central planning in Health Directorates.
- Increase number of private hospitals and healthcare centres and other specialised centres with medium sized ones. Then, to organise and regulate its distribution inside the Governorate with view to encourage citizens to get medical treatment and cut down costs of transport.
- Rehabilitation and retraining of nurses with regulations and conditions for their work in private sector hospitals together with encouraging private training institutions to train nurses.
- New strict regulations, policies and protocols with view to maintaining the highest standards of cleaning and sanitation within a hospitals.
- Decrease the number of patients occupying a room Internology Departments in public hospitals to allow them to obtain care services they need.
- Initiate new departments not available at the governorate particularly in private hospitals such as 'cardiac catheter & surgery, blood banks, ICU care, artificial dialysis, head & neck care, nutrition, sterilisation, fridges, burns section, televised endoscope, CT scan, mammography and MIRNAN in private sector hospitals.
- Increasing salaries of nurses, technical, support staff in private hospitals to recruit staff of higher scientific qualification.
- Promote the level of procedures in reception departments, professionalism in reception, its location and cleanness in it, procedures in therapy department, behaviour of doctors, performance of therapy departments, services in X-ray, services in laboratory department, pharmacy services all considered to be 'good' in public hospitals so as to meet higher levels in private hospitals.
- Promote all recommendations offered by reception staff, cleanliness and equipment in therapy departments, inpatient rooms, room services, those which are considered to be 'acceptable' in public hospitals to reach "very good" levels in private hospitals.
- Promote levels of catering in public hospitals.
- Decrease fees of treatment in private hospitals. We strongly believe that implementation of HI scheme shall contribute to achieving this purpose.
- Private sector hospitals were not able to give us sufficient information so we suggest to make additional study in cooperation with different categories of doctors to get their contribution in the subject.

Sources:

- -Statistical Group, Central Statistics Office, Syrian Prime Ministry, 2005.
- -Primary Results, Houses &Population Count, Central Statistics Office, Syrian Prime Ministry, 2005
- www.made-in-syria.com/ragga.htm

- Study about HI Scheme in Raqqa, Raqqa Directorate of health, MoH, Syria.

Formats of Questionnaires about Ragga Governorate Status:

1- Basic Data:

Hospital:	Address:
Sector: (Public/ Private)	Owner:
Telephone:	Manager:
Address:	-

2-Infrastructure Status:

2-1 infrastructure, equipment of specialised services (final services):

Tick the available specialty in hospital:

Gynecology, obstetrics, in- cubators, pediatrics De- partments	Out-clinics	
Internology	Surgery	

2-1-1: Gynecology, Obstetrics, Incubators and Pediatrics:

	No. of Rooms	Maximum Capacity of Patients
Labour and Delivery Rooms		
Gynecology Operations		
Incubators Rooms		
Inpatient Stay		

	No. of Rooms	Maximum Capacity of patients
ICU		
Cardiac Care		
Artificial Dialysis		
Cardiac Catheter		

2-1-3: Clinics Department:

_	No of Clinics	Maximum Capacity of patients
Cardiac Clinic		
Gastric, Endocrinal, Joints, Hematology Clinics		
Neurological, thoracic Clinic		
Ophthalmology		
Surgery(General, orthology, urinal, neurology, Cardiac		
Gynecologic, Obstetrics Clinics		
Pediatric Clinic		
Eyes Clinic		
Dermatology Clinic		
Emergency Clinic		
Otolaryngologic Clinic		
Dental Clinic		

2-1-4: Surgery Department:

	No of Clinics	Maximum Capacity of patients
General Surgery Rooms		
Cardiac Surgery Rooms		

2-2: Support Services:

Tick type of services available in your hospital:

Blood Bank	Sterilisation Department
Laboratory	Pharmacy Department
ICU	Fridges
Emergency	Inpatient Stay Department
Nutrition Department	X-Ray Department

2-2-1: X-Ray Department

x ray Doparanoni		
	Toll /Equipment	Maximum Capacity of patients
Simple X-ray imaging		
Televised X-ray		
CT Scan Unit		
Ultrasonic Echography		
Mammography Unit		
MIRNAN Unit		

2-2-2 Other Departments:

	No of Units	Maximum Capacity of patients
Blood Bank		
Laboratory		
ICU		
Emergency		
Nutrition Department		
Sterilisation Department		
Pharmacy Department		
Fridges		
Inpatient Stay Department		

3-2 Administrative Services:

Tick the specialty available in the hospital:

Management	Catering/ Kitchen
Transport	Cafeteria
Finance & Accounting	Security
Building Maintenance	Reception/Record of Visitors
Equipment Maintenance	Cleaning Department
Laundry Department	

	No of Units	
Management		
Transport		
Finance & Accounting		

Building Maintenance	
Equipment Maintenance	
Laundry Department	
Catering/ Kitchen	
Cafeteria	
Security	
Reception/Record of Visitors	
Cleaning Department	

2-4 List of Available Equipment in each Department:

3. Types of Accessible Services and numbers of Patients:

3-1 Obstetrics:

	Check Fees	Way of Payment	Estimated Cost
Normal Delivery			
Premature Delivery			
Miscarriage			
Caesarian			
Gynecologic Services			
Miscellaneous Gynecologic Services(therapy &surgery)			

3-2 Radiography:

	Check Fees	Way of Payment	Estimated Cost
Simple & Opaque X-ray			
CT Scans			
Echography			
Televised endoscope			
Mammography			
Simple X-ray imaging via Kinetic equipment			
MIRNAN Scanning			

3-3 Internology Department:

	Check Fees	Way of Payment	Estimated Cost
Diagnosis & Treatment of			
Internologic Disease			
Diagnosis & Treatment of			
Gastric Diseases			
Diagnosis & Treatment of			
Neurological Diseases			
Diagnosis & Treatment of			
Thoracic Diseases			
Diagnosis & Treatment of			
Endocrinal Diseases			
Diagnosis & Treatment of			
Hematological Diseases			
ICU			
Artificial Dialysis			

3-4: Surgery:

	Out-patient (visitors)	In-patients (admitted)
Minor, General & Plastic		
Surgery		
Neuro Surgery		
Cardio Surgery		
Bone Surgery		
Urinal Surgery		
Endoscope Surgery		

4. Level of HR and Manpower:

4-1: Statistics:

otatistics.	
	No
Management (Admin. Department)	
Doctor	
Nurse	
Midwife	
Technician- Engineer- Maintenance	
Service-Cleaning-security-supply- Drivers-Servicemen-building upgrade	
Support Departments Staff, X-ray, Laboratory, Pharmacy, Technical Assistant.	

4-2 Qualification and Experience:

Administrative Department:

Scientific Level:

Average Scientific Level	Number	Average Salary

Experience:

Overall Years of Experience	Number
0-5 years	
6-10 years	
Above 10 years	

Doctors Department:

Average Scientific Level	Number	Average Salary

Nurses& Midwives:

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Average Scientific Level	Number	Average Salary

Experience:

Overall Years of Experience	Number
0-5 years	
6-10 years	
Above 10 years	

Technical Department:

Scientific Level:

Average Scientific Level	Number	Average Salary
	_	

Experience:

Overall Years of Experience	Number
0-5 years	
6-10 years	
Above 10 years	
·	

Service Department:

Scientific Level:

Average Scientific Level	Number	Average Salary	

Experience:

Overall Years of Experience	Number
0-5 years	
6-10 years	
Above 10 years	

Support Department:

Scientific Level:

Average Scientific Level	Number	Average Salary

Experience:

Overall Years of Experience	Number
0-5 years	
6-10 years	
Above 10 years	

5- Cost & Expenses

5-1 Obstetrics:

	Check Fees	Way of Payment	Estimated Cost
Normal Delivery			
Premature Delivery			
Miscarriage			
Caesarian			
Gynecologic Services			
Miscellaneous Gynecologic Services(therapy &surgery)			

5-2 Radiology (X-ray):

	Check Fees	Way of Payment	
Simple & Opaque X-ray			
CT Scans			
Echography			
Televised endoscope			
Mammography			
Simple X-ray imaging via Kinetic equipment			
MIRNAN Scanning			

5-3 Internology:

	Check Fees	Way of Payment	Estimated Cost
Diagnosis & Treatment of In-			
ternologic Disease			
Diagnosis & Treatment of			
Gastric Diseases			
Diagnosis & Treatment of			
Neurological Diseases			
Diagnosis & Treatment of			
Thoracic Diseases			
Diagnosis & Treatment of			
Endocrinal Diseases			
Diagnosis & Treatment of			
Hematological Diseases			
ICU			
Artificial Dialysis			

5-4 Surgery:

	Check Fees	Way of Payment	Estimated Cost
Minor, General & Plastic			
Surgery			
Neuro Surgery			
Cardio Surgery			
Bone Surgery			
Urinal Surgery			
Endoscope Surgery			

5-5 Other Services:

	Check Fees	Way of Payment	Estimated Cost
Emergency			
In-patients			
Laboratory tests			
Medication/Drugs			

Questionnaire:

About Patient Satisfaction:

Staff Performance Level in Reception & Admission:

	Very Good	Good	Acceptable	Unsatisfactory	Bad
Regulations in Reception					
Professional Level in Reception					
Cleanness in Reception					
Guidance					
Place					

6-2 Level of Basic Services:

	Very Good	Good	Acceptable	Unsatisfactory	Bad
Regulations & Procedures					
Doctors' Treatment					
Nurses' Treatment					
Cleanness					
Performance Level					
Level of Equuipment					

6-3 Levels of Other Services:

What do you suggest to improve services:

	Very Good	Good	Acceptable	Unsatisfactory	Bad
How was service in radiography?					
How was service in laboratory?					
How was service in pharmacy?					
How was the level of food?					
How was level of in-patient rooms?					
How was level of service in inpatient rooms?					

	Very Good	Good	Acceptable	Unsatisfactory	Bad
What were most appealin	a things to you in t	his hospit	·al·		
	caling to you in he	enital·			
What were things not app	ealing to you in no	opital.			