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Healthcare financing in Syria: satisfaction with the current system and the role of national health insurance—a qualitative study of householders' views

Mania Mershed[1], Reinhard Busse[1,2] and Ewout van Ginneken[1,2]*
[1]*Berlin University of Technology, Department of Health Care Management, Berlin, Germany*
[2]*European Observatory on Health Systems and Policies, Brussels, Belgium*

ABSTRACT

This study aims to identify the satisfaction with the current public health system and health benefit schemes, examine willingness to participate in national health insurance and review expectations and preferences of national health insurance. To this end, qualitative semi structured interviews were carried out with 19 Syrian householders. Our results show that a need for health reform exists and that Syrian people are willing to support a national health insurance scheme if some key issues are properly addressed. Funding of the scheme is a major concern and should take into account the ability to pay and help the poor. In addition, waiting times should be shortened and sufficient coverage guaranteed. On the whole, the people would support a national health insurance with national pooling and purchasing under a public set up, but important concerns of such a system regarding corruption and inefficiency were voiced too. Installing a quasi non governmental organisation as manager of the insurance system under the stewardship of the Ministry of Health could provide a compromise acceptable to the people. Copyright © 2012 John Wiley & Sons, Ltd.

KEY WORDS: health financing; health insurance; qualitative interviews; health care; public health sector

INTRODUCTION

As outlined in the Syrian Constitution items 46 and 47, providing access to health and social services for all residents is the responsibility of the Syrian government. In principle, nearly all health services that are provided as part of the public system used to be free of charge and were generally provided by health centres and public hospitals. Since 1998, some public hospitals have been charging small payments for health services (Bensa *et al*., 2003). The general government's budget represents the main public source of health financing. The Ministry of Health as well as other ministries

*Correspondence to: Ewout van Ginneken, Berlin University of Technology, Department of Health Care Management, Straße des 17, Juni 135, 10623 Berlin, Germany. E mail: ewout.vanginneken@tu berlin.de

such as the Ministry of Higher Education, the Ministry of Local Administration and the Ministry of Defence organise health services. Although population access to health is the responsibility of the Syrian government, out-of-pocket payments, nevertheless, represent the dominant source of health financing, constituting about 61% of the total expenditure on health in 2008, slightly up from 59.6% in 2000 (WHO, 2010a). The majority of these payments are direct payments to private health providers, whereas the remainder are user fees imposed by several Ministry of Higher Education hospitals and Ministry of Health autonomous hospitals (WHO, 2003).

Compared with countries in the region, many of Syria's health indicators are above average. Life expectancy at birth in Syria rose from 67 years in 1990 to 74 years in 2009, which is one of the highest in the region (see Table 1). Important child health indicators, which are particularly relevant in understanding public health in a certain country, have improved compared to 1990 and are among the best in the region (see Table 1). The relatively good public health indicators are also reflected in age-standardised mortality rates in Syria. Non-communicable diseases are the main cause of death and account for 61% of the years of life lost by broader causes, compared with 23% by communicable diseases and 16% by injuries. In a country with an absent or underdeveloped public health system, communicable diseases typically account for the highest share of years of life lost (WHO, 2010a).

As of 2011, no national health insurance system exists in Syria. However, some small-scale health insurance schemes cover individuals working in public companies, some ministries and professional associations. Because these schemes mostly offer a limited benefit package, they are unable to protect their beneficiaries against catastrophic risks (Schwefel *et al.*, 2008). Since 2004, several private insurance companies have offered individual and group health plans in Syria. Yet, the number of covered individuals is still modest. A new decree (Legislative Decree No. 65 of 2009) should change this situation and forces the public administrative sector to

Table 1. Population health indicators in Syria and other selected countries in the region (2009)

	Life expectancy at birth (years)	Under 5 years mortality rate (probability of dying by age 5 years per 1000 live births)	Measles coverage among 1 year old (%)	Maternal mortality (per 100 000 live births)	Antenatal care coverage (%): at least one visit
Algeria	72	32	88	120	89
Egypt	71	21	95	82	74
Iran	73	31	99	30	99
Iraq	66	44	69	75	84
Jordan	71	25	95	59	99
Lebanon	74	12	53	26	96
Morocco	73	38	98	110	68
Saudi Arabia	72	21	98	24	97
Syria	**74**	**16**	**81**	**46**	**96**
Tunisia	75	21	98	60	96
Turkey	75	20	97	23	92

Source: WHO, 2010a. In boldface: subject of the article.

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contract the General Syrian Insurance Company to gradually cover all public employees for health insurance (Syrian Insurance Supervisory Commission, 2010).

The Syrian health system is facing many challenges. First, the limited raised resources in the health system are insufficient to meet a growing demand for increasingly costly health services. Total expenditure on health as a percentage of gross domestic product as well as expenditure on health per capita is among the lowest in the Middle East (see Table 2). Second, health services provided by the public system are of insufficient quality and quantity (State Planning Organization, 2006). Third, the public system lacks efficiency and accountability. Fourth, health system financing is fragmented because of the absence of one risk pool. Fifth, general government expenditure on health as a percentage of total health expenditure is among the lowest in the Middle East area, which has resulted in very high out-of-pocket spending (Table 2).

Implementing a health insurance system has long been seen as a solution to some of these problems and has been the subject of discussions among involved actors (government officials, administrators, professional associations). Solely relying on an expansion of tax financing was ruled out as a way forward because of the limited tax base and large informal economy, as well as the high degree of tax evasion and the low capacity to raise taxes in general. Therefore, a sustainable solution is expected to include a mix of taxes and contributions. And although studies exist mapping the concerns and priorities of policy makers, researchers and representatives (cf. El-Jardali *et al*., 2010), little is known about the people's satisfaction with the current system, public support for insurance reforms, the awareness about the concept of health insurance and the preferences of the people in terms of its design.

Table 2. Health expenditure in Syria and other selected countries in the region (2009)

	Total expenditure on health as % of gross domestic product	Per capita total expenditure on health (purchasing power parity international $)	General government expenditure on health as % of total expenditure on health	Private expenditure on health as % of total expenditure on health	Out of pocket expenditure as % of private expenditure on health
Algeria	5.4	437	86.1	13.9	94.7
Egypt	4.8	261	42.2	57.8	97.7
Iran	5.5	613	42.4	57.6	96.6
Iraq	3.3	107	70.2	29.8	100.0
Jordan	9.4	496	62.7	37.3	82.5
Lebanon	8.5	1009	48.3	51.7	78.7
Morocco	5.3	231	36.3	63.7	86.3
Saudi Arabia	3.6	831	68.2	31.8	53.4
Syria	**3.1**	**123**	**38.8**	**61.2**	**100.0**
Tunisia	6.4	500	54.1	45.9	87.1
Turkey	6.1	845	73.1	26.9	64.7

Source: WHO, 2010a. In boldface: subject of the article.

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When designing a health financing or insurance system, some key issues need to be addressed. First, decisions need to be made on public coverage. Coverage has three dimensions: (i) the proportion of the population covered; (ii) the range of benefits covered; and (iii) the proportion of the benefit cost covered (Rechel *et al*., 2010). Second, decisions have to be made on how to design the three financing functions, that is, revenue collection, pooling and purchasing (WHO, 2010b; Busse *et al*., 2007; Rechel *et al*., 2010). *Revenue collection* relates to the way money is raised to fund the health system. The funds are typically collected from households, organisations or companies and sometimes from contributors outside the country. Resources can be collected through general or specific taxation, compulsory or voluntary health insurance contributions, out-of-pocket payments (cost-sharing and direct payments) and donations. *Pooling* is the accumulation and management of prepaid financial resources, for example, through tax or contributions, to spread the financial risk associated with the need to use health services. Most countries complement pooling funded by pre-payment with out-of-pocket payments from patients directly to providers. *Purchasing* is the process of paying for health services. In practice, most countries use a combination of the following: (i) government budgets its own health service providers (integration of purchasing and provision) using general tax revenue and sometimes insurance contributions; (ii) a separate purchasing agency (e.g. a health insurance fund or government authority) purchases services on behalf of a population (a purchaser provider split); and (iii) individuals pay a provider directly for services.

This study aims to shed light on the preference of the people on these issues and thus the feasibility of introducing a national health insurance system in Syria.

METHODS

Qualitative interviews were carried out to collect information on the views of the people. The use of questionnaires to be filled out by selected respondents was discarded because 16% of Syrians aged 15 years and above is illiterate (2009) (World Bank, 2010). Moreover, many Syrians were assumed not to be familiar with some of the presented concepts, which necessitate explanation in person. The idea to use focus groups was rejected on the basis of the personal information that was asked (e.g. income level) and the bias that could result from the opportunity of group members to influence each other. Finally, a semi-structured interview guideline was developed on the basis of information from a literature review on health financing and the Syrian health system. The goals of the interviews were to (i) identify the satisfaction with the current public health system and health benefit schemes, (ii) examine willingness to participate in national health insurance, including ability and willingness to pay and (iii) review expectations of and preferences for national health insurance, specifically on stewardship of the system, scope of coverage and the health financing functions (collecting, pooling and purchasing).

The lack of reliable population data precludes a fully representative sample. However, to achieve a sample as representative as possible, the interviewees were selected according to different social-economic class and professional status. Table 3 summarises the participants' main characteristics. We selected 19 individuals and

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Table 3. The participants' main characteristics

	n	%
Gender		
Male	16	84
Female	3	16
Age (years)		
30 39	7	37
40 49	5	26
50 59	4	21
>60	3	16
Area		
Rural	12	63
Urban	7	37
Education		
Graduate	7	37
Secondary school	1	5
Primary school	6	32
Elementary school	3	16
Illiterate	2	11
Employment		
Government employee	8	42
Formal private employee	2	11
Self employed	6	32
Unemployed	1	5
Retired	1	5
Casual worker	1	5
Income (average monthly income per family member in Syrian Pound [S.P.])		
Lower income (−3000 S.P.)	6	32
Middle income (3000 7000 S.P.)	9	47
Higher income (+7000 S.P.)	4	21
Participation in health insurance		
Insured by health benefit schemes	7	37
Insured by private health insurance as a benefit from their work	3	16
Uninsured	9	47

interviewed them face-to-face in the provinces of Damascus, Swaida and Draa in October 2008. They were all householders over 30 years of age responsible for taking care of their family. A total of 86% of the interviewees were men because of the fact that women form only 13% of the work force in Syria (Central Bureau of Statistics: Labour Force Survey in 2009). The majority of the interviews took place either in the participant's home or workplace. Most participants accepted the interview immediately, and there were no problems in persuading them to participate. Each interview started with an explanation about the concept of health insurance and typically lasted about 40 min. Questions were open-ended and, if necessary, followed by further explanations of the terminology. The participants were encouraged to speak openly about their opinions and to ask questions if anything was unclear.

Eventually, 16 interviews were tape recorded and later transcribed for analysis. Three interviewees refused to be recorded but notes were taken instead that were later rewritten for analysis. The 19 transcripts were then discussed in the research team and

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summarised in both Arabic and English according to the main topics of the interview guideline. In case of interpretation difficulties, the Arabic version was used as source. Next, by using a coding system, these results were assessed for convergent or divergent opinions and experiences. This information was used to create charts of the data to ease reading across the whole dataset (Lacey and Luff, 2001).

RESULTS

After general questions about social-economic situation, level of education and demographic status, the participants were asked about health insurance. More than one-third of the participants stated that they were not familiar with the concept of health insurance and did not know what the term 'health insurance' meant. All participants received a neutral briefing of the general concepts before the interviewer continued with the questions that led to the results presented in the succeeding text.

Satisfaction with the current system

Overall, nearly two-thirds of the participants said that they are satisfied with the public health sector, although their satisfaction varied from mildly to very satisfied, whereas the rest of the participants were unsatisfied with this sector. Many experienced problems in their ability to pay. About half of the participants said that their income is insufficient and that they had to postpone their treatment or borrow money to pay for needed healthcare. 'Sometimes we take herbs or use other alternative treatments, to save the cost of medicine', one participant said. Furthermore, two participants mentioned that although public health facilities are free of charge, there are indirect costs such as the cost of transport and disruption of work. Lastly, more than two-thirds of the participants felt that the public health system was unable to financially protect them against catastrophic risks.

More than two-thirds of the participants acknowledged the important role of the public health facilities such as hospitals and medical centres in providing free medical treatment especially to lower incomes. Four participants stated that the public hospitals have good equipment and qualified staff providing good quality health services. Four participants felt that the availability of paid departments[1] in public hospitals has improved the performance of public hospitals: 'The paid public hospitals are better than private ones, especially in the treatment of heart disease'.

The delivery of health services in the public health sector was criticised for a variety of reasons, including long waiting times (nearly half of the participants), the existence of favouritism and special privileges for certain people in the delivery of health services (one-third of the participants), bad and arrogant conduct of health workers (four participants), lacking efficiency and quality of the health services in the medical centres (five participants) as well as insufficient hygiene, treatment quality, operations and care for patients in public hospitals (more than half of the participants). Nearly one-third of

[1]A paid department is a special department in a public hospital where patients can choose to be treated directly and without waiting lists, in exchange for a charge.

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the participants said the medical staff of the public hospitals does not work properly. 'I lost my twin children as a result of the negligence of nurses. I had to beg them more than once to do their job properly', reported a participant. Six participants said that not all public hospitals are stocked with all necessary medicines and medical instruments required to treat some chronic diseases such as cancer and kidney diseases.

In terms of the organisation of the public providers, four participants said that the public health sector suffers from bureaucracy, corruption, administrative problems, lack of accountability and a disciplinary system. Five participants complained that the public hospital's doctors either work for private hospitals or have their own clinics at the same time. One said, 'The doctors try to persuade the patients of the public hospitals to come to their own private health centres so that they can charge them money'. Many participants compared the doctors in public hospitals with 'merchants'.

Approximately half of the number of the participants was covered by health insurance provided by either their work or their associations at the time of interviewing. However, no one in the sample was fully satisfied with their insurance because (i) some of these schemes do not cover all the members of their families, (ii) the provided services are not comprehensive, (iii) a lack of free choice of doctors, (iv) the existence of access problems in the urban areas because of the inequitable allocation of the doctors contracted by the health insurance schemes and (v) in some schemes, insurance is cancelled after retirement.

Willingness to participate in national health insurance

The majority of the participants were willing to participate in a national health insurance system. However, their willingness depended on several factors, including timely delivery of health services without long waiting times (five participants), a substantial reduction of financial risks (four participants), good quality of provided services (five participants), insurance coverage continuing after retirement (two participants), coverage of all family members (two participants) and a reasonable and affordable contribution level proportional to their income (two participants), possibly through subsidies for lower incomes (one participant). In addition, three participants found that the government should create national health insurance. 'If this company was private I would not participate and I would advise every person not to participate in this company', explained one participant, and another one said, 'I do not want the public health sector to be abandoned; we should maintain the public health sector as the dominant sector'.

Only two participants showed slight hesitation about their participation in the proposed national health insurance. One was an 85-year old who did not see the need to join a national health insurance system because of the existence of free public hospitals and an Islamic charity that helps poor people access medical care. In addition, he stated social habits and religious beliefs as a reason not to participate: 'When I get ill, I fast for one day, then I am recovered. I treat myself. I am relying on God'. Despite this, he also said, '. . . if other people joined this insurance, I would participate as well'. The second participant stated that on the basis of experience with national health insurance in some neighbouring countries such as Lebanon and Jordan, the system

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was not very likely to be successful in Syria. However, he added, 'if this project were to succeed in Syria, it would be excellent'.

Nearly one-third of the participants said that their income was too low to spend any money on health insurance, although they were willing to participate in national health insurance. For example, one participant said, 'I would like to sell whatever I own in order to spend about 1000 or 2000 Syrian Pound (20 40 USD)[2] to join'. Another participant said, 'If the insurance contribution was a small percentage of income, it would not financially affect the insured people much, but it would be beneficial for all employees'.

Expectations and preferences of national health insurance

Stewardship of the system. Opinions were basically split in half over the preferred steward of the system. A total of 10 of the 19 participants thought that the private sector would be better able to manage national health insurance than the public sector. Five participants said the private sector would be better able to combat corruption: 'The private sector is interested in maintaining a good reputation and has stronger accountability, which avoids corruption'. Four participants said that because the private sector is profit driven, it is more efficient. One said, 'The private sector is interested in profit, while the public sector is free and careless in its work'.

The rest of the participants thought the public sector should govern the national health insurance system because it is more trustworthy than the private sector and has better supervision and accountability. Moreover, two participants believed the public sector would be more compassionate: 'The public sector tends to show more care towards the citizens than the private sector, and as a result, it would impose lower contributions in comparison to private companies, which are only interested in profits'.

Dimensions of coverage. Almost all the participants expected to receive all the needed medical services regardless of the contribution paid or the type of insurance plan. One participant justified this expectation as follows: 'I might pay for health insurance over many months without receiving any services from them, therefore I would have the right to receive all the services that I might need one day'. Almost one-third of the participants regarded hospital surgeries as the most important service to be covered by national health insurance. One said, 'I would prefer that the insurance covers everything, but some services are more important than others, such as surgery, because of its high cost and often many people have to borrow to have an operation'. Two participants believed that national health insurance should cover the cost of check-ups and medicine because a person is more likely to be ill than in need of an operation.

More than half of the participants said that national health insurance membership should be voluntary. Two participants said Syrians simply do not comply with mandatory decisions: 'In our community, if we mention the word "mandatory", people choose to alienate themselves'. Three participants said that citizens should have the choice to make their own decision that is suitable to their personal situation. Two

[2]According to 2008 exchange rates.

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participants said that mandatory membership would increase the financial burden on the family. One participant thought, 'If the membership was mandatory this would mean many people would use health insurance facilities and these health facilities would be overcrowded'.

The rest of the participants believed that only mandatory membership would help achieve universal coverage (four participants), mobilise enough funding (two participants) and reduce financial risk (one participant). One participant preferred an incremental approach: 'In the beginning, membership should be optional, but later, when national health insurance expands, improves its activities, and includes a proportionally high number of participants; then, the membership should become mandatory. Only if national health insurance was mandatory would it achieve universal coverage of all citizens, which is the ultimate aim of this system'.

Paying and collecting national health insurance contributions. About two-thirds of the participants said that they would prefer to pay for national health insurance through monthly flat-rate contributions more than half of them do not receive a stable income. One participant said, 'Taking into account my job circumstances, I would prefer paying a monthly lump sum. I drive a bus, sometimes I earn money and other times I lose money'. Another participant said this would be fairer than a wage-based contribution: 'It is unreasonable to pay a proportion of income, because people with higher income would pay higher fees for health insurance in comparison to those who have a lower income for receiving the same service'. Moreover, many participants have in an addition to their salaries other forms of income, for example from selling their agricultural crops. They preferred to have this part of income exempted from paying contributions for financial as well as practical reasons.

On the other hand, about one-third of the participants would prefer to pay a percentage of their salary for national health insurance. One participant who is working in the public sector and thus receiving a stable salary said that paying a percentage of salary for health insurance is fairer for employees with low incomes because of the difference between the salaries in the public sector.

The majority of the participants were willing to pay more for national health insurance compared with poor people. One participant thought the principle of solidarity already exists among the Syrian people in the form of several charities. Another believed, 'The poor members of the community must receive a portion of the rich people's funds, on the basis of the Islamic practice of Zakat rite'. About half of the participants linked their readiness to help poor people to their financial situation. Only one participant, an employee in a private company, stated that she would be ready to support elderly people and disabled children. However, she would not support those who are able to work, even if they were poor.

To support poor people to pay their contributions and access the national health insurance system, a majority of the participants thought that the poor people should pay a smaller or perhaps no national health insurance contribution. Eight participants thought that the support of poor people is the responsibility of both the government and privileged people. However, five interviewees said that supporting poor people to access the national health insurance is the government's responsibility. One said, 'We cannot force rich people to help the poor people; this is the government's duty'.

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Participants were aware of the lack of good information and how crucial such information is to support the poor effectively. Four participants proposed to carry out a study to estimate the proportion and income of poor people in the country before imposing the contributions.

More than two-thirds of the participants preferred the public sector to collect the national health insurance contributions. Nine participants said the public sector is more trustworthy and secure than the private sector. For example, one participant said, 'I do not trust the private sector because no law exists that obliges it to pay or provide its services, also, the private sector might escape and abandon its responsibilities'.

Pooling national health insurance contributions. The majority of the participants preferred risk pooling to be on the national level. For example, some expected collected revenue to be higher and that the insured people would get more benefits (three participants), whereas others believed that national level risk pooling would be better able to cover everyone regardless of their personal situation (nine participants). Three participants thought that national pooling would make travelling or moving within the country safer. One said, 'If I travelled to Aleppo and I had an accident there, would they bring me back to my county to receive the treatment? The insurance must be universal for all the country'. One participant believed that national risk pooling would be less prone to tribal influence: 'The majority of the projects that are at the village level encounter tribal interference. They are subject to arguments and they would soon fail'.

In contrast, two participants preferred risk pooling to be at the level of the workplace: 'I consider my work team as my own family, while at the national level the health insurance would be extended and uncontrollably large'. One participant preferred risk pooling at the level of the province: 'If the national health insurance system would become larger it would be more complicated and we would return to disorder, corruption, and fraud'.

Purchasing and providing health services. More than half of the participants said that the public sector is more qualified to purchase health services than the private sector. Six participants mentioned that the public sector has good supervision policies and is reliable. One participant said, 'The Syrian government has never imported or manufactured medicines that harm citizens'.

Nearly one-third of the participants expected the private sector to be more qualified to purchase the health services. Three participants said the private sector is keen on providing a better quality of service in terms of equipment and staff: 'The private sector is interested in quality rather than quantity. It would purchase the appropriate equipment for the right place'. Two participants said the private sector is more efficient in controlling costs and preventing corruption, and it is well supervised: 'The private sector is more efficient in preventing stealing and fraud'. One interviewee recommended professional organisations, such as the teachers union and the labourer union to purchase health services on behalf of their members. He believed that these organisations would know best about the needs of their members and how to advocate their rights.

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About half of the participants preferred public hospitals to provide health services under national health insurance. For instance, three participants said that they trust the public hospitals more and feel more secure. Six participants preferred private hospitals to deliver national health insurance services. Three participants were indifferent about a public or private hospital. One participant said, 'The public and private hospitals are the same for me. I would prefer to receive healthcare from the one who respects me as a patient. I care about personal treatment'. Two replied that the choice of doctor would decide whether they would visit a public or private hospital.

DISCUSSION

Our results show that the Syrian population is on the whole satisfied with their public health system and acknowledged its importance. Yet, many are unsatisfied about the out-of-pocket costs of health services, which is also evidenced by WHO data, as well as the inability of the system to protect them against catastrophic risks. As a result, they are forced to forgo treatment, borrow money and look for alternative treatments. The delivery of services in public providers is mostly criticised for the long waiting times, their low quality and insufficient supply of medicines and medical equipment. None of those in the sample covered under health benefit schemes was completely satisfied with the conditions of their policy (e.g. in terms of coverage, access, choice). This indicates that there is indeed a great need to reform the health system, particularly its financing.

The majority of participants in this study were willing to join national health insurance primarily if that would mean shorter or no waiting times, coverage of all needed services and less financial risk, but they expressed their concerns regarding the extra financial burden. Although throughout the interviews a deep distrust of the private sector is visible, a slight majority of 10 of the 19 participants would prefer a national health insurance under the stewardship of private companies. They feel that the private sector is more efficient and accountable, which would help in avoiding corruption in the system. This choice for a private set-up is somewhat of an outlier in the interviews as for other issues (collecting, purchasing) a public set-up was favoured. The choice was probably driven by another recurring theme in the interviews, namely the fear of corruption in the public system. It should be noted, however, that almost as many people used similar arguments for favouring a system under public stewardship.

Maybe these results can be interpreted as supporting a compromise, for example through making a quasi non-governmental organisation or another form of independent body, responsible for collecting, pooling and purchasing, whereas the Ministry of Health remains the steward of the system. The public could be more likely to accept such a model and perceive it as outside of the government, independent of politics, political opportunism, corruption and bureaucracy. In many former communist states of Eastern and Central Europe, which struggle(d) with similar levels of government distrust and corruption, such a set-up with an independent national health fund under the stewardship of the Ministry of Health is very common (e.g. Estonia, Latvia. Poland, Lithuania, Hungary, Bulgaria). This is by no means a perfect solution or a guarantee for stability as the balance between government control and the health insurance fund's

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autonomy can become blurred over time (cf. Gaal *et al*., 2011). The participants do not support mandatory membership, which seems to be driven especially by the fear of the extra financial burden although some are aware that this is a precondition for universal coverage.

The participants would prefer flat-rate contributions but also showed a strong sense of solidarity and generally supported the idea of lower contributions for lower income groups. Flat-rate instead of wage-based contributions makes much sense in a country where an estimated 30% 40% of the economy is informal and many people have unstable incomes (ILO, 2010). It would be close to impossible to assess income for the collecting organisation. Introducing differentiated flat-rate contributions for certain groups would still require an assessment of eligibility, but this may prove more technically feasible.

The concept of pooling caused some confusion among the participants and was often mistaken for geographical coverage. Nevertheless, the majority supported national pooling of funds expecting more revenue, more benefits and better coverage. A preference that can be supported by scientific evidence as central pool could indeed increase efficiency in the system (WHO, 2010b), which in turn could lead to more benefits and less geographical inequities.

As a purchaser of care, the participants favoured a public body. As providers, the people had a slight preference for the public hospitals. It should be kept in mind, however, that many of the participants never entered a private hospital because they cannot afford it. So, these results may not be entirely accurate. What is clear though is that Syrians want to receive the best services from the best doctors, regardless if they are public or private, and it is therefore likely that no strong preference exists.

Study limitations

The sample in this study was relatively small and only covers three provinces. A limited sample, however, is common among qualitative studies. Therefore, we believe that this study on the whole draws an accurate picture of the views and experiences of the Syrian population. Some of the finding may be biassed in favour of the middle-income people because in our sample, they have the highest share, but the variety of opinions in Syria is adequately covered. When better population information becomes available in the future, representativeness of samples can be improved.

CONCLUSION

This analysis shows that there is a need for health reform and that Syrian people are willing to support a national health insurance scheme. Yet, some key issues have become visible that should be of interest to policy and decision makers in Syria. First of all, because the cost of care is a huge concern in general, introducing national health insurance would have to take into account the vast differences in ability to pay. The Syrian people show a strong sense of solidarity and favour in supporting the poor to have access to the system. Flat-rate contributions that vary according to certain groups could be a possible solution. Apart from this, people are clear that their support depends

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on important factors such as short waiting times and sufficient coverage. Second, on the whole, the people would support a national health insurance with national pooling and a public set-up, but important concerns of such a system regarding corruption and inefficiency were voiced too. Installing a quasi non-governmental organisation as manager of the system, responsible for collecting, pooling and purchasing, under the stewardship of the Ministry of Health could provide a compromise acceptable to the people.

Finally, the question as to how transferable these finding are to other contexts in the region is a legitimate one. A fact is that many culturally similar countries in the region face similar challenges. Also, in these countries, introducing national health insurance is often discussed, and thus, Syrian population views could be valuable.

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