INDEPENDENT HEALTH-POLICY RESEARCH

Syrian National Health Reform Strategy
2027–2035

VOLUME II

Health Insurance Reform

Reconstructing Syria's health insurance system: a framework for universal health protection

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Briefing deck · Independent research edition

Aita Consulting
November 2026

THE CENTRAL WARNING

Insurance is not a card

Insurance is a set of **enforceable entitlements, pooled funds, contracted providers, payment rules, data systems and accountability mechanisms.** A card without them is a promise that cannot be kept.

Nominal promise: “care is free”

A written entitlement, scheme membership, an insurance card.

Effective test: can a person actually receive care?

A functioning facility and workforce, medicines and referral, and no unaffordable or informal payment.

STARTING POINT

Severe capacity constraints, and a public policy direction

16.5M

people expected to need humanitarian assistance in 2026

WHO Health Emergency Appeal 2026

513 / 1,728

public health centers fully functional in 2025

WHO Syria, HeRAMS data, 2025

≈20,000

doctors remaining in the country

UNICEF Syria, 2026

70 · 40%

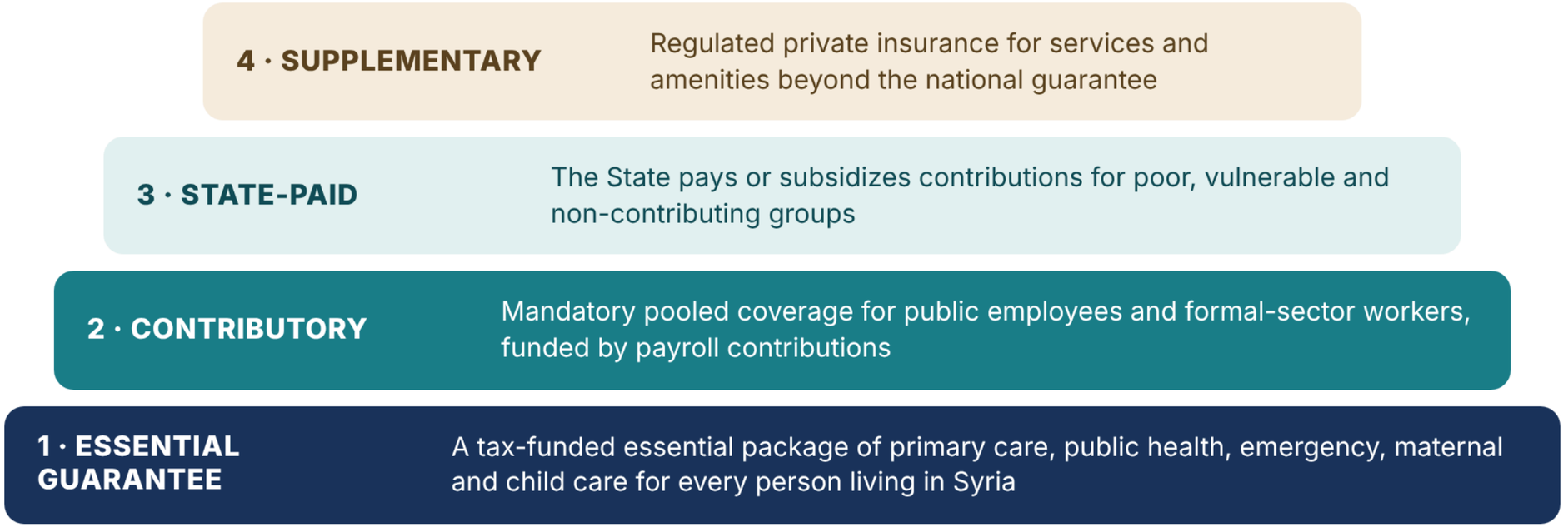
Compact targets for 2030: UHC service index 70; out-of-pocket spending 40% of health spending

National Health Compact, Nov. 2025

The National Health Compact commits to introduce health insurance for public employees beginning in 2027, reinstate National Health Accounts and roll out an Essential Health Service Package. This volume describes the institutions that would make those commitments durable.

THE PROPOSED SYRIAN MODEL

Four layers of coverage on one national guarantee



Not a European-style comprehensive insurance launch: Syria should build the institutions step by step, so that every entitlement it promises can be delivered and paid for.

KEY MESSAGES

Eight lessons that shape the design

01

Legal coverage is not effective coverage

Free on paper but unavailable, unreachable or out of medicines is not coverage.

02

Payroll is one channel, not the gateway

With a large informal economy, contributions alone would leave many outside.

03

Purchasing is a specialist function

Contracting, tariffs, claims, medical audit and fraud control need their own capability.

04

The essential package comes first

A costed, phased package is the base for any enforceable benefit package.

05

Primary care is the foundation

The operational foundation of coverage, not a residual service for the poor.

06

Connected but legally separate systems

Eligibility, contribution and clinical systems linked by the health number.

07

Move beyond fee-for-service

Toward capitation, case-based payment, global budgets and quality incentives.

08

Phase the implementation

Evidence, registries, costing and pilots before nationwide promises.

INTERNATIONAL EVIDENCE

Borrow design features, not a country template

System	What it shows
Türkiye	Consolidating fragmented schemes around a dominant public purchaser
Thailand	Tax-funded coverage for people outside payroll, with explicit benefits, capitation and case-based payment
Estonia	Digital claims as the operational backbone of purchasing
Rwanda	Subsidies and strong stewardship to include informal and vulnerable groups after conflict
Republic of Korea	Unified claims infrastructure, and why fee-for-service still needs expenditure control
Jordan	The cost of fragmented pools, exemptions and line-item budgets

Ten systems are reviewed in the volume, including the United Kingdom, France, Canada and the United States.

INSTITUTIONAL DESIGN

Health purchasing needs specialist, ring-fenced capability

The social insurance institution should not automatically become the national health purchaser. It may collect contributions, but purchasing requires its own skills and governance.

- Health actuarial analysis
- Provider contracting and tariff setting
- Claims adjudication and medical audit
- Fraud control and performance reporting

1 **Transitional: mixed national system (Model D)**
Tax-funded essential package, mandatory insurance for contributors, regulated supplementary cover

2 **Medium term: separate health fund (Model B)**
Ring-fenced accounts and its own governance, subject to legal, fiscal and actuarial analysis

THE REFORM ARCHITECTURE

Seven pillars, each necessary, none sufficient alone

1 · Universal essential guarantee

An explicit, costed and revisable package for every resident

2 · National purchasing function

Pooling, contracting, tariffs, claims and audit in specialist hands

3 · Rebuilt primary care

The operational foundation of coverage, not a residual service

4 · Interoperable social registry

Eligibility and subsidies, legally separate from clinical data

5 · Strategic purchasing

Capitation, case payment and budgets that reward results

6 · Regulated public–private contracting

Private capacity under common rules, not uncontrolled privatization

7 · Independent accountability

Ring-fenced accounts, audit, actuarial review and appeals

Outcome

Progressive, effective and financially protected universal coverage

PROVIDER PAYMENT

A blended model, introduced through pilots

Method	Use	Risk to manage
Global budgets	Facilities during stabilization	Rewards inputs, not results
Capitation	Primary care teams, per registered person	Under-treatment; protect access and quality
Case-based payment	Hospital admissions, starting with pilots	Coding inflation; needs audit
Fee schedules	Defined outpatient and diagnostic services	Volume growth; needs limits
Quality incentives	Vaccination, maternal care, chronic disease control	Gaming; needs balanced indicators

ON THE COMMON PATH TO 2035

Health insurance reform in five phases

2027

BASELINE

Map schemes, contributors, pools and money flows; National Health Accounts

Reliable baseline exists

2027–28

DESIGN

Cost the essential package; actuarial and fiscal models; purchaser options

Package costed, pilots funded

2028–30

PILOT

Public-employee coverage; essential package and payment methods in pilot areas

Safety and feasibility shown

2030–33

EXPAND

Formal and subsidized groups; consolidate public pools; electronic claims

Equitable gains verified

2033–35

CONSOLIDATE

Population-wide entitlement; mature purchaser; supplementary insurance regulated

Performance sustained

The same five phases as all volumes of the series. Planning windows, not commitments.

BEFORE PERMANENT CHOICES

The evidence a permanent model needs

EVIDENCE PROGRAM

- Map of coverage schemes, financing flows and mandates
- Validated beneficiary, provider, claims and expenditure data
- National Health Accounts and fiscal-space analysis
- Household out-of-pocket and facility costing evidence
- Actuarial baselines; costing and pilots of the essential package
- Institutional options for the purchasing function

MAIN RISKS

Risk	Mitigation
Fiscal overcommitment	Costed, phased entitlements; actuarial review
Cards before capacity	Verify eligibility, providers and package first
Unpaid claims	Ring-fenced funds; timely payment rules
Exclusion of informal workers	Tax-funded guarantee; subsidized membership

WHAT IT MEANS FOR PARTNERS

Building insurance that keeps its promises

Donors and development partners

National Health Accounts, package costing, actuarial baselines, registries, claims infrastructure and independent pilot evaluation.

Providers

Contracting will reward early investment in accreditation, coding, electronic claims and quality reporting.

Insurers

A regulated place above the national guarantee; claims and actuarial expertise may also support the public purchaser.

Technology companies

Eligibility, claims and payment systems built on the health number and national coding standards, in Arabic and English.

Investors

Published tariffs and timely payment are what make the market investable.

The test

Every entitlement needs a revenue source, a purchasing rule, provider capacity and a way to monitor it.

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Volume I — Strategic Architecture
Vision, system functions, governance, financing and the transformation sequence

II
Volume II — Health Insurance Reform
Universal health protection, pooling, the essential package and strategic purchasing

III
Volume III — Digital Health Transformation
Health information architecture, the health number, interoperability and data governance

IV
Volume IV — Primary Healthcare Reform
Frontline services, population-based care, referral networks and primary care performance

Four volumes, one common path to 2035. Each can be read alone; together they set out one direction and the order in which to travel it.

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