Private Health Insurance in Syria: Challenges and Benefits

Commentaries

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Abstract: *Private health insurance is one of the many tools countries use to provide health services for their citizens. However, the experience of private health insurance in developing countries is limited. The available research suggests that it has more of a negative effect than a positive effect on the health status of the people it is supposed to serve.*

Health insurance is a way of paying some or all of the costs of health care. It protects the insured person from paying high treatment costs in case of sickness or catastrophic events. Categorizing health insurance is difficult as there are several models according to membership, risk sharing, funding management, and health care benefits. Thus the known types are: social insurance, for-profit or non-for-profit Private health insurance, direct payment, and general taxation health system. For each one author had mentioned the advantages and disadvantages separately.

For the developing countries, it was claimed that developing the social security system will improve, and the demand for it will increase due to raised employment, improved tax and contribution collection systems. However, well over 80 percent of the population in developing countries remains uncovered against basic risks despite considerable efforts from policymakers, development institutions, and donor agencies.

In this article paper, we have presented potential challenges and benefits of private health insurance from the authors' perspectives based on a thorough literature review of private health insurance laws and regulations in middle-income countries.

Index Terms: *(Health, economics, insurance, Syria)*

I. Introduction

There are several pros and cons for private health insurance PHI, and there are several characteristics that usually combined with it and do more harm to the overall health system of a country than expected [1]:

• Moral hazard: The person covered by insurance might change his attitude toward risks as this person already knows that they are covered by insurance.

• Adverse selection: This happens because insurance companies reduce financial risk by raising premiums, which leads to opt-out of healthy individuals and increases the cost for those with higher risks as they stay in the pool alone.

• Cream skimming (Cherry picking): It happens when low-cost people select an insurance plan. Cream skimming occurs when an insurer knows more about consumers' expected costs than the consumers themselves and uses marketing or plan design to enroll a healthier-than-usual population.

• Supply induced demand: which occurs in the system due to asymmetric information between patients and health professions, resulting in more unnecessary and more expensive health care consumption.

II. PHI and Middle-Income countries

The Millennium Development Goals (MDG) set quantitative targets for poverty reduction and improvement in health, education, gender equality, the environment, and other aspects of human development [2]. The health-related goals were concentrated in limited numbers to help focus national and international attention on areas where actions are needed [3]. Low-income countries often rely heavily on government funding and out-of-pocket payments for financing health care [4]. An incomplete population registry, which is not uncommon in low and middle-income countries, limits the states' or insurance companies' ability to estimate an approximate number of health insurance beneficiaries [5]. Additionally, a large informal labor sector represents the percentage of the population who could join insurance schemes [6]. Moreover, there is a lack of trust in the insurance sector [7]. In order to obtain a better judgment, the author reviewed several low-middle income countries experience with private health insurance systems:

Latin America and the Caribbean: Private health insurance has grown rapidly in Latin America. However, indicators of a successful health insurance system have failed since the introduction of private schemes, which have been unable to contain health costs, promote equity, and reduce the gap between services in urban and rural areas [8].

The Middle East and North Africa: PHI is used in nine countries of the Middle East and North Africa region. Five of these countries have paid more than 5% of total health expenditure for PHI through a health prepaid system. In some countries such as Jordan, Lebanon, and Morocco, there was an exclusion of cost/low incomes. In addition, PHI is often concentrated in urban areas without any extending to rural areas [9].

Eastern Europe and Central Asia: In many countries, PHI schemes entered the market as part of the general transition to market-based economic systems. It was neither considered a significant channel of health care financing nor expanded to the low-income class [10].

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Sub-Saharan Africa: The mean PHI expenditure as a percentage of total health expenditure for those countries was 14 %, with extreme values were found at South Africa 46.2 and Ethiopia 0.2 [8].

East Asia and the Pacific: Despite its vast population, private insurance is relatively insignificant in the East Asia and Pacific (EAP) region. Aside from Japan, the most major insurance markets are the Republic of Korea, Taiwan (China), Hong Kong (China), Singapore, and Malaysia, where insurance penetration is around 5% to 7%, which is similar to the world average. In Thailand, Indonesia, Vietnam, and China, the insurance industry is growing in prominence. In East Asian countries, the positive association between insurance premium income and GDP growth appears to be particularly strong. After a broad industry slowdown following the 1998 economic crisis, development in the non–life insurance business has lately regained momentum [11].

TABLE 1: PHI EXPENDITURE AS A PERCENTAGE OF THI AS OF 2007 [8]

Country	PHI expenditure as a percentage of total health expenditure THI
Algeria	1.2
Egypt	0.4
Iran	1.5
Jordan	3.8
Lebanon	12.2
Morocco	15.5
Oman	8.9
Saudi Arabia	9.2
Tunisia	7.8
Bulgaria	0.4
Georgia	0.9
Hungary	0.4
Romania	1.9
Russia	6.5
Turkey	4.1
Ukraine	0.7

III. PHI IN SYRIA

As of 2010, Syria is a middle-income, developing country with an economy based on agriculture, oil, industry, and tourism. Nevertheless, Syria's economy has been facing serious challenges and impediments to growth, including a large and poorly performing public sector; low rates of oil production; widening non-oil deficit; systematic corruption; weak financial and capital markets; and high rates of unemployment along with a high population growth rate [12]. During the period of 2001 to 2010, the average GDP growth rate was about 4.3%. The GDP growth slowed to 3.2% in 2010 [13].

There are a variety of initiatives in place to provide particular health benefits to Syrians who work in the public sector (cover about 15% of the total population). Many ministries and public or state-owned businesses have extra funding set aside to help employees with healthcare costs. In terms of coverage, pricing, management, and benefits, such plans are reasonably diverse. According to a social security law from 1959, social insurance covering risks of old age, disability, mortality, work injuries, and accidents exists. In addition, Syria has a teacher's union with a health mutual fund for 280.000 members. The union ~~and~~ contracts physician-owned health clinics and pharmacies. In Syria, the health-related fringe benefits of major private companies are unknown. In fact, for a long time, health insurance has been on the political agenda. In 1979, a health-insurance bill was passed, but it was never implemented [14]. With the shortage of available materials and studies about private and public health insurance in Syria before the crisis in 2011, it was challenging to conclude rigorous analysis and recommendations about PHI in Syria.

IV. PHI IN SYRIA: EXPECTED CHALLENGES AND BENEFITS

A. Challenges

1. Developing countries have not shown successful experiences of PHI. Therefore, and because of cost escalating, adverse selection, moral hazards, Implementing PHI plans in Syria is expected to face several barriers and challenges.
2. Syria is considered a middle-income country, whereas previous research studies have shown that PHI works best in rich countries where PHI has a role as a supplement or complement, not as the primary insurance.
3. Syrian people are not familiar with this kind of insurance program. Therefore, implementing PHI programs without supportive raising-awareness and education programs about PHI might hamper the implementation.
4. Syria has recently started to initiate and develop the insurance industry, which is considered very weak. In addition, Syria is still suffering from the lack of organization, expertise, and infrastructure necessary to implement any extensive PHI.
5. The premiums will not be cheap for the majority of Syrian people, and they will not be able to afford it. Paradoxically, if the premiums were cheap enough for this majority class, the healthcare services would be limited and not attract consumers to buy.
6. Syrian government provides free access to public healthcare services, which attract the previous majority class as they prefer not to pay for healthcare through PHI program.
7. People with high incomes will be able to pay for private healthcare services. However, this class comprises a small percentage of Syrian society, and the majority will not benefit from private healthcare programs.

B. Benefits:

1. There is a demand by those who are able to afford out-of-pocket for extra healthcare services. PHI programs might attract people, especially those who prefer to receive health care in countries with advanced health systems and service delivery, which will contribute to economic development.
2. PHI will support the existing sizeable private sector, to which half of the total health expenditure is channeled.

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