ORIGINAL RESEARCH

Syria: Neoliberal Reforms in Health Sector Financing: Embedding Unequal Access?

Kasturi Sen and Waleed al Faisal

Abstract

The recent volatility and uprisings in several countries of the Arab world have been interpreted by the West solely as a popular demand for political voice. However, in all the countries of the region, including those in which there is ongoing violent opposition, the underlying economic dysfunction speaks for itself. The legacy of joblessness, food riots, and hunger is commonplace and is most often related to structural reforms and austerity measures promoted by the IMF and World Bank. These have played a significant role in reinforcing the rich-poor divide over the past three decades, fostering inequality, suffering, social divisions, and discontent, which are often overlooked by Western observers. In Syria, the state introduced policies for the liberalization of the economy as early as 2000; these were formalized into the 10th Five-Year Plan (2006-2010). Economic liberalization has been supported by the European Union with technical support from the German Technical Cooperation agency (GTZ). Changes made to the health sector and the labor market include: the piloting of health insurance schemes to replace universal coverage, the charging of fees for health services in public hospitals, and job losses across the board. While the West views discontent in Syria largely as political, its own role in promoting economic reforms and social hardship has been largely missed. In large part, discontent in Syria and in the region as a whole are a part of a phenomenon that has repeatedly highlighted the failure of policies that aim at rapid commercialization with little consideration for pre-existing disparities in wealth and resources. This paper traces some of the proposed changes to the financing of health care and examines the implications for access and equity.

Methods

Peer reviewed papers, datasets and grey literature were obtained from Google Scholar and Medline searches between March 5, 2011 and July 20, 2011 based on keywords and titles related to public-private partnerships (PPP), contracting out, Middle East and North Africa (MENA), health, health systems, and health financing. These included data and reports from the World Health Organization (WHO), the Economic and Social Commission for West Asia, the United Nations Development Program (UNDP), data from the Syrian Central Bureau of Statistics, the 10th Five-Year Plan, the Regional Health Systems Observatory in Damascus, papers on health sector reforms from the European Union (EU) and the German Development Cooperation (GTZ), population data from the US Bureau of Census on

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Acronyms used in this paper

GDP	Gross Domestic Product
HSMP	Health Sector Modernisation Programme
HIC	high-income countries
ILO	International Labour Organization
LMIC	low-and middle-income countries
MENA	Middle East and North Africa
MOD	Ministry of Defense
MOH	Ministry of Health
MOHE	Ministry of Higher Education
MOLA	Ministry of Local Administration
MOSAL	Ministry of Social Affairs and Labour
NCD	non-communicable disease
OPE	out-of-pocket expenditures
PHC	primary health care
PPP	public-private partnership
SHI	social health insurance
UNDP	United Nations Development Programme
WHO	World Health Organization

population transition, reports from International Labour Organization (ILO) on the social sector and a number of recent and unpublished theses on the health sector.[1,2] Publications from Syria are mainly in Arabic and translations are few and far between. Newspaper reports from *Syria Today* are available on line. Expert opinion and insight were provided by the Syrian physician and professor who is co-author of the present paper.

Background

In an apparent response to failing health services, international donors advocated structural changes to the health sector of many countries in the MENA region during the past decade. One aspect of these reforms was an overhaul of economic policy to adopt neoliberal approaches and open up markets in the health sector.[3] The changes based on the introduction of commercial practices in health have faced much criticism for their negative health and social outcomes in most other regions of the world where they have been applied.[4] Although in the MENA region the changes are couched in terms such as "modernization," greater efficiency, and quality improvement, they retain some of the key features of reforms applied in Asia, Africa, and Latin America during the 1980s and 1990s, then known as Structural Adjustment Programs (SAP).* These SAPs included contracting out of health services to private providers, the beginnings of public-private partnerships, measures for hospital autonomy supported by the principles of new public management, point-of-service user charges, and the introduction of various insurance schemes (social, public, and private), in theory to act as a buffer for some sections of the population.[5-8]

It was argued that these reforms would improve quality, better suit patient needs and choices, contain costs for the state, improve the organization of services, and prepare for the rise of non-communicable diseases (NCDs).[8,9] However in the case of Syria, donors claimed that PPPs had already proven their ability to deliver better quality care than the state, and would complement the ongoing role of private providers. Hence Gaertner of the GTZ argued that one needs to discard ideological considerations and accept that "what is best is what works."[10]

However, experience elsewhere suggests that the financing mechanisms being implemented in Syria could be a costly alternative to public resourcing and would need continued subsidization by the public purse.[11-13] It is also likely that current changes would accelerate the penetration of multinational health care and health insurance companies[14,15] premised on the introduction of individual health insurance payments.

Syria: Health services[16]

Historically, health services in Syria have been under the aegis of the state with a command and control structure and a strong emphasis on public health, primary care, health promotion, and disease prevention. However, the health system has been little studied owing to the absence of consistent data, a lack of research collaboration within the country and externally, and a dearth of researchers trained in the study of "health systems," a field for which analytical tools and concepts have been developed in the West.[1,17,18]

In terms of health indicators, the country shows a positive record with declining infant and maternal mortality rates (IMR and MMR) over the past two decades. This is highlighted in Table 1. Syria has had significant declines in IMR and MMR, from an IMR of 132 per 100,000 live births in 1970 to 14 per 100,000 live births in 2010, and from an MMR of 482 per 100,000 births in 1970 to 45 per 100,000 live births—a ten-fold decrease—in 2010. This is a notable achievement given Syria's relatively low per capita income.

Syria can also credit itself with comprehensive vaccination coverage, which has been complemented by improved living standards, greater citizen awareness of health issues, a reduction in illiteracy (especially among women), improved infrastructure, access to clean water and expansions of primary health care (PHC). There has been a commitment to the integration of health care at all levels – primary, secondary, and tertiary. Syria is also one of the few countries of the region that has been on target to meet the Millennium Development Goals.[19]

Table 2 shows trends in MMR in Syria in comparison with countries at similar levels of income in the region. Compared to Jordan and Egypt, the Syrian MMR indicators are high despite lower levels of donor inputs. To a large extent, these achieve-

*SAPs were to become known for the commercially driven overhaul of the health sector worldwide. They were promoted as offering better responses to clients (patients), increased cost-effectiveness and improved efficiency that would in result better value than public sector providers.

Table 1. Essential Health Indicators, Syria, 1970-2010 and 2015 (projected)

	1970	1993	2002	2003	2004	2010	2015
Infant mortality rate (deaths per 100,000 live births)	132	33	24	18.1	17.1	14.0	12.0
Under-5 mortality rate (deaths per 100,000 live births)	164	44	29	20.2	19.3	16.0	13.0
Maternal mortality rate (deaths per 100,000 live births)	482	107	71	65.4	58	45	32

Source: Central Bureau of Statistics, Ministry of Health, Syria.

Table 2. Maternal mortality rate (per 100,000 live births), Egypt, Jordan and Syria, 1990-2008

	Egypt	Jordan	Syria
2008	82	59	46
2005	90	66	50
2000	110	79	58
1995	150	95	77
1990	220	110	120

Adapted from: Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA, and the World Bank. Geneva: World Health Organization; 2010.

ments reflect the integration of components of Syria's health system, despite the predominance of organizational verticality under the aegis of various ministries. This integration was complemented by both improved literacy and awareness among women and the existence of free maternal health care; these factors have contributed to the relatively positive health status of women and children in the country.

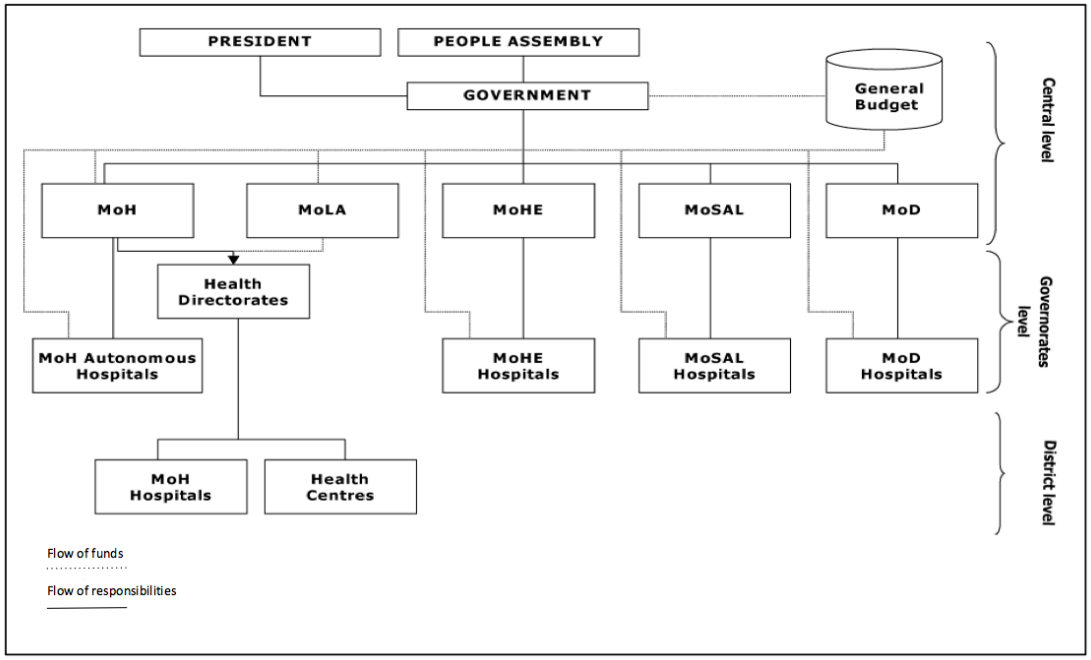
Organization of health care

The existing structure and organization of health services is highlighted in Figure 1. The system illustrates attempts to devolve functions to the tier of Governorates while retaining its underlying command and control structure.

Syria has provided free health care to all its citizens,[†] with a ceiling applied to charges made by private providers. The right to comprehensive health coverage is guaranteed by the Constitution. Overall coordination, management, and provision of services falls to the Ministry of Health (MOH). However, the actual system operates through several ministries (Social Affairs and Labor, Education, Defense, and Local Administration); some are better resourced than others, a situation that has resulted in health system segmentation. 80% of Syria's hospital beds are in the public sector even though private providers have increased by 41% since the economy was opened up in 2005. The responsibilities of the MOH are mainly in the areas of policy and strategy. Other ministries such as Finance, Education, Social Welfare and Defense, complement the MOH by providing financing, administration and health care services. The Ministry of Education, for example, is involved in school health. Several ministries (e.g., Defense) provide health care for their employees, not unlike 19th century Europe in which professional guilds had an important role in health care provision.[20] In the public sector, the provision of health services tends to be organized by membership in particular guilds (professions). All of the population utilizes different private facilities if and when they can afford them.

[†] This does not include medicines which—after consultations—are the costliest items for patients. A detailed list of charges for health interventions by the private sector is provided by the MOH as guidelines to be followed.

Figure 1. Organization of Syrian health services



Source: Health systems profile – Syria. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2005

Current estimates suggest that more than two-thirds of the population continue to use public inpatient facilities. The situation for outpatient care is different. Here a fee-for-service system prevails with private providers of all shapes and sizes available for consultations, diagnostic testing and the sale of medicines. The distribution of public spending is outlined in Table 3. The highest spending comes from the Ministry of Local Administration (MOSAL), which provides support services to all Governorates. A substantial amount is allocated to the central MOH, followed by the Ministry of Higher Education (MOHE), which has a large number of teaching hospitals. While there is a degree of service fragmentation by sector, the MOH retains a central and strategic function. This picture is shifting, however, with the emergence of greater privatization and commercialization.[21] Public health care spending was reduced from 8.6% to 5.4% of GDP between 1995 and 2006 but earlier spending effects continued to enable MMR to decline over the same period.

Shifting demand from middle classes

While there is still demand for public services for inpatient care, the emerging middle classes in particular prefer to utilize the rapidly expanding private hospitals and clinics due to waiting times and perceived quality issues.[1,2,22] Age-specific access to health services and utilization patterns are unknown but private providers have increased their overall presence in Syria—mainly in the large cities—by 41% since 2005. Figure 2 highlights declining public expenditures on health services, which reflects, in part, the effects of the modernization program over the past four or five years.

Health Sector Modernisation Programme (HSMP), 2003-2010

Since 2003, the Syrian state has been engaged in a Health Sector Modernisation Programme under the aegis of the European Commission[23] and the GTZ. The HSMP is part of an EU bilateral aid cooperation program to encourage the liberalization of the Syrian economy in administrative legal systems, trade, and small enterprise development. The 2001 publication of the report of the WHO Commission on Macroeconomics and Health had a similar effect in many low- and middle-income countries (LMIC), providing an impetus to increase a "stewardship" role for the state and reinforcing arguments for a separation of its administrative and financial roles.[11,24] The Health Sector Modernisation Programme was ratified in 2003 with substantial EU funding. It laid out a progressive implementation plan involving several phases to be carried over a number of years. The liberalization of the whole economy—a donor-assisted program that

Table 3: Public spending for health care, 2003

Ministry	Value (millions US$)	% of total public spending for health care
Ministry of Health (central administration, 4 hospitals)	137.72	25.71
Ministry of Local Administration (health care in 14 Governorates)	192.86	36.00
Ministry of Higher Education (11 teaching hospitals)	103.84	19.39
Ministry of Social Affairs and Labour (1 general hospital)	5.03	0.94
Ministry of Defense (5 hospitals)	18.89	3.53
Ministry of Interior (police health care)	11.11	2.07
Other public institutions	66.16	12.35
TOTAL	535.61	100.00

Adapted from: Dashash M, Kaderi R, Fadda MH, Schwefel D. National health accounts 2003 for Syria – A graphical overview

began in parallel—was funded with €140 million.[10,25]

The overall aims of the HSMP were to:

- Improve the performance of hospitals,
- Improve management of the health sector,
- Improve the quality of health services through accreditation,
- Seek new methods of health financing, including user charges.

The Health Sector Modernisation Programme is premised on the view that such reorganization is the only way to improve the quality and efficiency of services. Based on the above objectives, the reforms will involve the gradual withdrawal of state funding for the provision of health services. State monies will be replaced by a combination of private providers and a social insurance system. The state would contract private entities to provide primary, secondary, and tertiary care. Formal public-private partnerships are also planned. In theory, the social insurance scheme would act as the payer and gatekeeper of the new service structure, whose overall aim is to reduce costs to the state, improve quality (through the tendering and job specification process), and expand access with the expectation that prices would be regulated in the transition to a market economy.[9]

Privatization and financing of health care: Core elements

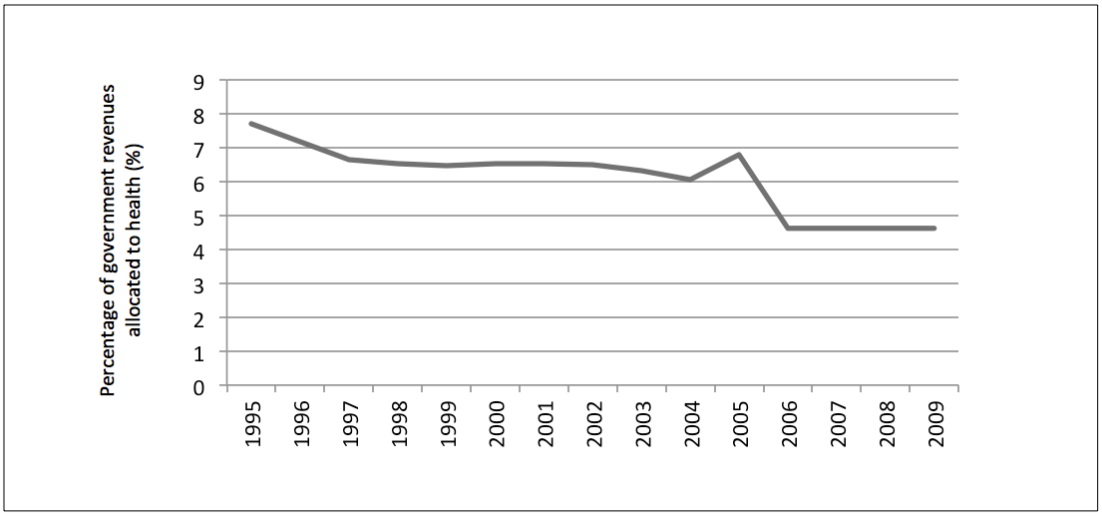
The commercialization of health and social sectors has been driven largely by PPPs[§] and, more recently, the contracting out of services.[**] Contracted services range from catering, laundry, and diagnostic services, to physicians running hospitals and primary health centers on a contractual basis. Many such arrangements have been undertaken in high-income countries for nearly three decades. The contractor is paid to deliver specific services; in the long run such contracting is, in effect, a partnership with the public provider. In the past decade, mechanisms for contracting out the delivery of health care have also been implemented in countries of the North and South, including Syria.[††] While the rationale is to improve efficiency, access and quality, and to provide additional resources, in practice, the economics of contracting out have often created a hole in the public purse.[13] In addition, contracts often fail to produce quality and continuity, nor do they stem

[§] As implied by their name, PPPs are partnerships whereby the private sector carries out certain tasks (e.g., running a school or a health service) while ownership and—most significantly—liability remains with the state.

[**] Contracting out involves private sector responsibility for one element of a service or a project. Ownership is retained by the state.

[††] The term for PPPs between countries and regions. For example, in the United Kingdom they are known as private finance initiatives (PFIs).

Figure 2: Percentage of government revenues allocated to health, 1995-2009



Source: National Health Accounts indicators, Syria, 2010. World Health Organization Global Health Expenditure Database. http://apps.who.int/nha/database.

the rising costs of service delivery. Many of the strategies for commercialization are premised on public financing of core infrastructure costs while services are delivered through a multitude of individual, community, and social insurance schemes. In all cases, however, the state remains the guarantor and can end up paying substantial costs for limited services if and when the private provider fails. This process generates costs which otherwise the State would not have to assume.[26,27]

PPPs and contracting out in Syria

PPPs have evolved into a major strategy to increase the performance of the health sector and have become a dominant presence in the region as a whole.[3,28,29] From its earliest stages, the Syrian modernization program included PPPs; these were mainly for non-clinical services. However, as of 2008, the state has shifted to the contracting out of primary health care and clinical services in select public hospitals. The lack of infrastructure, knowledge, and awareness in Syria about PPPs was acknowledged as early as 2003. But this did not prevent the adoption of a fully-fledged plan that would include contracting out PHC units to private physicians and NGOs, contracting out hospitals to specialist doctors, and contracting out medical supplies to private providers.[10] A 2007 review of contracting in the region by Siddiqi[30] noted that Syria, compared to other countries, remained in an experimental phase; their overall assessment of contracting was a cautionary one. Evidence to date shows that contracting out public services—even in the form of PPPs—is complex, due to a number of operational factors, including the absence of clear criteria for managing contracts (e.g., on quality assurance and cost) and the frequent inexperience of public providers with running complex contractual arrangements.[‡‡] The absence of regulation and standards for managing subcontracts also complicates matters. This becomes evident only when subcontracts fail to be ratified or they collapse. This has become increasingly commonplace.[25,27,31] Despite these problems, donors continue to persuade ministries of health in LMIC—in this case the State Planning Commission and the Ministry of Health in Syria—to act as stewards and to fulfill this role with regulations supporting the extension of PPPs.[§§,32,33]

User Fees

A integral part of health sector modernization in Syria is the introduction of user fees and charges for public services; these are in addition to the out-of-pocket expenditures already incurred by the population. In theory, the poorest are exempted from such fees and charges. Hospital policies regarding

[‡‡] Similar issues arise in many high-income countries.

[§§] Most reviews of contracting out suggest that careful scrutiny of management is key to their operational effectiveness and impact upon cost and quality (see ref. 15).

user fees are fragmented. With the exception of MOSAL and the MOD, user fees have been charged in MOH hospitals and health centers as well as in the MOH autonomous hospitals since 2003. Fees are paid for medicines and for private clinics. This is illustrated by Figure 3 which shows the increasing share of out-of-pocket costs in overall health care expenditure.

Assessing the implementation of user fees in Syria (which public provider is charging what fees) is difficult. Although monitoring and evaluation is taking place, the data have yet to be published. Nonetheless, evidence from both within and outside of the region on charging for health services clearly shows that it has a negative impact on access and equity.[6,8] The data suggests that fees have a particularly negative effect on those households who are not eligible for exemption.

Donors continue to promote "fee-for-service" as part of the commercialization of services despite widespread consternation regarding its regressive nature.[8,9] Theoretically, fees reduce demand and help defray the costs of running of a service. But their negative effects in most LMIC over the past decades are well-documented. Fees reduced access for those most in need of care and often led to catastrophic health costs and medical poverty. The evidence led to a WHO Resolution in 2005[34] calling for financial protection; this was followed by the annual report on the right to universal access.[8] The evidence on user fees[34] also shows that the means (fees at the point of service delivery) most often did not support the ends; utilization of services decreased (a core objective of users fees is to reduce unnecessary use) mainly among the less well off. Additionally, user fees did not contribute to paying for the costs of providing the service. Whitehead, et al. conclude from their review that user fees and out-of-pocket expenditures constituted a major medical poverty trap in most regions of the world.[6.see also 8,9,35] Faced with such strong opposition, the World Bank acknowledged that user fees were a regressive method of paying for health care and needed to be applied selectively.[36] Despite this admission, the principle of user fees has re-emerged in MENA and in Syria where the repercussions are likely to be heavy upon households.

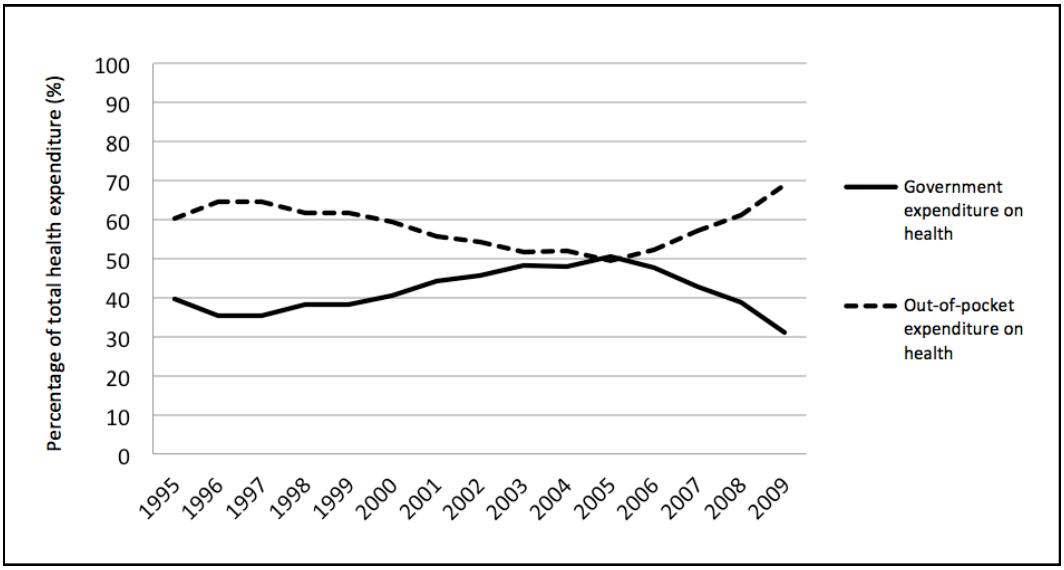
Social health insurance (SHI) schemes

Social health insurance is a different kind of charge (in addition to users fees) that, in theory, protects against risk. Unlike user fees, insurance payments are not at the point of delivery and the cost in most cases is paid by the public purse; the state, however, has little control over cost or quality.[*** 13]

Prior to current reforms, the financing system was premised on universal access, albeit with more choice of providers for public sector employees

*** Evidence from numerous studies in countries such as India suggest that payments continue to be made, except for a select list of complex health interventions in chronic conditions such as cancer and heart disease. The vulnerable public continues to purchase medicines, pay for some consultations, and, most significantly, receive little advice on management and prevention of recurrence.[37]

Figure 3. Government versus out-of-pocket expenditures on health, 1995-2009



Source: collated from National Health Accounts, Syria 2010

(who made minimal contributions toward primary, secondary, and tertiary care). For the majority of the population, access to care was supposedly guaranteed by the Constitution. Private insurance was minimal and mainly for those employed internationally.

A major feature of the reform will involve a shift in financing mechanisms. Existing mechanisms are largely contribution-based for formal sector employees and subsidized for the poor and informal sector work. Medications not available in the public sector must be purchased. Under the reform, financing will be through a new social insurance scheme. Traditionally, health financing in Syria has come from a combination of public funds from the general budget, some private insurance, and, mainly, out-of-pocket-expenses for outpatient consultations and medications. State spending for health care is derived from government revenues approved by the cabinet and administered *by the Ministry of Finance*. The SHI changes will be geared toward the essential package system as proposed by the World Bank in 2004 for the poor.[35] Worldwide, such packages are intended to upgrade infrastructure and generate a system of graduated payments for hospital services at the secondary and tertiary level. Targeting low-cost provision of health care for the poor is part of the reform process. This has been applied to the health sector in Syria and remains a complex process, with multiple layers of beneficiaries and claimants, and elements of risk sharing. But *just how* this will work in practice remains in question since medical and health records as well as administrative functions within hospitals are poor to non-existent. The social insurance scheme is being currently being piloted in a number of health districts. To date, however, there are no published materials on the workings of the new system. Therefore, any assessment can only be based on conjecture and the experience of other regions.

Health expenditures over time

In 2006, the per capita expenditure on health was US$ 59, accounting for 5.6% of the GDP; this is average for an LMIC. Funding was disbursed through several ministries or directly to a number of hospitals that fall under administration of the central authority of the MOH. The system of devolution of funding and administration is a complex one and likely to be regressive, especially in cases when employment is outside the formal sector. This is a main concern of the Syria Decent Work Program, an ILO-initiated project on the social sector that is running concurrently with the HSMP program.[39,40]

The public social insurance scheme, although one of the oldest of its kind in the region—it was founded in 1959—is restricted to public sector employees. According to a survey published in 2002, only 28% of the Syrian labor force is employed in the public sector; 37% are self-employed or voluntary, and the remaining 35% are in the private sector, including both employers and employees.[41] In 2008, the ILO reported that only 21.48% of the total labor force received social protection.[39]

Those who are self-employed or privately employed are eligible to join the proposed SHI. The system remains a complex with benefits only accruing after a minimum of 240-300 weeks (5-5.7 years) of contributions.[42] For those with inadequate or insecure incomes, such as agricultural or informal sector workers, paying into this or any scheme is problematic.[43-45] In such a setting, any health sector modernization program will need to ensure inclusive financing of services so that millions of men and women can continue to access care without lapsing into health-related debt. This is a particular concern for the elderly.

Co-payments

The issue of co-payments is an area in health financing that appears to have been insufficiently investigated, especially in the context of PPPs. If the state introduces cost-capping for particular interventions, it will inevitably raise the cost of care for the user who, as co-payee, will have to cover all fees in excess of the cap. In these cases the provider usually has many subtle ways of increasing charges. The user is largely unaware of the costs until faced with the bill. More than one observer of the Syrian health sector has emphasized the need to contain the cost of health care in the HSMP, particularly for copayments in the light of changes proposed to the management of the health sector.[2,18] It has been argued that, in the absence of laws and regulations, public sector managers will require a great deal of financial acumen to be able to critically appraise costs and purchase policies.[1,42] There is a growing but misplaced view among policy makers and professionals in Syria that a new health insurance scheme complemented by PPPs will lead to the welcome reduction of the state's role in service delivery and will act as a much needed panacea to contain costs and improve access to quality health services.[10,32]

However, evidence from other middle-income countries, such as those of Southeast Asia, does not

support the blanket use of PPPs or health insurance mechanisms as a solution to the problems of cost, quality, and access. A recent major review of health financing[46] suggests that trying to improve coverage is never a simple matter, nor is it an easy solution to all the problems in the health sector. Health systems need to continue to have strong core functions such as adequate and trained human resources, coverage of financial risk for the vulnerable, and stability of provider payments so that cost savings do not to affect clinical decision-making. Most importantly, policy makers need to learn from the evidence of other countries and regions so that a culture of evidence-based decision making develops. None of these factors are present in the HSMP documentation for the reform of the health sector in Syria.

Conclusion: Policy dilemma and contradictions

In an era of donor assistance and influence compounded by real economic pressures, it is possible for policies to contradict one another. The Health Sector Modernisation Programme, which includes the introduction of both insurance payments and fee -for-service for those able to pay, conflicts with policies for universal access and—in Syria's case—with the needs of an emerging ageing population.

It is increasingly evident that insurance status is related to inequities in low- and middle-income countries. Policies for different types of coverage have been avidly promoted over the past two decades. Nevertheless, they require much more fine-tuning, if not complete elimination. In a review of private financing in low- and middle-income countries, the OECD suggested that, unless managed with considerable care and appropriate regulation, health insurance schemes could weaken a country's medical system and reinforce the divide between rich and poor.[48] This has been the experience of countries such as Lebanon and Morocco; despite extensive health insurance coverage, the rich-poor divide in access to health services, particularly at older ages, is considerable.[43,48] A recent editorial from the American Stroke Association also highlights inequities in access to insured care in two countries—China and India—in which inability to purchase health insurance has been a key factor in health-related debt.‡‡‡ The author suggests that if a stroke occurs during working years, people without adequate coverage are seven times more likely than those with coverage to face catastrophic costs.[49]

The limited information available about the current financing of health services in Syria suggests that while the intention is to promote universal coverage, in practice this may not happen as pressure mounts in a multitude of ways for the state to cross-subsidize private providers. Most reports on the restructuring of the health sector in Syria advocate public-private partnerships as a means of reducing the cost to the public purse. However, additional costs must be taken into account: the cost of cross-subsidies, the costs of the administration and monitoring of service provision, and the costs of dealing with failures in care for those who fall outside of the formal sector. Workers in the informal sector, women, and the elderly will not qualify for insurance except on the grounds of extreme hardship; experience in Lebanon suggests that it will be problematic to enroll marginalized groups.[28,43] In addition, there will be the problems of management and implementation that are not uncommon in the process of commercialization; these will generate confusion and reinforce lack of access.[13,31]

Within Syria, there has been limited debate in the popular media about the applicability of health insurance in a country where 45% of the workforce is employed in the informal sector.[50] While salaried employees in the formal sector will be well-protected through much of the proposed changes, the same is not the case for those in the informal sector or for those involved in unsalaried work, including the majority of women, who have greater longevity than men. This issue was highlighted in a review of health insurance in *The Economist.*[51] The gains and benefits of private health insurance were compared to the costs of implementing different types of insurance schemes in LMIC. Several commentators suggested that most of the Syrian population have only very limited understanding of the meaning of medical insurance, which remains largely an imported idea. While Syria has a population of 22 million people, there were only 100,000 health policies issued in 2010.[51] Even the team involved in implementing the health financing reforms acknowledges that the reforms are beset by problems.[25]

Hence, despite the availability of curative care and a new program to manage NCDs through PHC, changes in financing mechanisms are likely to be highly problematic in both culture and practice. Targeting sections of the population as claimants for insurance will be highly complex. The health sector will be largely unprepared for the needs of an

‡‡‡ 80% of the Indian population pays out-of-pocket. In China, 65% of urban residents and 80% of rural populations are excluded from health coverage. [45]

ageing population who is uninsured. Those without past or present association with formal sector employment will be particularly vulnerable.[52] Assuring private providers a major role in the provision of health care is unlikely to improve access to specialized health care, such as diagnostic facilities, without a substantial cost attached. This has been the experience of countries both within and outside of the region.[7] It is likely that the incidence of catastrophic health care costs will escalate in Syria, a country where such costs were once under control. This will place an extraordinary burden on households.

A rush to liberalize the economy and the health sector has been undertaken at the expense of maintaining some of the current system's stronger elements, such as cross-subsidies and low costs that have led to positive health trends indicated by declining IMR and MMR.

Finally, the issues of public ownership and citizen voice appear to be largely absent in the reform. The poorest segments of the population are the most vulnerable to the changes implemented in the health sector of countries such as Egypt, Lebanon and Jordan.[§§§] The poor, who face substantive inequities in access to quality health care,[35,53] also have no means of making their voice heard. In Syria this group is composed of women, the elderly, and workers in the informal sector. While the proposed changes are reported regularly in the official press, there appears to be very little by way of consultation or incorporation of public views. The few articles in the press on hospital accreditation suggest growing alarm among smaller providers, the elderly, and the self-employed.[49] These groups depend, to a large degree, on state-civil society relations, which are generally abysmal throughout the region. The Arab Human Development Report[47] noted that human security has played a very limited role in the formulation of social policies in the region when compared to the significance attributed by governments to the security of the state.[47] In the absence of civil society voice or participation, the rise of neoliberal policy making is likely to create further disparities by entrenching the power of markets over the population at large.

While Syria remains in political turmoil, sanctions from the European Union and individual countries mean that the reform and modernization program is at a standstill. This might be a blessing in disguise, raising the possibility of reconfiguring the plans for the financing and delivery of health care. The social upheaval and reactions in the areas where pilot studies were implemented could suggest that a retrenchment of the labor force, together with attempts to separate the financing from the delivery of health care, may not be such a positive measure, especially for those faced with rising costs from chronic conditions. This issue, however, needs further investigation.

Moreover, citizens who have recently discovered "voice" need to ensure that they are heard loud and clear, not just about political reforms, but also about the privatization and corporatization of health services that have become the lynchpin of neoliberal policies across low- and middle-income countries. Policy makers on the other hand, need to learn about evidence-based thinking, rather than donor-directed policies, as in the case of Syria. These policies have been at the root of hardship and distress for many households through privatization and retrenchment. The social and political upheavals are a strong indication that these issues cannot be left aside, in this case in Syria .

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[§§§] 40% of Egyptians, one-third of Jordanians and Lebanese, and as many as 20% of Syrians live at or below the poverty line.[47]

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