

Health financing in Syria: from fragmentation and donor dependence to a phased and nationally-led transition

March 2026

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Key messages

- Syria's health financing system has shifted from a predominantly state-funded but only partially protective model to a fragmented landscape marked by humanitarian dependence, high out-of-pocket spending, and weak pooling arrangements [1-4].
- Humanitarian financing has sustained essential services, especially in non-government-controlled areas, but has largely been short-term, project-based, and weakly connected to system-building functions such as governance, pooling, and strategic purchasing [2,3].
- The current transition creates an opportunity to rebuild national stewardship, but this is taking place under severe fiscal constraint, weak institutional capacity, and continued donor volatility [2,5,6].
- The most credible path forward is not rapid nationwide insurance reform, but a phased transition centred on restoring basic public financing functions, reducing household financial burden, building minimum financing data systems, and introducing a realistic Essential Health Services Package [5,6].
- Early reforms should prioritise cost control, targeted financial protection, clearer fund flows, and simpler purchasing arrangements, while more ambitious pooling reforms should be approached cautiously and incrementally [5,6].

Why it matters

After more than a decade of conflict, Syria's health financing system faces a double challenge. Humanitarian aid remains essential in many areas, yet this model has left the system fragmented, vulnerable to donor volatility, and poorly equipped for a longer-term transition towards equity and financial protection [2,3]. Even before the conflict, out-of-pocket spending was high and financial protection incomplete, with public support for national health insurance closely tied to affordability and protection for poorer groups [1]. During the conflict, humanitarian actors became central in some areas, while households continued to bear substantial costs for medicines, diagnostics, transport, and specialist care [2-4].

Background

Before 2011, Syria's health system relied mainly on public revenues, supplemented by user fees and limited insurance arrangements for selected groups. However, financial protection was incomplete and inequities existed [1,4]. The conflict disrupted this architecture in uneven ways. In Northwest Syria, humanitarian grants and NGO-managed programmes became central. In other areas, constrained public financing persisted alongside rising household payments. Governance, pooling, and provider payment all became more fragmented, while donor support often focused on short project cycles rather than durable system development [2-4].

Experiences from fragile and conflict-affected settings suggest that this type of transition requires careful sequencing. Reforms are more likely to succeed when they begin with practical stewardship functions, basic transparency, and incremental strengthening of public financing arrangements, rather than immediate large-scale insurance or complex payment reforms [5,6].

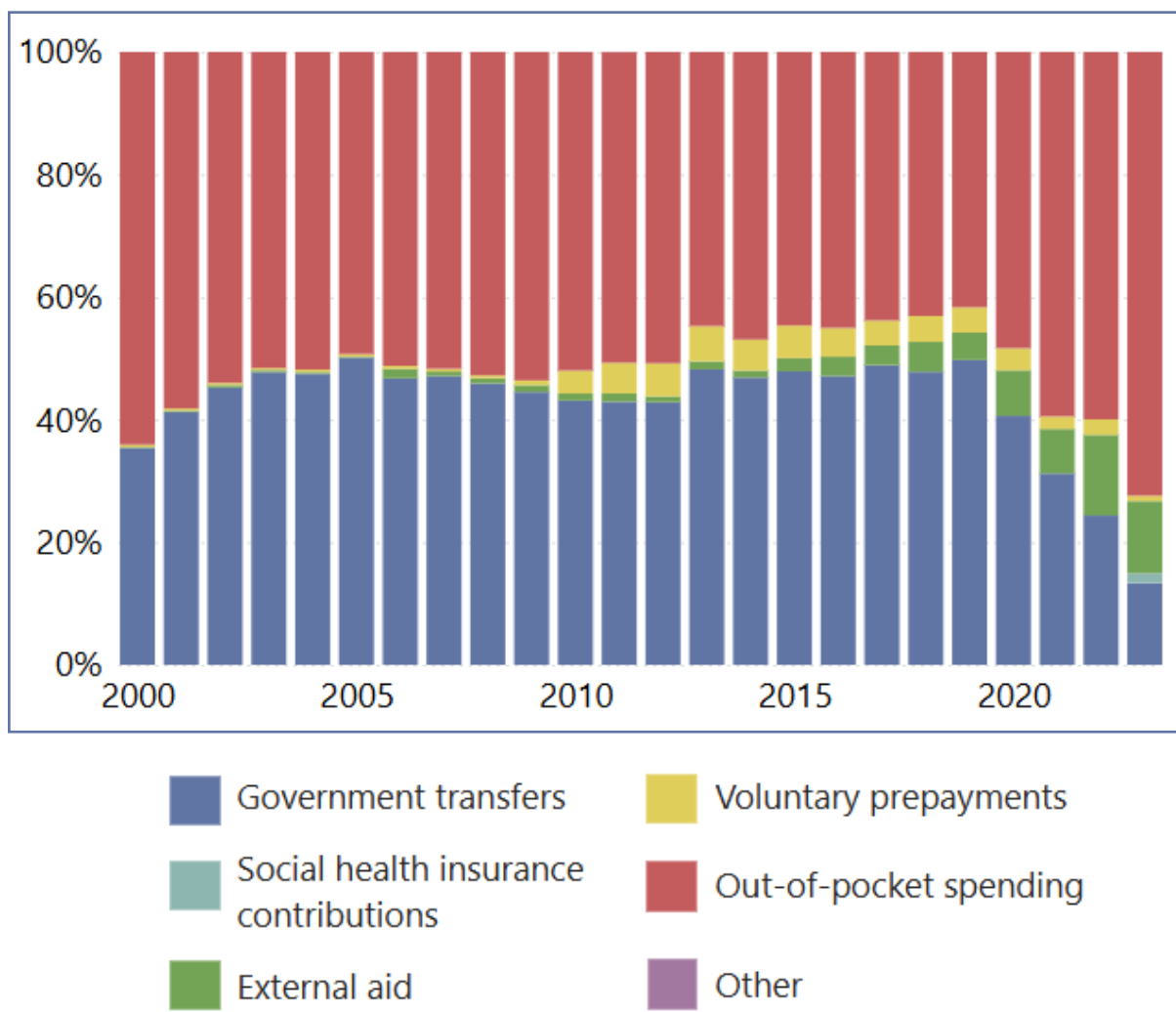


Figure 1 Sources of health expenditure in Syria, 2000–2023.
Source: WHO Global Health Expenditure Database (WHO, 2026).

Health financing in Syria today

Revenue collection: from public financing to donor dependence and household burden

Syria’s revenue base for health has weakened substantially. Public financing has declined, humanitarian aid has become central in many areas, and households continue to face major direct payments [2,3]. Informal and ad hoc financing strategies, such as local fundraising or small user charges, may help sustain services

temporarily, but they are unstable and insufficient for a durable financing system [2]. The literature from Syria and other fragile settings shows that such reliance on external aid and household spending tends to intensify inequity and weaken long-term planning [2,5].

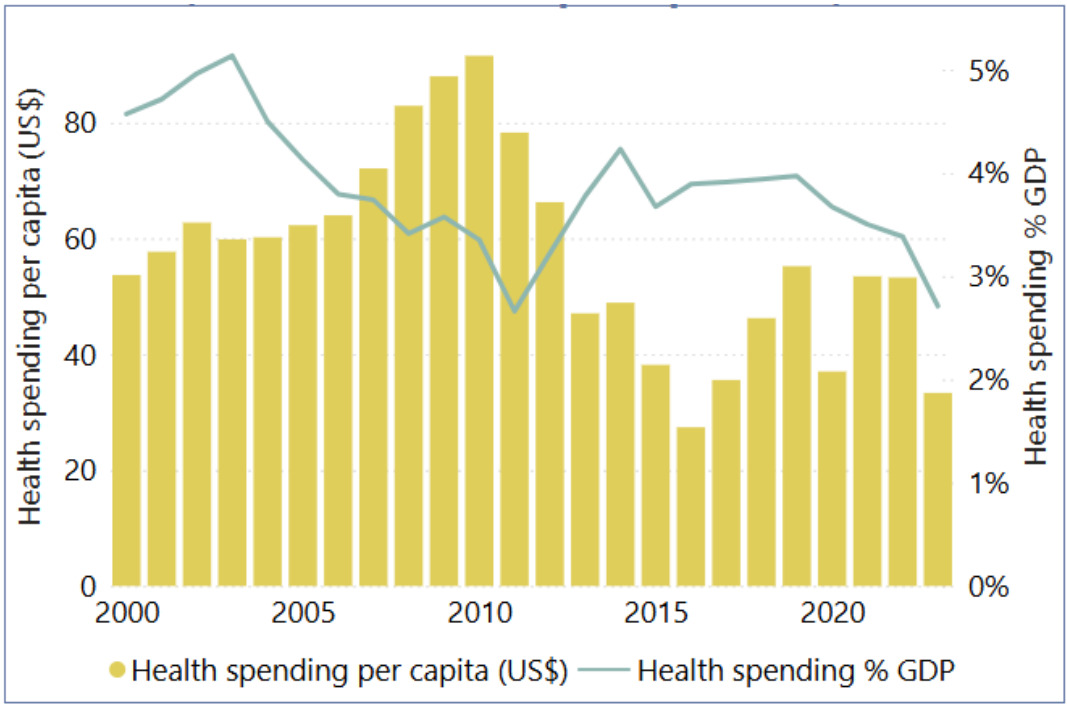


Figure 2 Current health expenditure (CHE) in Syria: CHE as % of GDP and CHE per capita, 2000–2023. Source: WHO Global Health Expenditure Database (WHO, 2026).

Pooling: limited before the conflict, fragmented during it, fragile in transition

Pooling in Syria was limited even before the conflict and should not be understood only as formal insurance. Public budgeting provided some pooling, but with incomplete redistributive reach and limited protection against financial hardship [1,4]. During the conflict, donor resources financed services but did not create durable, equitable risk-

sharing mechanisms [2,3]. Evidence from fragile settings suggests that early recovery contexts are better served by limited, subsidised, and explicitly targeted pooling arrangements than by premature attempts at broad national insurance expansion [5,6].

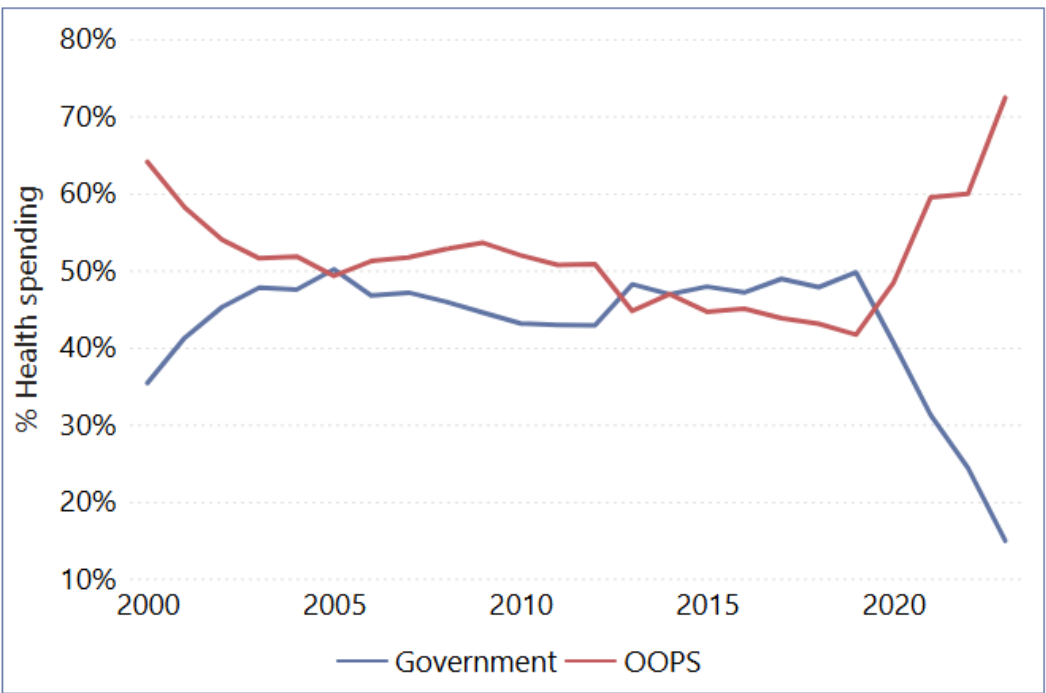


Figure 3 Domestic government expenditure and out-of-pocket spending as shares of current health expenditure in Syria, 2000–2023. Source: WHO Global Health Expenditure Database (WHO, 2026)

Purchasing and provider payment: fragmented and weakly strategic

Syria has not historically operated a mature strategic purchasing system. Before the conflict, payment relied mainly on line-item budgets, salaries, and administrative allocation. During the conflict, donor- and NGO-financed contracting became more important, particularly in Northwest Syria, but remained fragmented and largely input-based [2,4]. Comparative evidence from fragile settings suggests that simpler service agreements, clearer prices, pooled procurement, and limited output-oriented contracts are more realistic than complex performance-based reforms where data and stewardship remain weak [5,6].

Benefits and financial protection: donor-defined entitlements and major gaps

Before the conflict, Syria did not operate a clearly defined national health benefits package with enforceable entitlements [1,4]. During the conflict, service packages became more fragmented and were often shaped by donor priorities. This supported some primary and emergency services, but major gaps remained in chronic care, mental health, rehabilitation, and referral pathways [2,3]. A phased Essential Health Services Package could help define entitlements more clearly, but only if it is realistic, costed, financed, and linked to explicit subsidy and exemption rules [5,6].

Governance, public financial management, and data

Governance is central to any financing transition. The literature on Syria shows that the conflict weakened stewardship and fragmented governance across state, humanitarian, and hybrid actors [2–4]. Evidence from fragile and post-conflict settings suggests that rebuilding health financing requires a stronger interface between technical stewardship and fiscal decision-making, basic transparency in fund flows, and a minimum level of public financial management capacity [5,6].

Data systems are equally important. Syria's financing information remains fragmented and poorly linked to outputs, costs, and household financial burden [2,4]. The literature from fragile settings consistently shows that reform is more feasible when it starts with a limited but credible set of expenditure, provider payment, and service-use indicators [5,6].

Policy implications

A successful transition in Syria should be phased, pragmatic, and anchored in current institutional and fiscal realities.

First, restore basic public financing functions by clarifying what public finance currently supports, restoring core salary and operating budget channels where feasible, and mapping fund flows across levels and providers.

Second, establish a minimum financing dataset and routine expenditure tracking. A small but credible set of indicators on expenditures, provider payments, service volumes, referral costs, and household charges would improve planning, coordination, and accountability.

Third, introduce a realistic, phased Essential Health Services Package that defines priority services, links them to available resources, and includes explicit exemption and subsidy rules for poor and vulnerable groups.

Fourth, pursue cautious, incremental purchasing and pooling reforms. Early steps should include pooled procurement where feasible, standardised prices and reporting, and simple service-based contracts for priority services, rather than ambitious nationwide insurance reform at this stage [5,6].

Recommended actions

Immediate priorities

- Clarify current fund flows and financing responsibilities across levels and actors.
- Establish a minimum financing dataset and routine expenditure tracking.
- Introduce basic cost-control measures, including pooled procurement where feasible, a basic formulary, and indicative price ceilings.
- Strengthen targeted financial protection (e.g. through support for medicines), and exemptions for vulnerable groups.
- Use transitional coordination platforms to gather the Ministry of Health, Ministry of Finance, donors, NGOs, and technical actors around practical financing priorities [2,5,6].

Short- to medium-term priorities

- Develop and begin implementing a phased Essential Health Services Package.
- Pilot simple service-based purchasing for selected priority services.
- Rebuild pooling gradually through targeted, subsidised mechanisms rather than premature national insurance expansion.
- Strengthen the Ministry of Health–Ministry of Finance interface on budgeting, costing, contracting, and provider payment.
- Align external support progressively within a nationally-led transition framework [5,6].

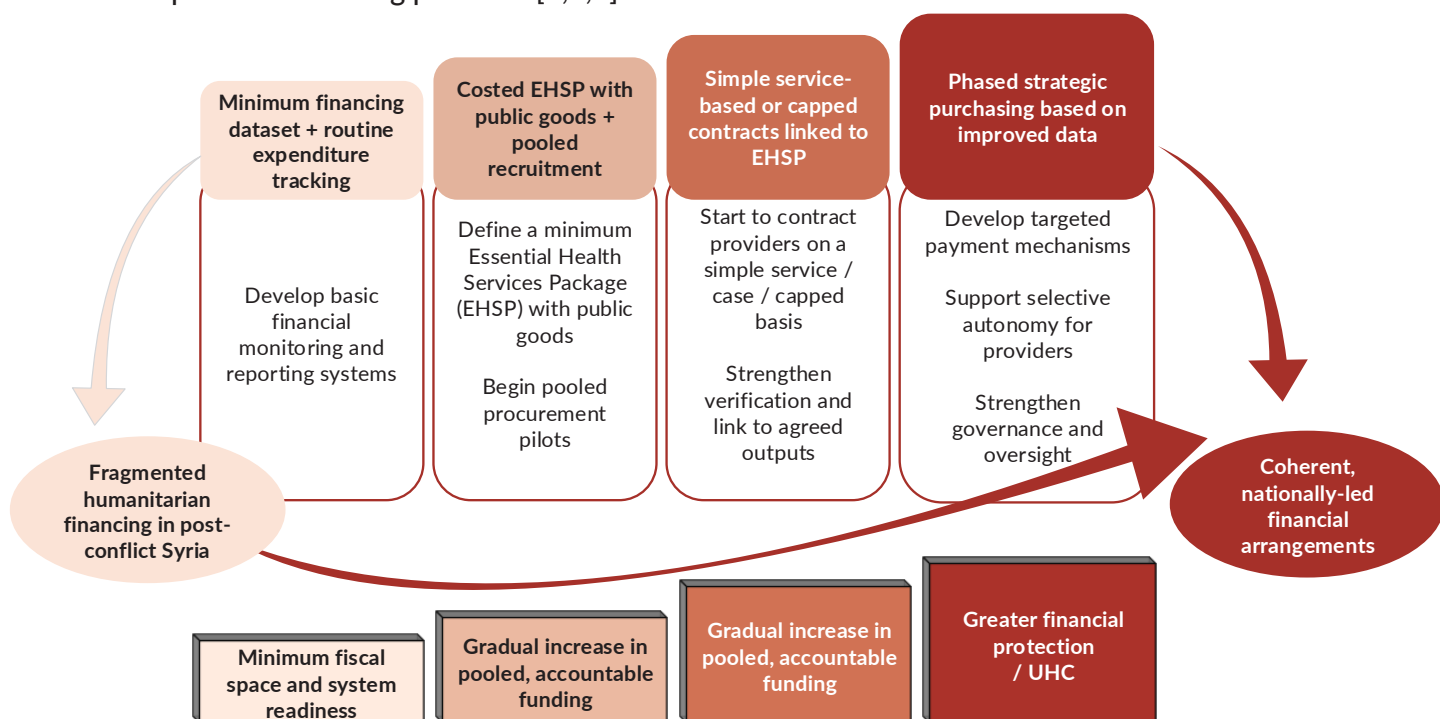


Figure 4 Illustrative transition pathway from fragmented humanitarian financing towards more coherent, nationally-led financing arrangements

Conclusion

Syria's health financing system cannot simply return to its pre-conflict form, nor can it continue indefinitely as a patchwork of donor-financed projects and household payments. The most credible pathway to stability is gradual rebuilding around a few practical anchors: restoration of basic public financing functions, a minimum financing dataset, a realistic Essential Health Services Package, clearer protection for vulnerable households, and simpler, more governable purchasing arrangements. International and Syrian evidence alike suggest that gradual, sequenced reform is more likely to improve equity, predictability, and national ownership than abrupt or overly ambitious restructuring [1–6].

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This brief is based on the ReBUILD study, *Strengthening health system financing in complex humanitarian contexts: An exploratory analysis from Northwest Syria*. More on that work here.

<https://www.rebuildconsortium.com/projects/health-system-financing-northwest-syria/>

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This project is funded with UK aid from the British people. However, the views expressed do not necessarily reflect the UK government's official policies.



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