

EMRO

HEALTH SYSTEM PROFILE

S Y R I A



Regional Health Systems Observatory
World Health Organization

2006

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FOREWORD

Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re-emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning. As the countries examine their health systems in greater depth to adjust to new demands, the number and complexities of problems identified increases. Some health systems fail to provide the essential services and some are creaking under the strain of inefficient provision of services. A number of issues including governance in health, financing of health care, human resource imbalances, access and quality of health services, along with the impacts of reforms in other areas of the economies significantly affect the ability of health systems to deliver.

Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation, can strengthen the scientific foundations of health policy at international and national levels. Comparison of performance across countries and over time can provide important insights into policies that improve performance and those that do not.

The WHO regional office for Eastern Mediterranean has taken an initiative to develop a Regional Health Systems Observatory, whose main purpose is to contribute to the improvement of health system performance and outcomes in the countries of the EM region, in terms of better health, fair financing and responsiveness of health systems. This will be achieved through the following closely inter-related functions: (i) *Descriptive function* that provides for an easily accessible database, that is constantly updated; (ii) *Analytical function* that draws lessons from success and failures and that can assist policy makers in the formulation of strategies; (iii) *Prescriptive function* that brings forward recommendations to policy makers; (iv) *Monitoring function* that focuses on aspects that can be improved; and (v) *Capacity building function* that aims to develop partnerships and share knowledge across the region.

One of the principal instruments for achieving the above objective is the development of health system profile of each of the member states. The EMRO Health Systems Profiles are country-based reports that provide a description and analysis of the health system and of reform initiatives in the respective countries. The profiles seek to provide comparative information to support policy-makers and analysts in the development of health systems in EMR. The profiles can be used to learn about various approaches to the organization, financing and delivery of health services; describe the process, content, and implementation of health care reform programs; highlight challenges and areas that require more in-depth analysis; and provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries. These profiles have been produced by country public health experts in collaboration with the Division of Health Systems & Services Development, WHO, EMRO based on standardized templates, comprehensive guidelines and a glossary of terms developed to help compile the profiles.

A real challenge in the development of these health system profiles has been the wide variation in the availability of data on all aspects of health systems. The profiles are based on the most authentic sources of information available, which have been cited for ease of reference. For maintaining consistency and comparability in the sources of

information, efforts have been made to use as a first source, the information published and available from a national source such as Ministries of Health, Finance, Labor, Welfare; National Statistics Organizations or reports of national surveys. In case information is not available from these sources then unpublished information from official sources or information published in unofficial sources are used. As a last resort, country-specific information published by international agencies and research papers published in international and local journals are used. Since health systems are dynamic and ever changing, any additional information is welcome, which after proper verification, can be put up on the website of the Regional Observatory as this is an ongoing initiative and these profiles will be updated on regular intervals. The profiles along with summaries, template, guidelines and glossary of terms are available on the EMRO HSO website at www.who.int.healthobservatory

It is hoped the member states, international agencies, academia and other stakeholders would use the information available in these profiles and actively participate to make this initiative a success. I would like to acknowledge the efforts undertaken by the Division of Health Systems and Services Development in this regard that shall have the potential to improve the performance of health systems in the Eastern Mediterranean Region.

Regional Director
Eastern Mediterranean Region
World Health Organization

1 EXECUTIVE SUMMARY

Syria is located in the Middle East, surrounded by Turkey in the North, Iraq in the East, Jordan and Saudi Arabia in the South and Lebanon, Palestine in the South, Mediterranean and Lebanon in the West. Syria spreads over a total geographical area of 185.18 km². The cultivable land is 80.000 km (approximately). The remainder is comprised of deserts and Rocky Mountains. It is further divided into a coastal zone and a much larger eastern plateau. The climate is predominantly dry and about three-fifths of the country receives less than 25 centimeters of rain a year. Fertile part of the land is a rich natural resource. Efforts have been continuous, and in 1980s the efforts were accelerated to increase the amount of arable land through irrigation projects.

Syria has medium-sized economy. In 2004 the population estimated was 17.993.000. More than 50% population lives in urban area. Over 40% of all the Syrians are less than 15 years of age. Almost 57% are between the age of 15 and 64 years. Life expectancy has steadily increased over the last few years, up to 69 years of age for men and 73 years for women. The region-wise findings reveal the population characteristic; with a literacy rate (official) of 93% for males as well as for females. The four universities; University of Damascus, Aleppo, Tishreen and Al Ba'ath the enrolment has a growth around 255.000 over the last 20 years. This number is expected to increase more after the approval of the legislation in 200. It also endorses the growth and development of private universities. From the administrative point of view, Syria is divided in to 14 Governorates (Muhafazat). Each one of these is normally divided into areas (Manatik), which are further divided into smaller units (Nawahi) and lastly the villages (Qura). These villages are the smallest administrative units.

The economy is dominated by the primary sector, with the vital financial achievements contributed by the agriculture and hydrocarbon extraction fields, together. It imparts more than 45% of the GDP. Some strategic sectors such as oil, cement production and power generation, are completely owned by the government. The government controls much of the cotton and grain production, also. There are certain other areas of economic activity such as fruit production and trade, which are considered to be less strategic thus, remain outside direct state control. The private sector despite its limited size and power generates a disproportionate share of the output. To limit prices and prevent illegal profiting the rigid economic laws introduced long ago, however, have driven much activity underground.

Around 51% of the population 15 years and the elderly are estimated to be economically active, creating a labour force of over 5 million (2004). Officially, unemployment is 11%. In terms of economic activity workers are employed in the following sectors: 29, 6% in agriculture and forestry, 13, 5% in industry, 12, 3% in building and construction, 14, 5% in hotel, restaurants and trade, 5, 4% in transport and communication and 24, 7% in other services.

The Syrian government is presently engaged in a process of economy liberalisation process and of modernisation of the health sector with the support from European Union. While maintaining social protection to more vulnerable population, one of the key issues is to reform the health sector in order to address the growing demand for quality of health services in times of globalisation.

Under the leadership of H.E president Bashar Al Assad, the Based on market-oriented reforms, the Syrian government has launched a program of economic modernisation that

includes: reviving the private sector, attracting domestic and foreign investors. To make the financial system more efficient through; liberalisation of the banking sector, boosting trade, improving the operating efficiency of public sector enterprises, strengthening the administrative capacity of the Syrian institutions. Surely, it would up-lift the country's level of growth and development. At present, there is a well established belief prevailing, that, the country must bridge-up the massive gap between its aspirations and its current economic status.

Syria is considered to be a country passing through a "well advanced epidemiological transition". This period is mainly characterised by:

- an overall decline in mortality rates
- declining rates of communicable diseases (although infectious and maternal/child related pathologies may still persist among disadvantaged population groups)
- a concurrent rise in the proportion of disease burden attributable to non-communicable diseases
- a rise of aging pathologies

Keeping under view the prevailing scenario, the Ministry of Health has developed a long-term policy / strategy (2000-2020), to develop the health sector. The strategy is based on three fundamental pillars: improve and strengthen the primary health care through the dissemination of Health Centres all over the country, increase the efficiency and the capacity of the secondary and tertiary delivery services in line with needs, enhance geographical and financial equity of the health care system, by allowing greater accessibility for the most disadvantaged people.

The setup of health services is categorized based on two fundamental features:

- Primary Health Care services which are delivered and run through a governmental network of PHC centres and the private sector which has little in providing preventive care to the population.
- The curative services on the other hand are characterized by a mix of public and private sector. The structured form is mainly in the public sector with a difference of service provision. The data available on interaction and existence of a referral system are not available, although outlined or sketched out.

The financing or flow of resources that provision is primarily funded by the government through regular budget and then the other main method is out of Pocket payments to the private sector. Information of drugs at Public facilities although it can be tentatively asserted, they form part of the Out of Pocket Payments.

The Constitution of Syria defines the right of all the population to comprehensive health coverage. The organizational structure of the statutory health system reveals to the Ministry of Health the responsibility for coordinating and managing health services provision. Further responsibilities for financing, administrating and providing health services are given to the following bodies: Ministry of Finance (MoF), Ministry of Local Administration (MoLA), State and Planning Commission (SPC), Ministry of Higher Education (MoHE), Ministry of Social Affairs and Labour (MoSAL) and Ministry of Defence (MoD). Additionally, the other ministries and state companies provide directly and indirectly health care services for their employees and dependents, as well as, the majority of the professional associations. The private role in delivering health care services has substantially increased, recently.

The organizational chart of the MOH has been approved by the Government. The new chart shows a functional structure of the central level of the MOH, based on main regulatory functions. Boards and committees address various issues such as quality management, regulation of private sector, health insurance, accreditation, etc. This organization aims to overcome the constraint of the excessive specialization of the directorates who very often are in charge of particular aspects of the same issue (e.g.: human resources). In this chart "regulation", which belongs to boards and committees, is clearly separated from "administration", which is a task of directorates.

Hospitals independence Financial & Administrative: the new orientation and priority objective of the Ministry of health is to transfer all hospitals gradually in to independent unit, that have it budget, flexible management and participation form the local community in its board. For that very achievement there is a dire need for; established 9 central hospitals with the objective of moving towards partial cost recovery and participatory management to improve the efficient performance of the hospitals

Accreditation, being essentially a regulatory tool, is usually a service provided by autonomous and impartial agencies. MOH should lead the definition of the national framework for accreditation; the role of "accrediting agency" should be given to an independent commission. Developing quality system and national accreditation framework is a priority of the MOH.

ISO certification is provided by several private companies to some public and many private hospitals under the supervision of the National Committee for Quality. The legal framework for licensing and the operational framework for ISO certification should be evaluated.

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2000	2002	2004
Human Development Index:	0.63	0.663	0.683	0.71	0.721
Literacy Total:	64.8	69.8	74.4	85.5	93 %
Female Literacy:	47.5	54.1	60.4	78	78%
Women % of Workforce	24.4	25.7	27	27.6	29
Primary School enrollment	108.3	100.7	108.6	100	100%
Primary education, pupils (% female)	46.50	46.65	47.20	49	49%
Urban Population (%)	48.93	49.84	50.06	50.1	50.2

Source: National information Center & Central Bureau of statistics

Key socio-cultural factors relevant to the health system

PRESENT-DAY Syria constitutes only a small portion of the ancient geographical Syria. Until the twentieth century, when Western powers began to carve out the rough contours of the contemporary states of Syria, Lebanon, Jordan, and Palestine, the whole of the settled region at the eastern end of the Mediterranean Sea was called Syria, the name given by the ancient Greeks to the land bridge that links three continents. For this reason, historians and political scientists usually use the term Greater Syria to denote the area in the prestate period.

Historically, Greater Syria rarely ruled itself, primarily, because of its vulnerable strategic status and situation between the Mediterranean Sea and the desert. As a marchland between frequently powerful empires in the north, east, and south, Syria was a very often battlefield for the political destinies of dynasties and empires. Unlike other parts of the Middle East, Greater Syria was valued as a fertile cereal-growing oasis. It was even more critical as a source of the lumber needed for building imperial fleets in the pre-industrial period.

Even though it was exploited politically, Greater Syria benefited immeasurably from the cultural diversity of the peoples who came to claim parts or all of it and who remained to contribute and participate in the remarkable spiritual and intellectual flowering that characterized Greater Syria's cultures in the ancient and medieval periods. Incorporating some of the oldest continuously inhabited cities in the world, Greater Syria was in a unique position to foster intellectual activities. By 1400 B.C., Damascus (Dimashq), Aleppo (Halab), Hamah (Hamath), Byblos (Gubla), Joffa (Joppa), Homs, Gaza, Tyre (Sur), and Sidon already had been established; some of these cities had flourished for many centuries. Because Greater Syria was usually ruled by foreigners, the inhabitants traditionally identified themselves with their cities, and in contemporary Syria each city continues to have a unique sociopolitical character.

A recurrent theme of Greater Syria's history has been the encounters between Eastern and Western powers on its soil. Even in the ancient period, it was the focus of a continual dialectic, both intellectual and bellicose, between the Middle East and the West. During the medieval period this dialectic was intensified as it became colored by diametrically opposed religious points of view regarding rights to the land. The Christian Byzantines contended with Arabs, and later the Christian Crusaders competed with Muslim Arabs, for land they all held sacred.

The advent of Arab Muslim rule in A.D. 636 provided the two major themes of Syrian history: the Islamic religion and the world community of Arabs. According to traditionalist Muslims, the greatest period of Islamic history was the time of the brief rule of Muhammad--the prototype for the perfect temporal ruler-- and the time of the first four caliphs (known as Rashidun, rightly guided), when man presumably behaved as God commanded and established a society on earth unequalled before or after. During this period religion and state were one and Muslims ruled Muslims according to Muslim law. The succeeding Umayyad (661-750) and Abbasid (750-1258) caliphates were extensions of the first period and proved the military and intellectual might of Muslims. The history of Greater Syria in the early medieval period is essentially the history of political Islam at one of its most glorious moments--the period of the Umayyad caliphate when the Islamic empire, with its capital at Damascus, stretched from the Oxus River to southern France.

A different view of Syrian history denies that the greatness of the Arab past was a purely Islamic manifestation. The history of the Arabs began before the coming of Muhammad, and what Arabs achieved during the Umayyad and Abbasid empires was evidence not only of the rich inheritance from Greek and Roman days but also of the vitality of Arab culture.

Since independence in 1946, Syria's history has been dominated by four overriding factors. First is the deeply felt desire among Syrian Arabs--Christian and Muslim alike--to achieve some kind of unity with the other Arabs of the Middle East in fulfillment of their aspirations for regional leadership. Second is a desire for economic and social prosperity. Third is a universal dislike of Israel, which Syrians feel was forcibly imposed by the West and which they view as a threat to Arab unity. The fourth issue is the dominant political role of the military.

Situated on trade and military routes between the Mediterranean and Mesopotamia, Syria (which historically included all of modern Syria, Lebanon, and parts of Palestine, Jordan, Iraq, and Saudi Arabia) had always been an object of foreign conquest. Settled (2100 BC) by the Amorites, a Semitic from the Arabian peninsula, it fell to the Hittites (16th-12th cent BC), The Assyrians and Babylonians (11th-6th cent. BC), the Persians (6-4th century BC), and the Greeks (333 BC). Syria was hellenized by the Seleucids and had fallen to Rome by 64 BC. After the Byzantine era (5th-7th cent. AD) Syria was conquered (633-40) by Muslim Arabs. Most Syrians had converted to Islam, and Damascus, as the capital of the Umayyad caliphate (661-750), became the center of the Islamic world. The area was later ruled by the Seljuk Turks, the Mongols, Saladin, Mamluks Crusades (11-13th century). It was part of the Ottoman Empire from 1516 until the end of World War 1, and in 1920 France received a League of Nations mandate over the Levant States (roughly modern Syria and Lebanon). During World War 2 Free French forces granted (1946) independence to Syria, the French troops did not leave until 1946. Syria and Egypt Formed in the United Arab Republic in 1958, but withdrew in 1961.

The society is composed of a number of cohesive groups recognizing a common heritage and exhibiting great solidarity. Both linguistic and religious characteristics define these groups; religious communities within the larger language groups' function as separate quasi-ethnic entities and in many cases have developed distinctive cultural patterns. Ethnic and religious groups tend to be concentrated in certain geographic regions and certain social positions. For example, about 40 percent of the Sunnis are urban dwellers; of those, 80 percent live in the five largest cities.

Social pathologies and unhealthy lifestyles identified in Syria are smoking , consumption of drugs and alcohol , unhygienic practices outside the house , lifestyles related to eating behavior (inadequate and im-balanced nutrition intake) , lack of or inadequate exercise , misuse and abuse of prescribed medicine , inadequate rest and sleep , non-use of seatbelts and helmets , fast driving of vehicles , overcrowded vehicles , watching television for a long time , excessive intake of tea and coffee , and in rural areas drinking of raw milk. The main health problems identified were: coronary heart diseases, malignancy, accidents, and psychosocial problems.

2.2 Economy

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2002	2003
GNI per Capita (Atlas method) current US\$	940	910	960	1090	1076
GNI per capita (PPP) Current International	2090	2960	3190	3360	-
GDP per Capita: (constant 1995 US\$)	642	801	793	805	-
GDP per Capita annual growth %	4.11	2.50	-1.87	0.73	4.4
Unemployment % (estimates)	-	-	-	11%	-
External Debt as % of GDP	222	188	169	157	-
External balance on goods and services (%GDP)	0.39	-6.90	8.06	8.77	-

Source: Central Bureau of statistics and National Survey done by State Planning Commission

Table 2-3 Major Imports and Exports

Major Exports	Crude oil, petroleum products, fruits, vegetables, cotton fiber, clothing, meat, live stock, wheat and Tobacco
Major Imports	Machinery and transport equipment, electric power machinery, food and livestock, metal and metal products, chemicals and chemical products, plastics, yarn, paper, wood

Key economic trends, policies and reforms

At the time of independence Syria had a relatively well developed economic foundation. Rapid economic growth began and was maintained since 1930 and lasting till late 1950s. Growth was based, primarily, on the availability of new land for cultivation, and financed largely by rich urban merchants, particularly from Aleppo. The new farms, which grew wheat, barley, and cotton as main crops, were larger ones, using mechanization and irrigation to its maximum. The limitations of land availability led to a decline in growth.

As a result of the varying sectoral growth rates, the economy gradually shifted from an agrarian-based structure prior to 1970 to an economy based on services and the commercial sector in the 1980s. In 1953, according to the World Bank figures, agriculture contributed nearly 40 percent of constant 1980 prices). Official Syrian government sources placed agriculture's share of GDP at 16.5 percent in 1984. From 1953 to 1976, industry, including extractive industries and electric power, increased from 10 to 22 percent of the GDP. In 1984, the industry contributed 15.1 percent of the GDP.

Construction, trade, and transportation retained approximately the same relative importance as they had up-till the mid-1976, government services contributed over one half of GDP share with an increase up to 61 percent, (Syrian official statistics).

Syria has its annual population growth rate at 2.4%, while its predominantly statistic economy in recent times is growing more slowly. Recent legislation allows private banks to operate in Syria. With sustained government cooperation the private banking sector would need years to develop. Keeping in view, certain factors like war between US-led coalition and Iraq might have driven back the real annual GDP growth levels below 1% in 2003, as compared to the previous growth levels of 3.5% and 4.5% in 2001 and 2002, respectively. The pressure on water supplies caused by rapid population growth, industrial expansion, and increased water pollution may place long-run economic constraints.

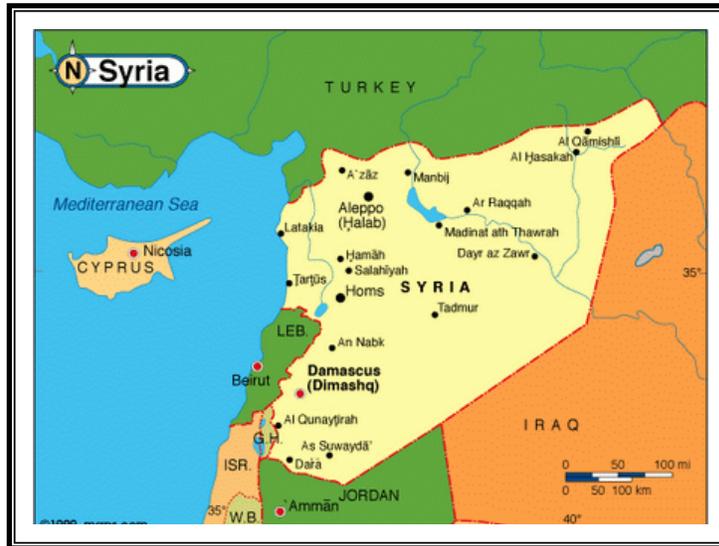
2.3 Geography and Climate

Starting from the Coast, to the Mountains to the Steppe and Desert, Syria is a land of great diversity. With 110 miles (180 kilometers) along the Mediterranean Sea, Syria has quite a short coastline. The coast lies between the Turkish province of Iskanderoun, and Lebanon. It includes both areas of Sandy shores and cliffs and rocky headlands. The coastal mountain range is also on the coastline. The coastal mountain range borders the coastal plain and runs from north to south. The mountains have an average width of 35 km, and their altitude declines from a modest 1729m in the north (east of Latakia) to 1602m at Jebel Aqra to 600m in the south, at the gap near Homs. Directly to the east of the mountains is the Ghab Depression, a 75km longitudinal trench that encompasses the valley of the Orontes River.

Anti-Lebanon mountain range is another mountain range is known as Jabal ash-Sharqi, which marks Syria's border with Lebanon. The main ridge rises to a maximum height of 8,625 feet near an-Nabk, while the average height is between 6,000 and 7,000 feet. Mt. Hermon (Jabal ash-Shaykh), Syria's highest point, rises to 9,232 feet (2,814 meters), although it is now under occupied territory in the Golan Heights. Smaller mountains are scattered about the country. Among these are Jabal ad-Duruz, which rises to 5,905 feet in the extreme south, and the Jabal Abu Rujmayn, which stretches towards northeast dimension across the central part of the country.

The Fertile Crescent: This semi circle of fertile land encompasses the Syrian Desert. This is the area where the crop growing process started, primarily. Starting from the Ghab depression it extends eastwards to create the most important geographical feature in Syria. With the addition of the Dam on the Euphrates, and modern irrigation this part of Syria is the area with the biggest production of cotton.

Map of Syria



The Syrian Desert: The reason behind Syria's undeveloped cultivation is the Syrian Desert, which comprises of 58% of the Syrian territory. These undulating plains, often called the steppe have a general elevation between 980 and 1,640 feet; they are seldom less than 820 feet above sea level. The area is not a sand desert but comprises of rock and gravel steppe; a mountainous region in the south-central area is known as al-Hamad, and the main oasis is situated at the foot of the Palmyrene mountains, which has very sulfurous water springs. The Climate here generally tends to be continental. The summer is long and extremely hot, while, the winter is short with severe cold winds.

2.4 Political/ Administrative Structure

Basic political /administrative structure and any recent reforms

Between the collapse of the Ottoman Empire in 1916 and promulgation of a permanent constitution in 1973, Syria adopted several constitutions, all reflecting an amalgam of West European (chiefly French), Arab, and Islamic political cultures. The governmental configuration is based on the Permanent Constitution of March 13, 1973. This charter is similar to the provisional constitution of May 1, 1969 (amended during February and June 1971). The Constitution provides republican form of government where it is called a democratic, popular, socialist and sovereign state "and stipulates that the people are the ultimate source of national sovereignty".

Among the principles expressed in the Constitution is the specification that;

- The president should be a Muslim
- The main source of legislation be Islamic fikh (doctrine and jurisprudence)

- The Baath Party is “the vanguard party in the society and the state”.
- In addition to this, the state is directed to safeguard the fundamental rights of its citizens enabling them to enjoy freedom, and, to participate in political, economic social and cultural walks of life established within the limits of the law. Free exercise of religious belief is guaranteed as long as such exercise does not affect the public order.

The Constitution's economic principles are set for a planned socialist economy, but also recognize three categories of the property. The three categories are;

- Property of the people including all natural resources
- Public domains nationalized enterprise
- Establishments created by the state, collective property, such as assets owned by popular and professional organizations; and private property

The powers exercised by the government are divided by the Constitution into executive, legislative, and judicial categories. The Constitution is noted for strengthening the already formidable role of the presidency; the framers of the Constitution were clearly more concerned with the supremacy and stability of presidential powers than with the issue of checks and balances among the three branches of government. Official concern for political and governmental stability is reflected in the relatively difficult procedures for amending the Constitution. A bill to the Constitution may be introduced by the president or one-third of the members of the People's Council (parliament), but its passage requires approval by a majority of three-fourths of the People's Council as well as by the president.

Key political events/reforms

Two major Syrian events took place in 2000, the nomination of a new government in April and decease of H.E. President of Syria Hafez Al-Assad. On July 2000 people had chosen President Bashar Al-Assad, created expectations of a significant change in the Syrian attitude to economic and political reform.

The policy agenda in the fields of political system, human rights and civil society remains extremely modest. Though a gradual opening towards political pluralism is probably envisaged, the political reform agenda currently appears to be put on hold. A special ministry is responsible for administrative reform. It has established reform until in key ministries and a comprehensive proposal for reform of public administration has been published.

3 HEALTH STATUS AND DEMOGRAPHICS

3.1 Health Status Indicators

Table 3-1 Indicators of Health status

Indicators	1990	1995	2000	2002	2004
Life Expectancy at Birth:	66.4	68.2	69.7	70.2	71.2
HALE:	-	58.0	59.0	59.8	61.3
Infant Mortality Rate:	37.0	30.0	24.0	18.1	-
Probability of dying before 5th birthday/1000:	44.0	36.0	29.0	20	-
Maternal Mortality Ratio:	123	107	71	65.4	-
Percent Normal birth weight babies:	93	95	95	95	95
Prevalence of stunting/wasting:	-	-	-	25.7	-

Table 3-2 Indicators of Health status by Gender and by urban rural

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	68.7	73.2
HALE:	-	-	58.0(01)	60.5(01)
Infant Mortality Rate:	18.3(00)	27.9(00)	19	16
Probability of dying before 5th birthday/1000:	16	22	22	18
Maternal Mortality Ratio:	51	80	-	65.4
Percent Normal birth weight babies:	-	-	98	94
Prevalence of stunting/wasting:	-	-	-	-

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality		Morbidity	
1.	Cardio-vascular	48.8	Digestive Diseases	16.8
2.	Tumors	9.2	Respiratory system	15.1
3.	Accidents	7.3	Cardio-vascular	11.7
4.	Respiratory system	6.4	Accidents	11.5
5.	Genitourinary diseases	3.5	Genitourinary diseases	7.5

Rank	Mortality		Morbidity	
	6.	Endocrine diseases	3.3	Blood Diseases
7.	Digestive Diseases	2.9	Infectious and Parasitic Diseases	5.2
8.	Nervous diseases	2.0	Musculoskeletal & connective tissue	3.4
9.	Congenital malformations	2.0	Tumors	3.0
10.	Infectious and Parasitic Diseases	1.7	The Eye and adnexa	2.9

Source: MoH Data

The health indicators of Syria show a steady progress over the years, especially the infant mortality rate, mortality under five years, maternal mortality rate and life expectancy. It can be a contribution of the current health programs, initiated in last 15 years.

3.2 Demography

Table 3-4 Demographic indicators

Indicators	1990	1995	2000	2002	2004
Crude Birth Rate:	37.0	30.9	29.0	28.8	26.8
Crude Death Rate:	6.1	5.1	4.5	4.4	3.4
Population Growth Rate:	3.3	3.1	2.4	2.3	2.5
Dependency Ratio:	1.0	0.9	0.7	0.7	0.7
%population <15 years	47.8	44.8	40.7	38.9	39.6
Total Fertility Rate:	5.3	4.2	3.5	3.4	3.8

Table 3-5 Demographic indicators by Gender and Urban rural

Indicators	Urban	Rural	Male	Female
Crude Birth Rate:	-	-	4	2.5
Crude Death Rate:	-	-	5	-
Population Growth Rate:	-	-	-	-
Dependency Ratio:	-	-	-	-
% Population <15 years	31.6	28.8	30.7	29.6
Total Fertility Rate:	3.4	4.4	-	3.8

Demographic patterns and trends

Syria is one of the most densely populated countries in the Middle East and in 2000 had an overall average population density of approximately 92 persons per square kilometers. There are considerable regional variations. The population growth rate has been estimated around 3 % per year, offsetting much of economic growth. The recent figures indicate a demographic transition, with the rates falling to 2.5 – 2.7 %. It will take 20 years further before this has effect on the labor output.

At present, more than 40 % of the population is less than 15 years by age. Widespread unemployment and under-employment have emerged, as well as a structural flow of “brain-drain” emigration of skilled labor. Overall unemployment is around 12 %; official sources indicate that the unemployment rate among those aged 15 to 24 may have gone beyond 70 % in 1999. In 1999, an estimated 1.5 million Syrian national were working abroad, providing a major social safety net and supplementary livelihoods to Syrian residing in Syria.

An estimated 85 percent of the population adheres to some form of Islam. 10 percent of the population observes some form of Christianity. Urbanization is progressing at a rapid rate. The explosive urban growth of the 1960s had tapered off by 1980s. Rural to urban migration, the lower mortality rates of urban groups, and the influx of refugees contributed to precipitous growth in the major cities. However, the administrative incorporation of rural areas adjacent to some urban centers has inflated some growth figures. Between 1960 and 1970, Syrian's urban population increased by between 50 and 57 percent. The period between 1970 and 1980, cities grew by approximately 40 percent. In 2000, an estimated 50 percent of the population lived in urban areas. Although nearly one in four Syrian citizens lived in either Damascus or Aleppo, a significant part of the urban population was distributed relatively evenly among a half dozen other major cities.

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

Outline of the evolution of the Health Care System

Constitution mentioned that all kind of health services and social care especially item 46 and 47 are under the responsibility of the Government of Syria to all people, for that until 1998 all Kind of health treatment free of charge after that some hospitals started to be autonomous hospitals. Most of the information and reference in Syria is related to year 1970. For that purpose all the health data gives a comparison between 1970 and 2002, 2004 or any other year.

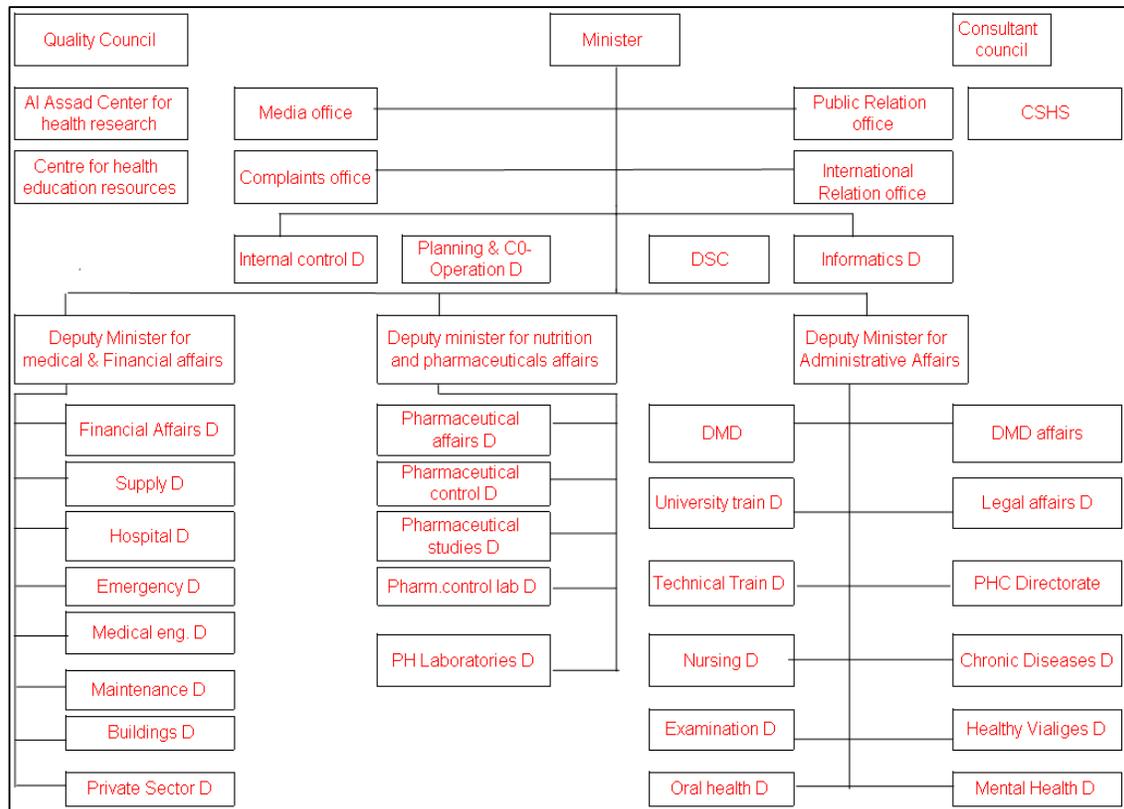
The information collected and analyzed reveals the complexity of the Syrian health sector. The core characteristics of the sector are given as under:

- A substantial improvement in summary health indicators and life expectancy
- Diseases profile expressing the magnitude of chronic diseases and existing risk of communicable diseases
- A widespread, generally under equipped but well staffed free public offer of care with areas of high technology available in the main cities
- The presence of a well established private sector working in integration with the public sector is performing below the targeted mark
- A well established move towards modernization of the public health sector (reorganization of the MOH, autonomy of public hospitals, development of public health care)
- The existence of various schemes of health insurance covering selected categories of the public and private employment

The Constitution of Syria defines the right of all the population units for comprehensive health coverage. The organizational structure of the statutory health system furnishes the responsibility of provision of coordinating and managing health services to the Ministry of Health. Added responsibilities for financing, administrating and providing health services are prearranged to the following bodies: Ministry of Finance (MoF), Ministry of Local Administration (MoLA), State and Planning Commission (SPC), Ministry of Higher Education (MoHE), Ministry of Social Affairs and Labour (MoSAL) and Ministry of Defence (MoD). Additionally, the other Ministries state companies and majority of the professional associations provide health care services for their employees as well as to the dependents upon them, directly and indirectly. The role played by the private sector for delivering health care services has substantially increased, in recent times.

4.2 Public Health Care System

Organizational structure of public system



The health system is based on primary health care. It is delivered at three levels: Village, district and provincial. The organogram is mentioned as under:

- At village level, there are rural health centers and health units.
- At district level, there are larger health centers including training facilities and specialized physicians. District health centers are staffed with at least one physician, one nurse, one public health technicians, obstetricians, pharmacy technicians, laboratory technicians, midwives and health visitors. On average, there are 10 health workers per district health center. A small district general hospital number of bed 50 also exists in each district.
- At provincial level, there are urban health centers staffed with specialized physicians and dentists in addition to various technicians, family planning services, control and prevention of communicable diseases, environmental control, preventive care for chronic non-communicable diseases, and health education. At the provincial level, there are also large general hospitals and specialized hospitals. At the national level, there is a network of ambulance, blood bank and drug distribution services.

In order to decentralize health care delivery process a district health system was introduced in 1990. Each health directorate was allocated with its own budget provided by the Ministry of local affairs. An enough authority was given with certain flexibility to implement the programs within the scope of present development strategy.

Key organizational changes over last 5 years in the public system, and consequences

The organizational chart of the MOH has been approved by the Government. The new chart shows a functional structure of the central level of the MOH, based on main regulatory functions. Boards and committees are meant to address various issues such as quality management, regulation of private sector, health insurance, accreditation, etc. This organization aims to overcome the constraint of the excessive specialization of the directorates who often are in charge of particular aspects of the same issue (e.g.: human resources). In this chart "regulation", which belongs to boards and committees, is clearly separated from "administration", which is a task of directorates.

The organizational structure drives the mobilization of the agent (defined by qualification and position in the statutory grid) to a post (defined by tasks and duties). At this level recruitments match agents with posts. At this level also, training, basic or in-service, intervenes to qualify an agent for a given post. Defining training needs and programs demands the preliminary design of organizational structures with operational specificity in the description of the various posts.

Hospitals independent unit Financially & Administrative: the new orientation and priority objective of the Ministry of health to transfer all hospitals gradually in to independent unit. This unit would have its own budget; flexible management and participation from the local community included in its board. For that purpose, established 9 central hospitals with the objective of moving towards partial cost recovery and participatory management to improve the performance of the hospitals

Accreditation, being essentially a regulatory tool, is usually a service provided by autonomous and impartial agencies. MOH should lead the definition of the national framework for accreditation; the role of "accrediting agency" should be given to an independent commission. Developing quality system and national accreditation framework would be a priority of the MOH.

Under the supervision of the National Committee for Quality ISO certification is provided by several private companies to some public and many private hospitals. The legal framework for licensing and the operational framework for ISO certification should be evaluated. Accounting for the existence of to improve the certification framework and to foster accreditation independent mutual health insurance schemes in which employers' contract with providers for a given set of services Syria seems to be the most urgent issue.

Any planned organizational reforms in the public system

With the help of European commission (2002 to 2009), a big project termed as health sector modernization program will lend a hand to the health sector in Syria in 6 areas:

Policy and planning in central and regional

Health care delivery

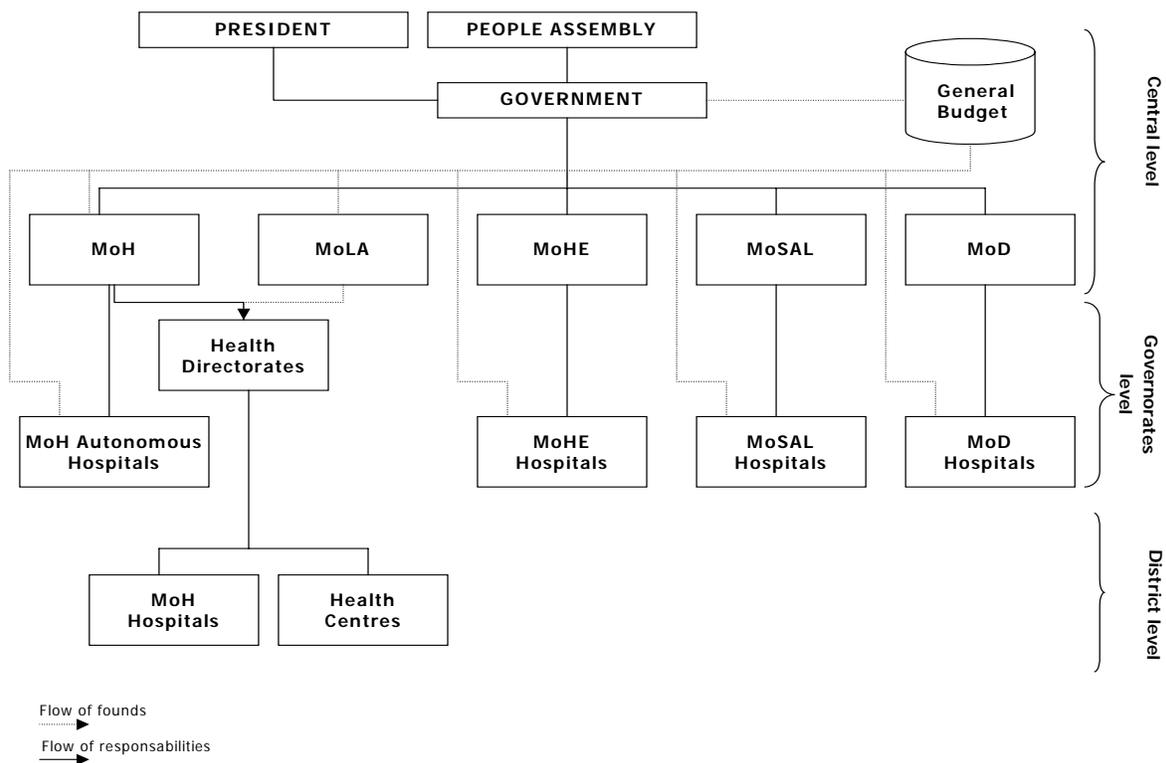
1. Improve the performances of the hospitals
2. Improve the management of health sector
3. Quality of health services (accreditation)
4. Health financing.

4.3 Private Health Care System

Doctors working in the public sector are allowed to have their own practices in the private sector.

4.4 Overall Health Care System

Organization of health care structures



The health care delivery system in Syria is represented by the role played by a mix of public and private sectors providers:

1. Public service providers funded by the government budget are managed by the MOH, MOHE, MOD and MOSAL. The Ministry of Health is the prime health services provider, employing about 71.500 staff and operating in 67 hospitals (including specialist hospitals) with a total of 11.155 beds, and running 1.534 health centers as well as the medical points for primary and preventive care. The other parallel public sector system comprises of one hospital of the MOSAL, some hospitals run by the MOD, 12 university hospitals managed by the MOHE;
2. Private providers offer a wide range of ambulatory and secondary health care services in 376 small hospitals (6795 beds), more than 12.000 pharmacies and clinics.

Brief description of current overall structure

The Syrian health care system is a mix of private and public provision.

The government is working to ensure availability of services in urban as well as in rural areas. Although most of the villages in Syria have a government clinic or health center, rural areas have smaller number doctors and clinics. Doctors who have finished medical school and who do not intend to specialize are obliged to practice in rural areas for at least two years, usually through a government health center. The same is obligatory from the dentists and pharmacists. Since government salaries for doctors are quite low. They are allowed to set a private practice, while working in a government health center, also.

Services are offered free of cost to all the citizens at government clinics and health centers. Government employees and their dependents can also fully or partly reimburse their charges / claims incurred during private health care and medication. Some Syrians prefer to pay for high-quality private services, rather than using free public services.

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

National health policy, and trends in stated priorities

The MOH Strategy for health development has the following components:

1. PHC is seen as the key component
2. Promotion and development of secondary and tertiary services in line with needs (general hospitals).
3. An equitable and accessible distribution of health services, taking in account every citizen's right to receive care in agreement with the Syrian norms.

Implementing these three components requires:

- Development and promotion of health human resource.
- Development of training programs for health human resource.
- Provision of adequate financing.
- Provision of appropriate equipment.
- Promotion of emergency care and formulation of a national emergency plan.
- Development and promotion of performance, through raising sense of responsibility and encouraging a positive attitude to information technology and systems that allow enhancing quality control and reducing unnecessary bureaucracy.
- Conduct medical, pharmaceutical, engineering and management researches in order to contribute to solving current health problems.
- Continue upgrading of the national pharmaceutical industry and adopting proper methods to promote drug quality control, which will ensure an improvement in the quality of the products and increased use of locally available raw materials.
- Promotion of methods of communications with citizens in terms of good treatment and upgrading and developing health information (i.e. through the media), including health education which is reliable and which serves to activate and encourage the role of the citizen to participate in the maintenance and care of equipment as well as public health building.
- Consider the health sector as a development sector and not as a consuming and commercial services sector, including the promotion of human development initiatives such as Healthy Villages.

Commitment to these components requires a review of the current health legislations in order to develop and upgrade health regulation to enhance the role of the MOH and improve inter sectoral cooperation between the partners in health.

There are no formal research programs or links in any of the hospitals. The Ministry of Health, however, encourages research in medical fields. There is an annual prize, Al-Basel Prize, for research in different medical fields.

Formal policy and planning structures, and scope of responsibilities

The mechanism of health policy setting is the responsibility of the government and the party at the central level. The written health policy is consistent with the socio-economic policy. However, the implementation of this policy is not satisfactory because of poor managerial skills and lack of well qualified health human resource.

Health planning takes place at the central as well as regional level /s. Especially for next five year plan 2006-2010, State planning commission has asked all the ministries and governorates in Syria to initiate preparation of the tenth five year plan ordered in the following steps:

1. Situation analysis 1993 – 2003.
2. Points of Strengths and weaknesses of the health sector.
3. Expectation of health indicators at the end of year 2010.
4. Challenges of health in the next five year.
5. View of health sector.
6. Projects and programs in the next five year plan

Each governorate has established planning committees headed by governor include members (director of planning – director of health in the governorate – Director of education, director of agriculture ...etc)

These committees prepare all the projects and sending it to the ministries.

At the same time committee established in each ministry headed by Minister

It would include members (deputies' minister – directors –etc.)

To evaluate projects to achieve the health goals the following steps are needed:

1. Decreasing the prevalence of non-communicable diseases
2. Decreasing maternal mortality rate

The national government with the support from the local governorate health directorate is the supervising authority for the management of the hospital. The Government does not interfere with the management of non-governmental hospital. Local communities are not involved in the governance of local hospitals. In general, each hospital serves a defined geographical area. This is not always true because patients can turn into any civilian hospital, whether private or public, in whole of the country.

Analysis of plans

If we have an abstract look on health sector, we can appreciate that there is no clear identity for this sector. Until now, no kind of health insurance is offered to the people of Syria, nevertheless, most of health services still free of charge. At the same time weakness cooperation between ministries to give the health services, In addition to this, the role of private sector is yet not clear.

The strengths and weaknesses in the health sector are summarized as follows:

Strengths:

- Enough number of health workers and institutions that cover all the governorates of Syria.
- Inexpensive medical procedures and fee /charges rather in comparison with the same scenario in the neighboring countries.

- Improvement of health indicators

Weaknesses:

- There is no same reference for the health sector (Ministry of health – Ministry of higher education, Ministry of Defense, Ministry of social affairs ...etc)
- There is no clear health policy sponsored by the government of Syria.
- There are no full time public employees
- Lack of resources allocated for the health provided by the government.
- There is no clear participation of private sector.
- Inequitable distribution of health institutions and health workers by the same governorate and among the governorates.

Key legal and other regulatory instruments and bodies: operation and any recent changes

President Assad issued the Laws No 24, 25, 26 and 27 which provide for establishing a number of Autonomous hospitals in different governorates in Syria. According to the provisions of the said laws, the hospitals enjoy legal personality and financial and administrative independence, and are directly linked to the MOH. These hospitals aim to render different medical and treatment aid, to ensure training for physicians, residents, students of intermediate institutes and nursing schools. It is to carry out medical research in different areas and specialties. Syrian President Bashar Al-Assad issued decree no 88, which gives a provision for ratifying the cooperation agreement on health and medical sciences co-signed by Syria and Morocco.

5.2 Decentralization: Key characteristics of principal types

Information not available

5.3 Health Information Systems**Organization, reporting relationships, timeliness**

During the last two years, the MOH has undertaken an enormous effort to boost all aspects of health information systems and has invested a considerable amount of money for equipment and human resource development. Moreover, software development for data collection and analysis as well as introduction of new program module is another initiative.

Data availability and access

Data collection activity from private hospitals is done regularly. The private sector is obliged to report monthly, private clinics or otherwise they may face sanctions, if they do not obey. Some evaluation of the quality of data and collection methods has been made, also.

5.4 Health Systems Research

Information not available

5.5 Accountability Mechanisms

Information not available

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Table 6-1 Health Expenditure

Indicators	2000	2002	2003	2004
Total health expenditure/capita,	64.00	62.00	62.10	61.18
Total health expenditure as % of GDP	5.40	5.50	5.18	5.5
Investment Expenditure on Health	25%	26%	30%	28%
Public sector % of total health expenditure	47.2	49.1	50	49

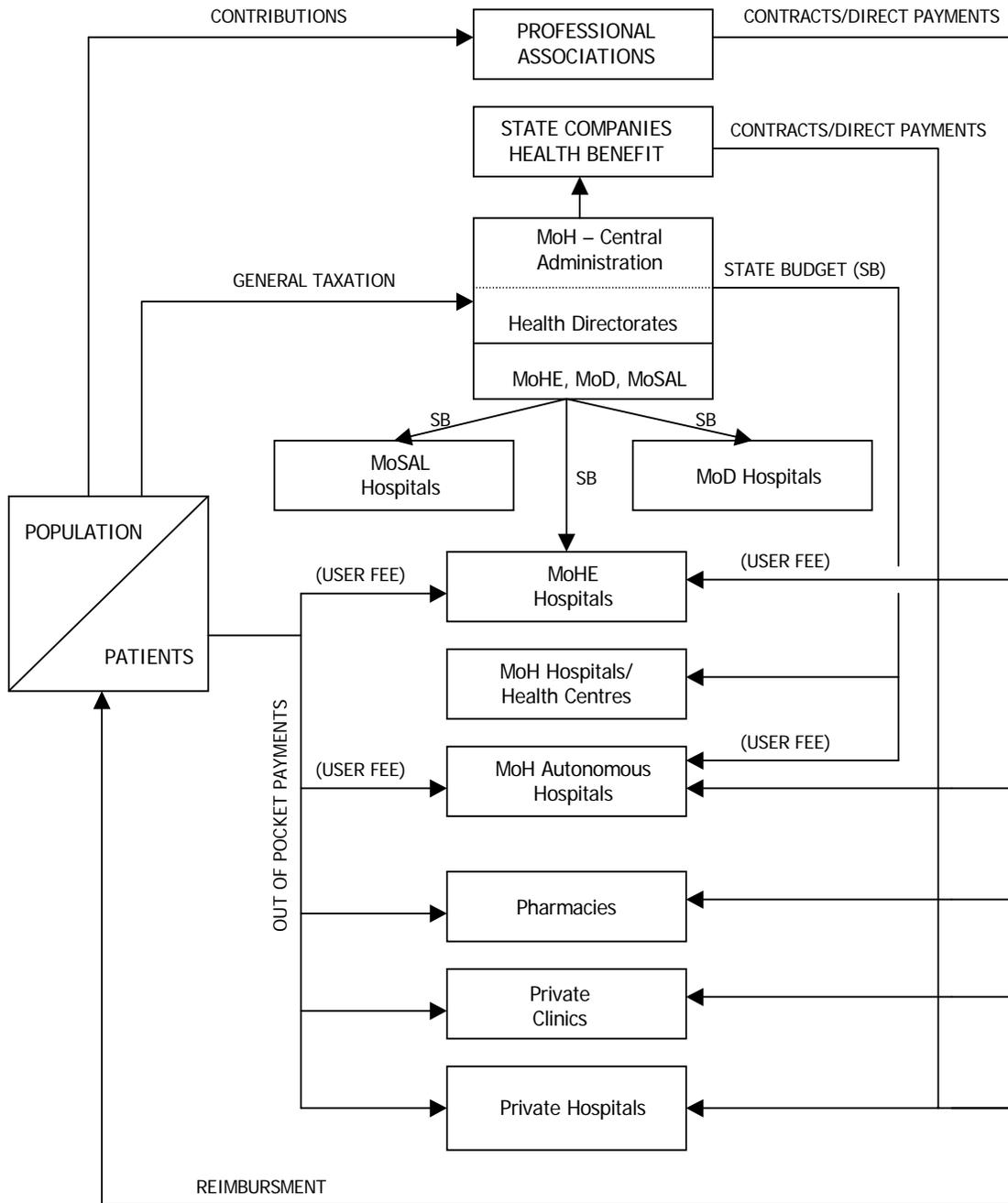
Table 6-2 Sources of finance, by percent

Source	1990	2000	2002	2003	2004
General Government	NA	47.2	49.1	50	49
Central/ State/ Provincial	NA	16	14	14	12
Local/ Social security	NA	31.2	35.1	36	37
Social Security	0	0	0	0	0
*External sources	NA	0.8	1%	1%	2 %
Private	NA	52.7	50.1	50	51
Private social insurance	0	0	0	0	0
Other private insurance	0	0	0	0	0
Out of pocket	NA	52.7	50.1	50	49
Non profit institutions	NA	NA	NA	NA	2%
Private firms and corporations	0	0	0	0	0

*Central Bureau of statistics Syria – JICA Office in Syria – European Investment Bank

Trends in financing sources

The financing flowchart is opened in the figure. In general, there are three major types of financing agents: the public sector, the professional associations and the households. The public sector refers to the expenditures of various ministries, and it includes expenditures of owned state companies. In terms of the primary sources of funding, the public sector is mainly funded by the state budget through general taxes, while professional associations are funded by private funding (employees/workers).



The first pathway of funding consists of MOF funding, which goes principally to other ministries (MOH, MOHE, MOD, and MOSAL) and state companies, which in turn transfer the money to government providers for the care.

The second major pathway consists of direct household funding. The greater part of the household funding passes directly to private sector health care providers (private clinics, hospitals and pharmacies) without any financial intermediation, and for a more or lesser extent to the public sector by paying user fee / charges. Private insurance is not available in Syria. However it was reported that not many individual households are insured with Lebanese commercial insurance company.

The third pathway consists of professional associations. A proportion of households funds, not yet identified, pass to the professional associations, which in turn finance mostly private providers. In some specific cases they also finance services provided by it (usually primary health services).

Health expenditures by category

Table 6-3 Health Expenditures by Category

Expenditure	2002	2003	2004
Total expenditure: (public- private- donors)	41.500 billion S.P	47.500 billion S.P	54.500 billion S.P
% capital expenditure		62.10	61.18
% by type of service			
Public health	5.1	5.1	5.1
Outpatient care	20.0	17.9	15.9
Inpatient care	34.8	36	37
Drugs	37.6	38	38
Long term/ Rehabilitative care	2.5	3	4
% by item			
Staff costs	30	31	32
Drugs and supplies	37	38	38
Other	33	31	30

Source: Situation analysis done by State planning Commission, MOH, European Experts 2005

Trends in health expenditures by category: commentary

Activities and services provided by MOH facilities are financed by two sources: the budget from the MOH (centrally managed) and the budget from Ministry of Local Affairs (which is de-concentrated in Governorates. Its utilization is done under Governors' supervision).

MOH budget has five chapters for five categories of expenditures:

1. Salaries (existing and new posts)
2. Maintenance of relevant bio-medical equipments and drugs for the national public health programs
3. Biomedical equipments (for public hospital and health centers) and training
4. Different expenses for participation in the WHO board, Arab League Board, publications, etc.
5. Inter-departmental debt (which is always nil).

Ministry of Local Affairs through budgets of the Governorates covers three categories of expenditures:

- i) Constructions and rehabilitations

- ii) Non biomedical equipments for hospitals and health centers
- iii) Drugs other than those for national public health programs

Budgeting is initiated at the beginning of June with the receipt of the note issued by the MOF. A Cabinet note of instructions may precede the MOF note. Discussions on proposed expenditures are run separately. The MOH holds discussions with the Ministry of Finance (MOF) for the expenditures on chapters I, II, IV, and V on the budget for MOH; Chapter IV is discussed with the State Planning Committee (SPC). The Governorates discuss with the Ministry of Local Affairs and the MOF on civil works. MOH and Health Governorates concert at some time.

Ministry of Local Affairs participates to discussions between MOH and SPC. Nevertheless, these actors never meet all together during the preparation of the budget. The SPC is the main regulator of major investments. It supervises multi annual programs of investment. MOF is the regulator of running expenditures. Reallocations may intervene during the year at central and governorate level.

Interpreting strategically the budget of MOH, the MOH funds are meant to provide staff, equipment, maintenance, training and public health programs.

6.2 Tax-based Financing

Levels of contribution, trends, population coverage, entitlement

On health care 43-50% of the total expenditure is directly from derived from the government budget. The health care services are technically "free" at the public facilities in Syria.

The sources of public health financing in SAR are mainly a combination of oil revenues and general tax revenues. Tax revenues are progressive from 10% to 45% for societies, and, from 5% to 15.5% for personal income. However, few data are available concerning how progressive is the health financing system in respect of income. Nonetheless, it has been reported that 60% of the economy does not contribute to income tax, and that private sector companies are evading high profit taxes. To drain resources from elusion and evasion toward the health sector may represent a double opportunity for the government as a larger income and profit basis will increase the source of public financing.

Key issues and concerns

In this framework, a policy of general tax reduction would hamper the chance to promote a fairer financing. Health inequalities will increase. The rich will be in receipt of far good health services with their own spending. The poor will cope with less health care than before. On the contrary, a fair health financing requires a larger and progressive taxable income to protect everyone's health. Economic constraints limit the possibility of huge increases in tax collection and thus in public expenditure through this source. However, it is important to highlight that the experience of upper income countries shows that reasonable standards in terms of equity and quality of services require increasing amount of public funding. As a consequence, this scenario would rely on the government commitment to give high priority to public health funding and to show its value in terms of health improvement, reasonable equity and social cohesion.

As an alternative source, financing health care may also be considered as the possibility of earmarked taxation for health.

6.3 Insurance

Table 6-4 Population coverage by source

Source of Coverage	1990	1995	2000	2002
Social Insurance	-	-	-	-
Other Private Insurance	-	-	-	-
Out of Pocket	-	-	-	-
Private firms and corporations	-	-	-	-
Government	-	-	-	-
Uninsured/Uncovered	-	-	-	-

Trends in insurance coverage

The health care system in Syria is financed through government budget and the rest would be drawn, primarily from out of pocket expenditure. There are no large scale social or private insurance programs working.

6.4 Out-of-Pocket Payments

There are two main types of out-of-pocket payments made in Syria. The first and most relevant one is direct payment by the users to purchase private health care services and the drugs. The second one is demand-side cost-sharing: a co-payment for diagnostic procedures, outpatient visits and inpatient services that are becoming more and more important both in the MOH and MOHE, the providers units.

The first results of the private health expenditure survey conducted in 2002 revealed that the Syrians spend, on average about SP 1.605 per capita per year. It makes a total amount of SP 27, 5 Pillion. The majority of the out of pocket payment is used to purchase private physician's clinics services and drugs, while a smaller amount is spent on private hospitals. Considering the average amount of out of pocket payments per year, more than 50% of the households spend less than SP 1.200; almost 19% spend more than SP 3.000, of which 10% spent more than SP 4.600.

(Direct Payments) Private sector user fees: scope, scale, type of provider involved, issues and concerns

For the private hospital, 90% of the revenues are acquired from patient co-payments. The remaining 10% derived from donations. For the Red Crescent Hospital, 60% of the revenues come from patient co-payments, 30% approach from grants and donations, and 10% arrive from lab and pharmacy revenues. Private and NGO hospitals collect invoices directly. The usual mode of payment is through cash in Syria.

Fee for services provided are known in advance in NGO and private hospitals. The private hospitals do not provide free of charge services. The NGO hospitals provide free of charges services to the children and poor families.

Public sector informal payments: scope, scale, issues and concerns

The current capacity and practices of management of public health expenditures will be analyzed through a public expenditure review activity. The review will be run by the National Health Accounts Team with the support of external resources. The results will be of the sequence mentioned as follows:

- A description and analysis of the practices of the legal and institutional framework, the budget process, budgetary procedures in force including procurement rules and on-going reforms
- An analysis of financial flows within the health sector, with a spotlight on the social sectors and constraints affecting budget programming and budget implementation (for deciding what type of methods of financing to implement (as per above)
- An analysis and assessment of monitoring and reporting methods, as well as the internal and external control mechanisms of the budgetary process
- Selection of key indicators for recognition of budget effectiveness and efficiency

The assessment of how well public expenditure is managed. It will include analysis of the existing situation and the prospects for improvement. Indicators must be specific by means of which progresses can be measured.

Population sample:	44.138	
Not valid answer (15,8%):	6.967	
Projected Total private health expenditure (in SP):	27.493.650.000	
Estimated average private health expenditure per person per year (in SP):	1.605	
<i>Results to the question: "Which type of services do you pay for?"</i>		
Type of services	% Yes	% No
Private clinics (ambulatory)	72,20%	27,80%
Drugs	70,50%	29,50%
Public Health Centres	45,50%	54,50%
Public Hospitals	31,20%	68,80%
Private Hospitals	17,40%	82,60%
Outside Syria	0,50%	99,50%
<i>Results to the question: "How much do you spend for health care?"</i>		
Range (in Syrian Pounds)	%	Cum. %
0	20,10%	
1-200	3,90%	24,00%
201-600	12,10%	36,10%
601-1200	16,20%	52,30%
1201-1800	12,80%	65,10%
1801-2400	9,00%	74,10%
2401-3000	7,20%	81,30%
3001-3600	4,60%	85,90%
3601-4000	2,00%	87,90%
4001-4600	2,30%	90,20%
4600 and over	9,80%	100,00%

The initial assessment will designate whether there is any need for additional work in the course of the program, especially in terms of diagnostic work, detailed work and measurement of progress.

Cost Sharing

In 1996, a community development project (Healthy Villages), was established. This project aims at mainly for strengthening and preparing the community to achieve its tasks.

The communities in the selected villages recognize their Needs, spotting the problem priorities and planning or conducting Specific programs to solve these problems (healthy, social, educational) etc.

This project depends mainly on the community who manages the Project through (Village Development Committee) and financing. The major areas covered by this project are PHC, basic education, healthy housing improving; income, safe food, safe water and sanitation. This experience started in 1996 in three governorates (a village in each governorate) as an initial phase. In 1997, the expansion phase started to cover all governorates (2-3 villages in each). This community-based developmental program, developed in affiliation with WHO and UNICEF, and in collaboration with the Ministries of Education and Municipalities, is managed by the community. This program aims to assure a sustainable development for the community and to assist the population to identify the felt and actual problems it faces and setting the priorities for action.

6.5 External Sources of Finance

Levels, forms, channels, use and trends

In the last few years' different programs in cooperation with bilateral and multilateral donor agencies have started in Syria. The biggest one is the "Health Sector Modernization Program" run by the EU in affiliation with the following:

1. **WHO** (42 health programs, Establishment of School for Public Health (1989)
 - Establishment of Center of Health Systems Management (1997)
2. **UNDP** (Goal setting for health sector (National Millennium Goals), Human development report, AIDS, Healthy Village program
3. **UNICEF**: study on use of iodine salt, Mother and Child health care, Vaccination
4. **UNFPA**: Supporting family planning.
5. **UNAIDS**: AIDS.
6. **EC**: Health Sector Modernisation Program (2004-2007), 30 Mio EURO
7. **EIB**: Loan for equipment of 17 MOH hospitals (each 120 to 200 beds), 100 Mio
8. **Syrian Arab Red Crescent (SARC)**: Humanitarian activities
9. **Greece**: Support of the Brucellosis Program.
10. **Italy (Italian Cooperation)**: Center for specialized nurses. Hospital equipment for Al-Marra Hospital in Idleb Governorate, 7 Mio US\$
11. **Japan (JICA)**:
 - Some hospital equipment for the Damascus Hospital
 - Hospital equipment for Al-Golan Hospital, 4.3 Mio US\$
 - Support of the emergency system (delivery of ambulances with radio communication system)

- Community based primary care (including Family Planning) in North East Aleppo.
12. Cooperation with **international institutions, universities and NGOs:**
- **Aga Khan:** Training Nursing program in the hospital sector, standards for hospital nursing, training of nurses, support of the Red Crescent Hospital. Management of some new 200 beds hospitals in Syria
 - **University of Liverpool:** support of the Center of Health System Management

6.6 Provider Payment Mechanisms

Hospital payment: methods and recent changes; consequences and current key issues/concerns

National and local authorities together decided and chalked out the priorities of the hospitals. It is difficult to understand these priorities because of the intermingling of the authorities between the governorate health directorate and the Ministry of health.

Revenue for public hospitals is drawn from the central government and the municipal authorities, together. The financial relations are difficult to understand. These revenues come as block grants from the government. There is no established procedure for reviewing the basis for revenue calculation from public sources. There are no incentives for good financial performance.

In public hospitals, there is no real budgeting. The governorate and the health directorate prepare its budget as one lump sum for all its hospitals and health centers and other operating units. There are no separated budgets for hospitals.

While drafting the budget there are no established procedures for consultation with operational departments within the hospital. Therefore, the budgetary process is not linked with departmental goals. Services are provided free of charges. Consequently, no revenues are collected. No reviews are made for the revenues and expenditure. Public hospitals cannot borrow. Private and NGO hospitals can, at least theoretically, borrow from banks.

The board of directors is responsible for preparing the annual budget in NGO and private hospitals dimension. For NGO and private hospitals, the financial staff prepares the budgets after consulting different departments. The board of directors approves the budget. The board of directors of each hospital sets the priorities. Again, there are no incentives for good financial performance, nor, there are sanctions against poor financial performance.

Payment to health care personnel: methods and any recent changes; consequences and current issues/concerns

Public sector workers are paid a monthly salary as per national pay scale in correspondence with the qualifications, degree of management responsibility and years of experience. The salary does not depend upon quality, quantity, type of service or number of patients treated. There are no clear financial incentives for health workers to increase productivity and possibility to provide cost-effective treatments. Payment methods are, however, in the process of being changed.

Nine new autonomous hospitals in the MOH will introduce specific incentives related to type and quantity of services performed. The very low salary level for the health care professionals is one of the biggest concerns of the Ministry of Health, and the majority of

physicians supplement their salary by working in private clinics and hospitals (dual practice).

In addition to that MOH and MOHE submitted a new law to the parliament in the last nine months ago to give 200% of the existing salaries to the health workers. They will work only in public sector.

7 HUMAN RESOURCES

7.1 Human resources availability and creation

Table 7-1 Health care personnel

Personnel per 100,000 population	1990	1995	2000	2002	2004
Physicians	144	146	137	108	96
Dentists	85	85	68	57	32
Pharmacists	71	59	54	42	30
Nurses and midwives	159	165	196	164	137
Paramedical staff	85	85	74	66	32
Community Health Workers	NA	NA	NA	NA	NA
Others (Administrative)	110	101	89	73	66

Trends in skill mix, turnover and distribution and key current human resource issues and concerns

While the public employment in the health sector is ruled by the General Statute of the Civil Service (1974) and there is no specific legal status for the health personnel, the Syrian health sector is becoming more and more diversified and complex in terms of services provided, actors and demand.

Quantity and quality of health professionals is not yet a subject for planning with a long-term view. The introduction of new forms of financing or the regulation of hospital autonomy and of private sector needs a sum of competences in many different fields.

Table 7-2 Human Resource Training Institutions for Health

Type of Institution	Current		Planned		
	Number of Institutions	Capacity	Number of Institutions	Capacity	Target Year
Medical Schools	4	1235	3	600	2006-07
Postgraduate training Institutions	7	230	-	-	-
Schools of Dentistry	4	703	3	300	2006-07
Schools of Pharmacy	3	655		200	2006-07
Nursing Schools	17	800	1	110	2006-07
Midwifery Schools	17	120	-	-	-
Paramedical Training	6	974	-	-	-

Type of Institution	Current		Planned		
	Number of Institutions	Capacity	Number of Institutions	Capacity	Target Year
Institutes					
Schools of Public Health	1	30	-	-	-

*Capacity is the annual number of graduates from these institutions.

The Syrian Arab republic has four public Faculties of Medicine and Dentistry, and three Faculties of pharmacy, University of Damascus, Aleppo University, University of Tishreen in Latakia and Al Baath University in Hama. In addition to two private Faculties of Medicine in rural area of Damascus and Tartous. Nursing schools have been established in all the governorates of Syria. In addition to 4 schools in four governorates Damascus, Deir El Zour, Homs, Tartous, Al – Hasakee- and Aleppo, where the universities, and paramedical educational institutions have been established.

Accreditation, Registration Mechanisms for HR Institutions

Until now, no kind of Accreditation or some mechanism is available in the MOHE for universities or faculties; rather a new law started in 2001 to have private universities in Syria. It will enhance a need to have a special body in Syria to evaluate the situation in the universities and will give accreditation.

7.2 Human resources policy and reforms over last 10 years

In the last ten years there has been a significant rise in the number of doctors, dentists, pharmacists, nurses and midwives. The greatest rise has been in the number of doctors, creating an imbalance between different kinds of staff in the health sector. From 2002 to 2004 physicians number rises by 14%, but the majority of them have chosen high degree for specialization (+26%), while general practitioner increased only by 4.5%. This situation has helped to the growth of the private sector, without addressing the needs of the primary care sector. The numbers indicate 1, 4 physicians and 2, 0 nurses and midwives per 1000 persons, respectively.

Theoretically, legislation requires full time employment for physicians and paramedics in public health sector, however part-time private practice by most physicians and nurses is widely and openly practiced.

In 2001, several departments were instituted to respond to the needs to develop human resources for health, at the following levels:

- University _ for physicians, Dentists and pharmacists
- Technology- For the graduates of the Health Institutes
- Technical - For the preparedness of Nurses and Midwives
- Health manpower planning unites a planning, advisory unit for health human resource development and training.
- Management Development- for quality assurance and control of health systems
- Examinations and Testing units to develop assess measures and conduct examinations.

7.3 Planned reforms

- 1- Establishment of the **Center for Strategic Health Studies (CSHS)** with three main tasks: an advisory role towards the MOH, training and teaching, and a research function. The following four Centers will be established within the CSHS:
 - Center for Population and Demographic
 - Center for Health System Management
 - Center for Health Economics
 - Institute for Public Health.
- 2- Establishment of special body under the prime minister call

The Syrian Commission of Medical specializations and its responsibility are:

- Setup standards for training and the trainers.
- Setup specifications of the training centers.
- Establishment of specialized committee to accredit centers and hospitals.

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

Table 8-1 Service Delivery Data and Trends

TOTAL (percentages)	1995	2000	2002	2004
Population with access to health services	96	99	99	99
Married women (15-49) using contraceptives	42	45.8	45.8	46.4
Pregnant women attended by trained personnel	78	86	87	-
Deliveries attended by trained personnel	90	-	-	-
Infants attended by trained personnel	96	96	98	98
Infants immunized with BCG	100	100	100	100
Infants immunized with DPT3	98	97	97	100
Infants immunized with Hepatitis B3	88	93	93	98
Infants fully immunized (measles)	93	93	93	100
Population with access to safe drinking water	79.5	82	82	82
Population with adequate excreta disposal facilities	52	71.8	81	81

URBAN (percentages)	1990	1995	2000	2002
Population with access to health services	90	97	99	99
Married women (15-49) using contraceptives	-	52.8	-	-
Pregnant women attended by trained personnel	-	91	-	-
Deliveries attended by trained personnel	-	96	99	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	100	-	-
Population with adequate excreta disposal facilities	-	-	-	-

RURAL (percentages)	1990	1995	2000	2002
Population with access to health services	-	88	95	-
Married women (15-49) using contraceptives	-	-	-	38.1
Pregnant women attended by trained personnel	-	83	97	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	30	-	-
Population with adequate excreta disposal facilities	-	-	-	-

Access and coverage:

Access to primary care:

The access to PHC services is good with more than 95% of the rural population having access to health center. There were 1534 PHC centers reported in 2005. Currently, there is approximately one PHC Center available for 12.100 inhabitants.

Public health centers are well accessible and a good number of staff is present in both public hospitals and health centers. The PHC network is really a remarkable strength of the MOH. There is a great potential for Public health programs and especially vaccination are nationally available, but need to be more strengthened to cover new risks, such as cancer, diabetes, cardiac diseases and provide basic curative care through PHC network.

Access to secondary care:

The access to secondary care services is good with more than 70 % of the rural population having access to the secondary care services. There were 25000 hospital beds reported in 2004. Currently, there is approximately one bed available for 680 populations.

While there is anecdotic evidence that general curative care is weak in the PHC centers, curative care being provided mostly by public hospitals or private facilities. Private sector is well established, providing all types of care. Relations between hospitals and PHC network should be reshaped in terms of substitution for hospital care, or almost for shifting that part of primary care, that is now provided by hospitals. Integrated delivery of care is a concept to explore, but keeping in mind that it needs appropriate financing mechanisms, new payment methods, integrated planning, and management of a part of resources at the local level of service integration. Integration of management of care cannot be done based on strict administrative boundaries, actually deserves functional integration.

8.2 Package of Services for Health Care

Information not available

8.3 Primary Health Care

During the period of Eighties and Nineties the Ministry of Health (MOH) of Syria has instituted some health programs to reduce infant and childhood mortalities, Control of Diarrheal Diseases, Expanded Program of Immunization, Control of Acute Respiratory Infections, Breastfeeding, etc. These programs led to reduction of child mortality from 99/1000 in 1980 to 24/1000 in 1999 to 18.1 in 2001. Acute Respiratory Infections (ARI) and Diarrheal diseases are still the major causes of morbidity and mortality among children 5 years in Syria. The vaccination coverage in Syria is high, the coverage reached to 100% for BCG and 98% for polio and DPT.

Infrastructure for Primary Health Care

Settings and models of provision

The Primary Health Care (PHC) delivery system is the responsibility of the MOH. The services are provided through 1534 health units and centers spread all over the country. These facilities (1534) include health centers, medical spots for preventive services, specialized centers (malaria, TB, Diabetes) and comprehensive PHC training centers. There is a good coverage of population by the health staff.

Public/private, modern/traditional balance of provision

Public-private ownership mix;

Most of the preventive and curative health services are provided by the government health sector. The new design from Ministry of Health in the year 2001 allowed the private sector to open private centers or clinics. Now we have 40 private centers in addition to that private sector, which provides 25% of curative services.

Private sector: range of services, trends

The private sector offers a complete range of services to those who can afford to pay. The lack of a coherent policy to be adopted by the MOH and the size and role of the private sector has enabled it to develop in a completely unregulated fashion.

The private sector has seen a rapid growth in particular in the last decade in some urban areas (Damascus, Aleppo, Homs), putting additional strains on public sector service affected by constrains on public expenditure.

Private sector health services provision derives from a significant private demand (patients directly paying or sponsored by employers) and it is facilitated by dual practice. It signifies that most of doctors practice both in public and private sectors. This creates serial distortion in equity.

Private sector plays a relevant role in the primary health sector through clinics and pharmacies accessible in urban and to a lesser extent in rural areas.

In 2004, Syria had 376 private hospitals and 6.743 beds. Earlier than this, these hospitals are mainly small in size (on average equipped with less than 20 beds), representing a potential problem in terms of quality of care, as well as inefficiency in resource utilization.

In theory, private hospitals should apply official tariffs set up by the Ministry of Health. These tariffs are perceived highly underestimated. It is likely that these are not adhered and adopted by many facilities. The private sector has a particular fiscal regime, which allows private hospitals to be exempted from paying income taxes if they agree to keep 10% of their beds for uncompensated care.

Referral systems and their performance

As we have mentioned earlier, no referral systems exists, nowadays. The MOH has put as priority in the next five-year plan to establish referral system in some governorates.

8.4 Non personal Services: Preventive/Promotive Care

Information not available

8.5 Secondary/Tertiary Care

Table 8-2 Inpatient use and performance

	1990	1995	2000	2002
Hospital Beds/1,000	1.9	1.6	1.4	1.4
Admissions/100	435000	515819	689547	825594
Average LOS (days)	3.5	3	2.48	2.20
Occupancy Rate (%)	73	75	81.16	82.9

Public/private distribution of hospital beds

The Ministry of Health is responsible for provision of hospital services in collaboration with Ministry of Higher Education, and Ministry of Defense, Ministry of Social Affairs and Labor and the private sector. As a matter of fact, the referral mechanism is not well developed hospitals are often utilized extensively for provision of primary care services.

About 75% of the total beds are for public sector. 25% are intended for private sector. Allocation of the hospitals is as per the range of size for the year 2004. Public sector hospitals range lies between 20-800 beds. 62% of these beds have more than 100 beds, while private sector hospitals ranging from 10 to 100, 78% of them have less than 20 beds.

Table 8-3 Public private distribution of hospital beds

Hospitals	1970	2000	2005
MOH Hospitals	28	55	67
MOH hospitals beds	3099	9887	11155
Units of care	108735	11803039	17493831
Surgeries performed	44500	303494	425357
Emergency attendances	170919	2172250	3043440
Private Hospitals	49	325	376
PVT Hospital beds	1196	5625	6795

Hospitals in Syria are classified into three categories as per the level of the building and level of the facilities and furniture of the rooms and suites. The number of beds is not the foundation of classification. All types of hospitals have limited roles to play. Hospitals are working curative purpose only. Primary care services are among the responsibilities of an independent department of the Ministry of health. The relationship with social service departments is, not well organized.

In all the hospitals there is an out patients clinic. There is an emergency unit, where most of the injured persons are treated. At the district level (total 91 districts) there is a health center. There is a health center at a village level (not in all villages). There is normally no X- ray service available in the health centers.

There are no financial surpluses in public hospitals, as there are no service charges. In Red Crescent Hospital, there are no financial surpluses too. The hospital is usually a financially balanced unit of care. In the private hospital, shareholders contribute to in the financial surpluses of the hospital. The services are available free of charge in public hospitals. In the private sector and NGO hospitals, the users of the service pay in cash.

Teaching relationships does not exist between hospitals and clinics. Public hospitals do have residency programs for medical graduates. Physicians are transferred from clinics to hospitals or otherwise depending upon the decision made by the governorate health director. There are no residency programs running in private and NGO hospitals.

Autonomy of public hospitals is a priority objective of MOH. Hospitals boards have been established in some central hospitals with the objective of moving towards partial cost recovery and participatory management. To provide these services a lot has to be done on several aspects; the financing of the hospital, pricing of services, internal organization, all aspects of management, strategic planning of the services

MOH Hospitals

The Ministry of Health operates 67 hospitals equipped with 11155 beds. The hospitals are usually administrated by a head doctor who is a practicing clinician along with a hospital administrator. The administrator acts as an assistant for monitoring and supervision of day-to-day activities. Both are appointed by the Ministry of Health, on candidacy indicated by the health directorates. The head doctor, usually, is appointed as per set criteria. The criteria are based on length of service and reputation and not necessarily upon the managerial abilities.

Capital planning (e.g. number and type of facilities) and current expenditures planning (e.g. human resources) are defined by the MOH in accordance with the Health

Directorates, and eventually approved by the State and Planning Commission and the Ministry of Finance.

Hospitals budget is determined according to historical expenditure (the budget is calculated on the basis of previous years expenditure).

Key issues and concerns in Secondary/Tertiary care

Efforts for introducing quality management in health facilities are not yet successful. Syrian pharmaceutical sector proved to be receptive to introduce quality tools.

The reasons for the poor acceptance of quality initiatives in the health sector have to be understood. For certain ensured enforcement of Standard Operational Procedures (SOP) may encounter some resistance in reasoning of necessary change in working styles or of investments to satisfy conditions. QM initiatives failure in the Syrian health sector is also probably due to a top-down approach in introducing this management technique, which is essentially consensual, or to the fact that the agents supposed to accept QM were not the good targets. Advantages of applying QM techniques or Quality Improvement Plans should be appraised, in terms of better services and reward such as personal satisfaction or other incentives. Policy for QM should follow a period of pilot introduction in some possible volunteer hospitals and health centers, and after that results may be divulged. The MOH should evaluate what kinds of instruments are needed to manage quality.

The status of the public hospital sector is not brilliant. Buildings and equipment need renovation, internal organization is not oriented to performance, and hospitals are overstaffed. Within the objective of increasing the efficiency of the hospitals, autonomy may help provided that a strong hospital policy enforces reorganization and promote performance.

The main problem will be designing an effective and fair policy of conversion or pre-retirement of staff as an answer to the necessary reorganization of these services. This may be the major constraint to contribute efficiency of the hospitals by putting public hospitals on a competitive ground, and avoiding that public hospital to become empty shells or second choice providers for low income groups with no other choice.

The second problem will be assuring sufficient financing to provide quality care, without overcharging prices, and considering that cost recovery should not imply decreasing of budget subvention. If prices are to be kept at a fair level, billing of services will not cover more than 30% of global costs (i.e. inclusive of salaries), but even more than 100% of costs not inclusive of salaries. Staffing is really a sensitive issue.

Reforms introduced over last 10 years, and effects

In 1998, in order to improve effectiveness, efficiency and quality the MOH lunched a reform to gradually grant "autonomous status" to public hospitals. The first hospital to achieve this status was the Al-Bassel Institute for Hearth Disease and Surgery . In 2003 other 4 hospitals have been added:

1. General Organism of "Martyr Mamdouh Abazza" Hospital in Qunaitra;
2. General Organism of Damascus Hospital
3. General Organism of "Ibn Khaldoun" Hospital in Aleppo
4. General Organism of "Avicenna" Hospital.

The main characteristics of the new "autonomous model" are:

- Establishment of a Board of Directors composed by 7 representatives, normally including 3 people from the local community to help ensuring consistency with community's expectations;
- Autonomy on financial and administrative matters;
- Appointment of professional managers or physicians who possess adequate management skills;
- Autonomy in recruiting personnel and in determining (at least to some extent), financial incentives for the employees;
- Possibility to generate revenues from fees charged to outpatient and inpatient.

8.6 Long-Term Care

Information not available

8.7 Pharmaceuticals

Syria has an important national pharmaceutical industry that has registered a substantial growth from a number of 11 manufactures in 1970, to the number of 54 in 2005, reducing considerably its dependence on imported pharmaceuticals. All of the manufacturers have reached the international standard of Good Manufacturing Practices (GMP); and ISO certified.

Currently, 88% of these manufacturers belong to the private sector, and 12% to the public sector. Syria produces about 4.600 drugs, covering 90 % of the needs and the export to 42 different countries. Imported drugs are mainly limited to oncology products, insulin, vaccines and injected hormones.

Essential drugs list: by level of care

Standard treatment, therapeutic guidelines for communicable diseases have been prepared in the Ministry of Health Directorate of Primary Health Care, for the public sector health services.

Manufacture of Medicines and Vaccines

In the Country production of pharmaceuticals has witnessed major development. In 1970, 11 pharmaceutical plants were producing about 100 pharmaceutical items. The local production accounted for only 6% of the total consumption of the medications. In 2001, 54 plants were producing 3214 products, which accounted for 88% of national consumption.

Regulatory Authority: Systems for Registration, Licensing, Surveillance, quality control, pricing

A 14 member Technical Committee is the decision making body for matters concerning drugs under the purview of the Ministry of Health. The committee is headed and chaired by the Minister of Health. It meets for two hours on every Sunday and Tuesday nights. Apart from the Minister himself , the committee is composed of the deputy Minister of Health for Pharmaceutical Affairs, the four directors concerned with drugs (the directors

of Drugs Control , of Pharmaceutical Affairs , of pharmaceutical studies and of the National Drugs Quality Control and Research laboratories)professors from the faculties of pharmacy and medicine , the directors of Thameco and Dimas , the secretary of the scientific council for the national pharmaceutical industry, and the head, or their reprehensive , of the pharmacist and the medical associations (Syndicates). The secretary for the technical committee is the director of the pharmaceutical studies.

All decisions concerning drug policy formulation and implementation, importation plans and local manufacture and approval of drug applications and registrations are handled by technical committee .sub-or evaluation committee for areas such as control or licensing of factories, for results of inspection and drug sampling, for drug registration and pricing and for revision of the essential drug list prepare the work for decisions to be taken by the technical committee.

The Ministry of Health is officially responsible for drug applications; drug control, inspection, and quality control analyses play very much an advisory and not a policy role in their quality assurance work with the manufacturers. Strict compliance with internationally accepted standards and norms is however mandatory before a manufacturer gets a license to produce. The Ministry of Industry can only issue a license for manufacturing after inspection of the Ministry of Health Evaluation committee and the approval by the Ministry of Health Technical Committee. The manufacturer will then be given the permission to file an application for product registration. Special requirements for batch analyses of product certain therapeutic classes such as cardiovascular drugs or sterile products are laid down by law.

The Directorate of pharmaceutical Affairs is responsible for implementation of regulations. For drug product pricing, for issuing of import licenses for pharmaceutical raw materials needed for local industry, for registration of imported drugs approved by the Technical Committee and for issuing certificates of origin for locally manufactured drugs. Syria's National Drug Quality Control and Research Laboratories have a well trained staff which has increased from 14 in 1989 to 140 in 1997. With the help of a UNDP grant, executed by WHO with UNIDO cooperation. The laboratories have been fully equipped with modern instruments and equipment.

Short term consultant support under the UNDP grant, and also from the German bilateral assistance (GTZ), has been implemented very effectively through national and external collaboration. The government has provided premises and organized flow of administrative, and managerial procedures have been instituted for sample analysis, statistics and reporting.

Systems for procurement, supply, distribution

Around 2000 products are manufactured locally, representing 85% of the total drug consumption in the country, approximately. The remaining 15% comprises imported products, those Syria itself cannot produce. Pharmex, or Saydaleya, under the Ministry of Economy imports these products.

Reforms over the last 10 years

Syria formulated its National Drug policy Q4DP in 1992. The policy was adopted in 1993. The NDP is set within the framework and objectives of health activities and the principles which stem form the basis of the country's policy and five year health plans. Promotion and support for local production of drugs, and restriction of imports is one of the main objectives of the Syrian national, which has 14 major features, and objectives. Another equally important objective is to provide drugs of reasonable quality and price and in

quantities sufficient to meet the health needs of the population. A national list of essential drugs constitutes the framework for local manufacture and imports.

The pharmacists' Syndicate or Association governs regulations on the profession and the practice of pharmacy. The Syndicate is represented in the Health policy Committee, in the MOH as Technical committee, and in the meetings of the Ministry of Industry, Economy, and Education. It collaborates closely with the Ministry of Interior in the control of narcotics. The Syndicate head, a professor at the Faculty of pharmacy in the Damascus University, is assisted by a secretary general and a staff of 12. The Syndicate will shortly publish its third edition of a hard cover drug information book or "NHIMS" .

Current issues and concerns

Although the objectives of supporting and developing the local industry and establishing a good quality assurance system have been met, rational drug use plus education and training in this area needs strengthening. Drug financing and pricing are important for emerging areas, which need attention and study.

8.8 Technology

Information not available

9 HEALTH SYSTEM REFORMS

9.1 Summary of Recent and planned reforms

The process of modernization of the health sector in Syria began in 2000.

The following main reform steps have been started:

1. Rethinking the role of the MOH and its organizational structure. Capacity building at MOH headquarters
2. Developing an integrated district delivery system (healthy district)
3. Implementing the Healthy Villages Program
4. Extending the degree of public hospital authorities, 9 hospitals received the status of a partially independent hospital through Presidential Decrees.
5. Establishing the national Health Research Center and preparation of the establishment of the Center for Strategic Health Studies (CSHS) with three main tasks: an advisory role towards the MOH, training and teaching, and a research function. The following four institutes will be established within the CSHS:
 - Institute of Population and Demographic
 - Center for Health System Management
 - Institute of Health Economics
 - Institute of Public Health.
6. Developing modern managerial skills: A Master Courses in Health System Management and short course in Hospital Management are developed and performed.
7. Developing a reliable Health Information System including a Decision Support Service.
8. Upgrading of Nurses Education System
9. Developing a Quality Assurance Program
10. Establishing the National Health Account program
11. Promoting the local Pharmaceutical Industry and introducing quality improvement measures such as the Good Manufacturing Practice (GMP).
12. Continuing the different programs in the health sector such as (Iodine deficiency control, Chronic and Non-communicable Diseases Control ,Heart diseases control ,Diabetes control ,Tumour control ,Domestic and Communicable Diseases Control Programs, National Immunisation Program to add additional vaccines such as Hepatitis (Hep A and B, H1b), Meningitis (ACWY), Rubella and Mumps;

European Commission started in 2002 a big project call Health sector Modernization program. They deal with the following areas:

- Policy, planning and regulation
- Health care delivery system
- Management capacity building
- Performance of hospitals
- Quality management

- Health care financing

The review should make recommendations at a minimum in the following points:

- Allocative efficiency of the health sector
- Institutional organization and capacity
- Private sector development and regulation
- Infrastructure investment policy
- Hospital policy and outpatient care policy
- Health promotion and public health activities
- Different aspects of management from financial management to management of health facilities
- Human resources development
- Management of quality and certification/accreditation of facilities
- Health care financing

It is very difficult to monitor and evaluate the impact of reforms in a complex, multi-product organization. If modernization objectives are not clearly stated or difficult to measure, evaluation of success or failure in achieving the objectives may be difficult or impossible.

The process of modernization must lead to changes in the behavior of providers and the patients before their net effect shows up in final impact indicators in terms of health outcomes, efficiency, equity and quality. Changes in the behavior of providers and patients provide proxies for impact.

Attention must be spent in "quick wins" that would increase public confidence in the reform process; shorter waiting lists, shorter waiting time, good availability of drugs, friendly staff, good guidance in the hospital, easy access, good parking space, friendly exterior and welcoming colors, good recreation areas with canteens, etc. It is indispensable to address and assess patient satisfaction and to ask patients/relatives, for the changes they greet most and identification of the most missed elements. The normally slow process of change may become visible and understandable to the patients and their relatives.

Changes have occurred in the relationship between care and cure, between nursing and medical personnel. Nursing care has become an equivalent part of patient care besides medical interventions. This means accepting nurses not as assistants of the physician but as an equal partner, having the common goals in helping the patient to pass through a stressful, often unpleasant time being hospitalized and getting the best health outcome for the patient.

Future reforms

Modernization of the Hospital Sector

Improve the performance of government-owned services, particularly hospitals, through organizational modernization of the service providers themselves. This modernization has included:

- Increasing the managerial autonomy of the health facility.
- Transforming the hierarchical and centralized bureaucracy into parasitical corporations that are exposed to market-like pressures.

- Changing the owner and/or holder by selling out entire health facility (privatization) or transferring the management from the public sector to the private company.

They are often referred to as “new public management” or “marketizing” reforms, which rely on the combination of increased independence, and market-based performance pressures. A core concern of these reforms is good hospital governance.

Even well designed modernization processes will fail without the political consensus to implement it, or if strong stakeholders as e.g. the medical profession and labor unions are not brought on board, or if the political cycle is too short and subsequent governments reverse or dilute the reform policies. Compromises on labor reforms and political interference with decision rights and accountability arrangements were among the most damaging factors for the process of modernization. Winning support from the medical profession and hospital management was critical to the more successful reforms.

Groups in society that have deep-rooted “anti-market” value systems can negatively influence the modernization environment especially in the case of complex reforms aimed at efficiency gains without easily identifiable “short-term wins”.

There is also a political governance which issues how the representative bodies (e.g. The Parliament) are holding ministries accountable for health sector and hospital performance and governance within the hospitals (how hospital managers are holding departments accountable).

The environment of private sector activities, especially, in terms of contracting and regulatory enforcement, directly influences the feasibility of autonomy and cooperation processes. It is particularly important to examine what is already going on in the private sector as an important predictor of what will be the outcome of hospital reforms.

It is not recommendable to go through the “big bang” and radical changes. The incremental approach – on the other side - runs the risk of going over at least five to ten years. But it passes through a process with a learning phase by using more limited hospital autonomy or piloting a limited number of hospitals, an approach which is actually applied in the hospital sector in Syria.

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10.1 Source Documents

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- Physicians Association
- Dentist Association
- Pharmacist Association

National Information Centre

The National Information Center in Syrian Arab Republic is an Arabic center specializes in information and documentation depending on the following documentation is the most scientific way to control information).

On 1/7/1991, the center was founded with the aim to document the most important sides of the national life of the Arab Nation in these issues (information, policy, economy, law military, education, social, and informatics).

Moreover, the center aims to give the ARAB PEOPLE and the interested in the ARAB WORLD issues every thing they need to use from researches, files, and studies through modern technology and advanced information systems, and communication ways to help the beneficiary in suitable time.

The center works hard to select, check, collect, deal and store information, studies, and statistics depending on the motto of the center (Documentation Is the Memory of the Homeland).

All the information is available in modern advanced profile for all those who need it (interested individuals, researchers and decision makers).

The Regional Health Systems Observatory is an undertaking of the WHO Regional Office for the Eastern Mediterranean. The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health systems in the EMR. Its primary goal is to contribute to the improvement of health system performance and outcomes, in terms of better health, fair financing and responsiveness of health systems. The aim of this initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health systems and to serve as repository of information on health systems.

This document is part of a series of in-depth health systems profiles, produced and updated by the Observatory using standardized approach that allows comparison across countries.

They provide facts, figures and analysis and highlight reform initiatives in progress.



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