

Except for the pension schemes, this is beyond the scope and purpose of this report. It is within the scope and purpose of this report to reiterate that investment in human and social capital is very important in this context. Education and health are not only drivers of development they are also very effective measures of social protection. Nevertheless, the government has to give back-up and stewardship. This is missing to a large extent, still, in Yemen.

The Poverty Reduction Strategy Paper of 2002 (RoY 2002) addressed three overall basic goals: “

- (i) Achievement of economic growth, creation of job opportunities and expansion of the economic opportunities for the poor by remedying the structural causes of poverty, focusing on the prevention of poverty and providing sustainable means of livelihood.
- (ii) Enhancement of the capacities of the poor, increasing their assets and the returns derived from such assets, towards more equity by improving the social, productive and economic conditions of the poor and those who are close to the poverty line.
- (iii) Reduction of the suffering and vulnerability of the poor by supporting the SSN (social safety net).”

Its four axes or pillars were defined as

- Achieving economic growth
- Human resources development
- Improving infrastructure
- Granting social protection

In its fourth pillar “social protection” two areas are mentioned specifically: social safety nets and social security. Social security intends to achieve a “vertical expansion in the security system to include health insurance and horizontal to cover a larger percentage of employees in private enterprises and self employed”. The second was not achieved, so far, but it has to be mentioned clearly that the existence of pension funds in the public sectors is a very important achievement, even if they could be improved and strengthened, still. To the first one, this study on a national health insurance system for Yemen tries to contribute.

## **4. Existing health benefit / insurance schemes**

### **4.1 Solidarity schemes**

Nobody plans to be sick or disabled, but illness and accidents happen. With the high cost of health care and the fact that it is increasing according to the inflation-rate, the average Yemenite family will not be able to manage health care costs without some assistance. Compared with Yemen’s 75%- out-of-pocket financing of health costs – some of the interviewed Yemenite experts estimated the amount even higher – most industrialised countries have established hybrid systems in which the public sector, which has the greater share of responsibility, works alongside the private sector, both in the funding of health care. Even with insurance, out-of-pocket expenses can be quite high, making it necessary to include funds for health care in the family budget. A good health insurance program protects against economic disaster in two ways. First, health insurance that covers medical treatment in hospital, surgical and other medical expenses will greatly reduce personal expenses. Second, disability income insurance will replace at least a portion of income lost due to illness or accident. The latter was a central motivation in many European countries in the 19<sup>th</sup> century to build up both community-based and company-based sickness funds. In the early 20<sup>th</sup> century the national German statistics for example had counted round about 70.000 of them. Most of them were community-based, others were company-based or for special groups of employees or professionals. The most important risk package in the very beginning was the continued pay of wages in case of sick leave, later the package covered also medical treatments and drugs, the treatment for family members (wife/partner, children) was included according the principles of solidarity. Nowadays the number of sickness funds in Germany is strongly reduced (round about 260), they are required by public statute to balance income and spending and they are not allowed to make a profit. Later on a Health Care Structure Act gave almost every insured person the right to choose a sickness fund freely. To provide all sickness funds with a level field for

competition – that is to avoid having all insured people choose schemes with a low contribution rate because of a historically good risk profile – a risk structure compensation scheme was introduced.

#### **4.1.1 Discovery and identification**

Active participation in decision making and the setting of policy as well as political priorities is an important determinant of the scope and pace of changes on the societal level and with regard to human development. In spite of the overall democratic context created during the unification process, civil society in general appears to be rather weak and uncertain in Yemen. In spite of the existing democratic framework, a relatively restrictive legal and administrative environment tends to constrain people's participation and emancipation. However, the new NGO law adopted in February 2001 is expected to have a positive impact on informal social networks, especially those based on tribal affiliation, and there is a strong traditional social safety net of charitable support for the very poor (UNDP ny). In general, Yemen has a rich history of solidarity and local self-help initiatives, and mutual aid is evident in the tradition of collective payments for costs of projects for the common good at village or tribal level (Beatty 2002, p. 14).

The most famous and successful local self-help initiative in Yemen has been the cooperative movement initiated in 1962. However, since the 1980s, it was co-opted by the government, and subsequently lost its vitality and effectiveness. Since then, other civil society organisations began to take their place, but none have had the dynamism and reach of these cooperatives (ibid.). Nonetheless, traditional informal co-operation modalities at the community level seem to be still important mainly in rural areas. Most community development occurs using such traditional or informal structures. There is a growing trend by government, international development organizations, and to some extent, local NGOs, to adopt community participation approaches, with a large number of projects in existence that include most of the service sectors, and implemented in most geographic regions in Yemen. Many of these projects are quite large both budget-wise, and in geographic scope (Beatty 2002, p. 3).

A series of informal and small scale solidarities can also be found in urban settings; most of them are organised amongst professional and labour groups, such as teachers, taxi-drivers, hospital staff, port workers, and other. In several Governorates, teachers associations have managed to implement solidarity schemes of the education personnel, but sustainability has been different according to local groups and areas. According to information gathered during interviews and through the opinion survey (see 2.3 and part 3 of our study report), at least in Sana'a and Aden teachers organised in the Regional Offices of the Ministry of Education maintain solidarity schemes financed by regular contributions. Comparable schemes have been established amongst hospital staff, i.e. in the Al-Saba'in Hospital in Sana'a where all staff contributes monthly 100 YR to a solidarity fund nourished additionally by the revenue of a telephone shop in the hospital.

#### **4.1.2 Structure**

One of the most characteristic features of solidarity schemes in Yemen seems to be the low knowledge about their existence and performance. Experiences with mutual support, co-operative structures and solidarity are scattered and often to be found in remote areas. In spite of the richness of approaches towards mutual help and alleviation of disasters, systematic collection of experiences and lessons learned is lacking, and only recently some experts started to focus on solidarity in the Yemeni society.

The two solidarity schemes that could be assessed during the study period emerged from bottom-up initiatives started by the employees in order to help the colleagues to face the financial burden of disease. Both schemes involve formal sector employees, however, employer participation is not given and essentially unwanted. Being informal, employee-driven initiatives, affiliation is voluntary, and coverage limited to a relatively low financial allowance in case of need. However, it is remarkable that

both schemes apply automatic payroll-deductions for contribution collection. One of the schemes creates additional income through the delivery of an extra service.

Organisation and performance are relatively weak and rely on highly committed staff that does not receive relevant extra payment for administration and other related tasks. As benefits are delivered directly to enrolees, independent from the health care providers they apply to, neither contracting nor payment of providers are in place. Risk management, fraud detection and other typical tasks of health insurance schemes are not perceived as necessary, and the relationship between the employees and their schemes rely on confidentiality and good faith.

### 4.1.3 Performance

In Yemen, social protection against health risks is even lacking in the formal economic sector. Many public health care providers often give priority access to affordable or even cost-free care for public employees and especially for members of the security forces. For personnel in private companies, however, health care is only available as market product they have to pay for every single item. Thus, severe and chronic illness can induce impoverishment even for those citizens who receive a regular salary and belong to the better off in Yemen.

### 4.1.4 Impact

In which way are solidarity schemes or community health insurance systems of interest for building up a National Health Insurance in Yemen? What are the strengths? What are the weaknesses? And what is the basis for implementing such a system in Yemen? This might not be completely clear in the context of a strategy towards a national health insurance system. In fact, mutual help organisations, support among specific groups and solidarity schemes are usually very small-scale and far away from including a relevant number of people. However, they might become starting points for broader schemes with more comprehensive benefits, especially if there is a considerable number of these schemes in place.

Besides the old European experiences with community based health schemes there are meanwhile some years experience with locally developed self-governing Mutual Health Organisations for example in West-Africa (see Huber 2003). Locally developed, self-governed health insurance schemes are seen to have great potential to enhance access to quality health care and contribute to the social and institutional development of society. Some of those experiences might be interesting for the Yemen Project. This is on the background that Yemen has got several trials to build up and strengthen some decentralised elements of its health care system:

- Since 1999: Building up of a district based health system in all 21 governorates with 229 districts of which the majority is rural
- Try to transform pretty different projects and activities into a sustainable and comprehensive strategy since 2000
- Try to implement a motivating system, giving incentive for those units that are more efficient and have better results
- Limited decentralisation of budgets at least to governorates level.

In general there are at least two strengths of community and district based health insurance systems: One is the higher degree of outreach penetration achieved through direct participation of insured people or at least their representatives. The other is the better acceptance and compliance especially in rural districts. On the other hand there are evidently weaknesses that explain the fact that the building up of such a system needs a lot of time and covers in the beginning often only a small minority of the population:

- Low level of revenues that can be mobilised from poor districts
- Frequent exclusion of the poorest of the poor from participation
- Small size of the risk pool is a problem in the case of high expenditure and catastrophic diseases

- Limited management capacity.

Following the results of the interviews with Yemenite experts there seems actually not to be a broad basis for implementing a community based health insurance system. Impact and compliance of the current district based health care system are evidently far away from being satisfying, especially taking Yemen's national health goals into account. Nevertheless it will be necessary to refer to existing decentralised administrative units to build up a nation-wide health insurance. Existing schemes and organisations might play at least a complementary role building up a nation-wide insurance system on a longer run.

#### **4.1.5 Constraints and opportunities**

One major constraint for extending the scope and coverage of solidarity schemes and establishing a national health insurance scheme derives from the impact of cost-sharing established more than ten years ago. Although a relevant number of experts argue that cost sharing and out-of-pocket payments produces cost consciousness on the user side and may thus prepare the citizens to accept an insurance scheme (Shaw/Griffin 1995), theoretical considerations rather imply that user charges tend to thwart the logic and assets of broader health insurance schemes. Direct cost sharing of patients is rather an antagonism to prepayment for risk prevention and tends to undermine the citizen's expectations and confidence in existing social protection systems. With regard to fairness and accessibility, prepayment is preferable to out-of-pocket-payment even in the case of small risk pools or for a small benefit package in order to mitigate the worst effects and to prevent impoverishment due to of illness (WHO 2000, p. 38; 97-99).

#### **4.2 Community based health insurance schemes**

Yemen's low economic capacity and inadequate institutional setting makes it difficult to implement comprehensive social health insurance in a short and even medium term, and sustainability will remain uncertain for a long time. Thus, supplementary community based health insurance (CBHI) schemes for the non formal sector and rural population might accompany a national compulsory scheme for the formal sector. CBHI schemes can contribute to improve financial access to health care as well as quality of health service delivery, enhance community participation, and strengthen administrative and financial management capacities in health centres and district hospitals.

Community- or co-operative based initiatives promise to protect against the adverse welfare implications of out-of-pocket payments. Thus, international technical co-operation is increasingly promoting informal health insurance schemes as a precursor to the more sustainable development of social insurance in low-income countries. It has had mixed success but does offer a way for the rural population to have some third-party protection (Arhin-Tenkorang 2001, p. 10; Mills/Bennett 2002, p. 213f). The review of community financing schemes allows for the conclusion that governments can contribute to the effectiveness and sustainability of community health financing schemes by well-targeted subsidies, publicly financed protection against fluctuations in expenditure, reinsurance for catastrophic events, and case management (Preker et al 2002, p. 149). The use of reinsurance - where community insurance schemes buy insurance to protect against random fluctuations in claims - has been recommended as a means of improving the viability of community insurance schemes in the informal sector (Dror 2001, p. 675f). By spreading the risk over larger population groups reinsurance reduces the probability of insolvency in the community insurance scheme (Dror/Preker 2002, p. 111-116). This approach remains largely untested in practice. The expectation is that such a mechanism has the potential to reach population groups that government and private health services do not, including socially excluded groups (such as those with mental health problems) (compare Dixon et al. 2002, p. 12). In the long term, it is hoped that these schemes can be knit together into a system of universal protection (Mills/Bennett 2002, S. 208).

Currently, one project to implement a community-based scheme exists in Al-Shamaytayn in the Governorate of Taiz. The concept was developed on the basis of experiences in Laos and will still have to be adapted to the conditions in Yemen. Thus, the insurance scheme is still in preparation and has not yet started in the field. Affiliation will be voluntary, and was expected to be even above 50 % of the target population of approximately 40,000 persons. The subscription unit will be the extended family. The monthly contribution will vary between 3,2 and 5,2 US-\$ according to the household size. The benefit package will include all services available in the Governorate hospital of Al-Shamaytayn: general and specialised outpatient care as well as inpatient care for the four basic specialties. The hospital will be paid according to a capitation system, and no health centre will be included in the provider network.

However, a visit of the study team in Shamayatayn revealed that the project to implement a community-based scheme still has to overcome a series of constraints and difficulties before it can start. Obviously, community participation seems to be surprisingly weak for a scheme that ought to be based on the citizens and offer options to satisfy their most relevant and felt health needs. The Health Council of Shamayatayn is only partly informed and hardly involved in the project. At the same time, relatively high expectations have been created in citizens with regard to the scope of covered health benefits. These expectations will be difficult to fulfil for any kind of community-based scheme; thus, disappointment is relatively likely to come up if the scheme will not be able to start providing services within a couple of months. On the other hand, the only provider foreseen for the community-based scheme, Al-Khalifa-Hospital in Shamayatayn, has not yet agreed to co-operate. After several months of preparation, and the elaboration of very detailed procedures and forms, provider contracting is still lacking. Taking in account that trust in the Al-Khalifa-Hospital is low, and that a series of irregularities at the central level were reported, the options of the Shamayatayn community-based health insurance scheme to see the light of the day seem to be badly affected.

Many experts advocate essentially three different models of CBHI, namely district CBHI schemes, hospital-based or provider schemes, and CBHI through NGO or a Mutual Health Organisation on a local level. A major conceptual input came from similar experiences in Armenia, but the adaptation to the specific conditions in Yemen turned out to be more difficult than expected. In spite of some relatively detailed and concrete considerations with regard to the implementation of CBHI, the proposals of Oxfam are still waiting to be translated into reality.

The success and viability of CBHI schemes can be promoted by different strategies. The benefit package should be affordable and include basic services tailored to health care needs and preferences of the population. The actual costs of the benefit package should be taken into account when the premium is calculated. Through attaining organisational and financial efficiency, the scheme can find effective ways of dealing with adverse selection and moral hazard. Achieving a high membership rate and provide the option to have the whole households as subscription unit improves sustainability. Additionally, international donor and NGO support can contribute through technical and financial support.

A short long-term approach and period of learning will be necessary in order to adopt the concept of community based health insurance to the socio-cultural context in Yemen. Several steps like the formulation of a framework, implementation of small pilot schemes in an early stage, evaluation and reformulation of the framework, second generation of larger pilot schemes, re-evaluation, implementation on a wider scale, etc. have to be envisaged from the beginning. Strong government commitment will be an indispensable prerequisite for the whole idea to succeed. Government plays a critical role in promoting good design and implementation of CBHI schemes. It is responsible of the policy, legal and regulatory framework, and it has to ensure that the implementation of CBHI schemes does not interfere with other legislation, that members' necessities and interests are protected, and that technical support is available for creating new schemes.

### 4.3 Company based health benefit schemes

Company-based health insurance schemes offer similar advantages as community-based health insurances. They are close to beneficiaries' interests and include often forms of direct participation of insured employees what strengthens the acceptance and compliance of the schemes. There is also the additional advantage of employer's engagement that might have a positive impact on efficiency and goal-orientation of the scheme. However, some weaknesses and constraints are also evident: Company health benefit schemes reflect often a paternalistic relationship between employer and employees, and they rely partly on individual case-to-case decisions rather than on vested rights. Even more important is the fact that the size of the schemes is in many cases too small for an effective coverage of risks especially when it comes to high expenses and catastrophic diseases. Another disadvantage is the problem that this is not a way to get the poorest of the poor involved into the Insurance System. Nonetheless employers' and employees' contributions are a basic element for building up and financing a National Health Insurance System.

#### *The opinion of the leaders*

58 % of opinion leaders say:  
Employee, wife, children and parents should get health insurance benefits

*Source: GTZ&EC survey 2005*

In contrast to community-based schemes there is evidence that company-based health insurances do work already in Yemen. The general lack of social protection in health affects also the employers and has lead many companies to offer support for medical expenses and to cover medical treatment costs. The company-based health benefit schemes obey partly the legal obligation to assure protection against work accidents and professional diseases. However, in many cases the scope of these schemes goes beyond the coverage of labour-associated health problems and includes other than the working persons as well as general health problems. The legal basis for the private sector is the above-mentioned Labour Law, complementary and referring to the stipulations of the Social Insurance Law (mainly Articles 118 and 119 of the Labour Law, see chapter 26 of part 3 of our study report).

Certainly it makes sense to integrate the practical experience of Yemen's existing schemes into the building up of a National Health Insurance. On the background of the special Yemenite situation and the experience in industrialised countries with company based health insurances it is recommended to consider the following ways and measures of integrating the good practise of existing company based funds in Yemen:

To define a basic benefit package referring to the good Yemenite practise of company-based schemes and to codify it in a National Health Insurance Act. To allow a free choice among non-for-profit sickness funds and to permit additional benefit packages (for example for medical treatment abroad) that have to be financed by additional contributions of employers and employees. For this and for developing an implementation plan it is absolutely necessary to have a profounder overview including concrete dates as to existing company-based funds (size of the fund, insured people, benefit packages, contributions, contracts, quantity and quality of administrations' staff etc.) Data collection was initiated by our study group,<sup>31</sup> but further assessment and analysis has to be done by the health insurance directorate in the Ministry of Health. In any case it is necessary to detect and to hold on good practise and to create a win-win-situation also for existing schemes.

- To provide all health schemes with a level field for competition a risk structure compensation could be introduced as part of the National Health Insurance system. The goal of such risk structure compensation would be to equalise differences in contribution rates (referring to the defined basic benefit package) that are attributable to variations among insurance funds in income

<sup>31</sup> Chapters 12 and 30 of part 3 of our study report.

levels and risk structure. According to Yemen's national health goals and regarding the planned contribution rates of the Final Draft of the Social Health Insurance Law the pooling system will need a strong additional financing from tax revenues. Public transfer payments legitimate at the same time an obligation for company-based health insurances to insure not company's people including unemployed ones.

The regulations of the Labour Law give generous protection and access to high sick-leaves to those employees and workers that are temporarily disabled to work due to health problems. During the first two months, the employee is entitled to a full-wage sick leave, during the third and fourth month he receives 85 %, during the fifth and sixth month 75% and still 50 % of his regular wage until the end of the eighth month. The high expenses for ill staff should produce a high motivation for company owners to support or implement a national or social health insurance system that covers also sick leaves.

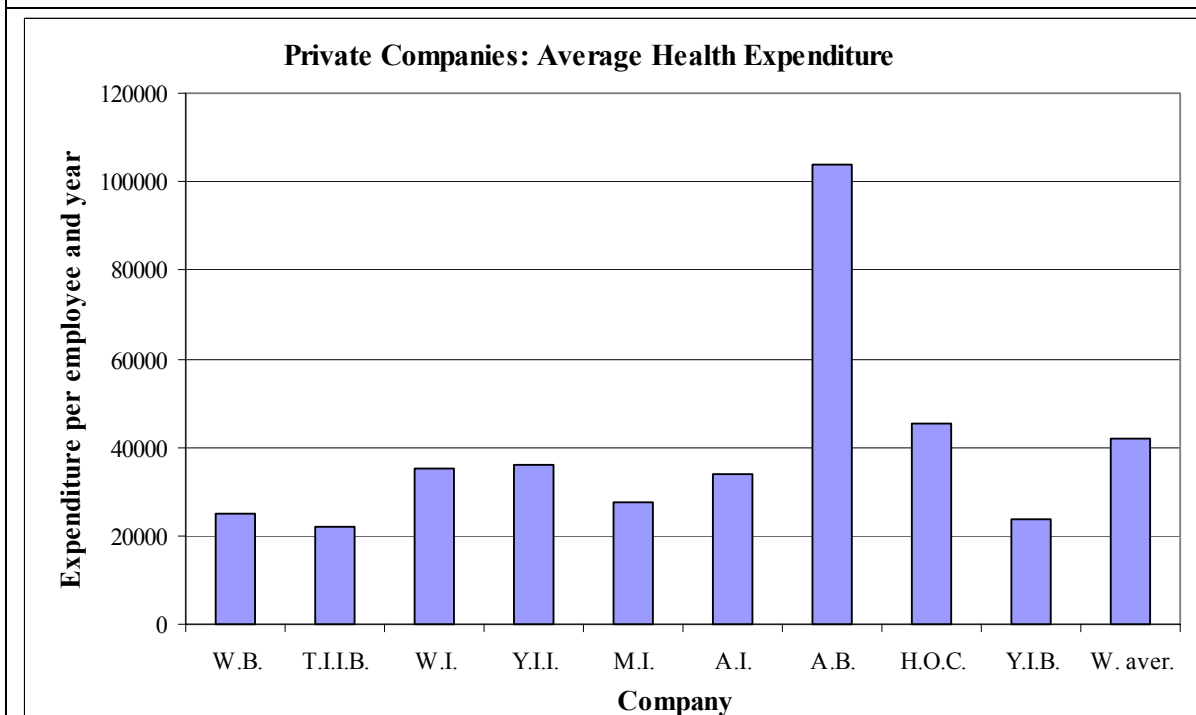
During this study, the team achieved to detect, contact and analyse briefly a total number of 20 company health benefit or insurance schemes in Yemen (9 private, 9 public, and 1 mixed companies). The existing schemes in Yemen show a broad set of benefit packages and regulations with regard to financial protection against health care costs. However, a greater variety is to be observed in the private sector companies where coverage might be restricted to regular allowances meant for health expenditures or be rather comprehensive for all employees. Public companies seem to offer a more homogeneous and relatively comprehensive benefit package although total and especially per capita expenditure varies between ca. 30,000 and more than 100,000 YR per employee and year.

Several company scheme managers referred either to recent changes of benefit coverage or access conditions or to emerging plans to introduce new and additional benefits. Obviously, the situation of private as well as public company schemes underlies a continuous development and adaptation process. This becomes also clear in a statement of a recent consultancy: "With the exception of YHOC (Yemen Hunt Oil Company) the schemes all depend either on an appointed company doctor(s) or reimbursing employees for receipts obtained from medical practitioners and pharmacies for goods and services provided. None of these schemes makes any attempt to collect the necessary data that would allow the managers to assess the extent of abuse, overuse or fraud. All the care provided is on a fee-for-service basis and it is unlikely that any of the companies are getting full value for the amounts they pay without that type of managerial assessment." (Constable 2002, p. 10) Different from this valuation based on the assessment of only five schemes, this study concludes that company based benefit schemes offer a broad range of interesting experiences with regard to the organisation and control of health care provision.

After assessing a total number of 19 company health benefit schemes, a series of conclusions can be deducted from the organisation as well as from continuous adaptations of the various schemes in place. During the study period, the team has been able to approach 9 private enterprises (3 small size with 30, 40 and 50 employees; 4 middle-size enterprises with 140-400 employees; one large company with >1,000, and one company-group with almost 9,000 employees), one mixed (nearly 4,000 employees), and 9 public companies (three middle size with 200 to almost 700 employees; and 6 large companies employing between 1,100 and 10,000 people).

Company benefit schemes represent the most prevalent source of third party coverage of health services in Yemen. Concerning the pricing of benefit schemes, these are particularly interesting as they provide a rough but real-data estimate of the costs of health services currently provided in Yemen. The following figures resuming our main findings with regard to company schemes in Yemen provide an overview of per capita spending on health care. In general terms, private company schemes show a broader range of scope and coverage with regard to benefits as well as to membership compared to public enterprises that tend to grant a relatively comprehensive benefit package and to spend more money on health care.

Figure 4 Average health expenditure in private companies



Source: This figure shows only those private company schemes that do not restrict health benefits to employees and cover the whole family; thus the per capita spending is supposed to cover the health needs of the employee and his/her dependents. The data rely on own calculations according to information provided by personnel responsible for the health benefit schemes (for abbreviations see list of abbreviations or table below).

While most private enterprises are spending between 20,000 and 40,000 YR per year and employee covering the whole and sometimes extended family, one internationally operating bank pays more than 100,000 YR, mainly for treatment abroad. In all private company schemes shown in the figure above, the employee and his whole family, sometimes even including the parents, are entitled to benefits. For this group of private enterprises, the average of per-capita payment is 39,125 (range 21,875 – 103,680 YR, standard deviation 23,853); and the weighed average taking in account the total number of employees according to company and benefit schemes is even 41,960 YR. This might be an indicator that larger companies tend to spend higher per capita amounts for health care of employees.

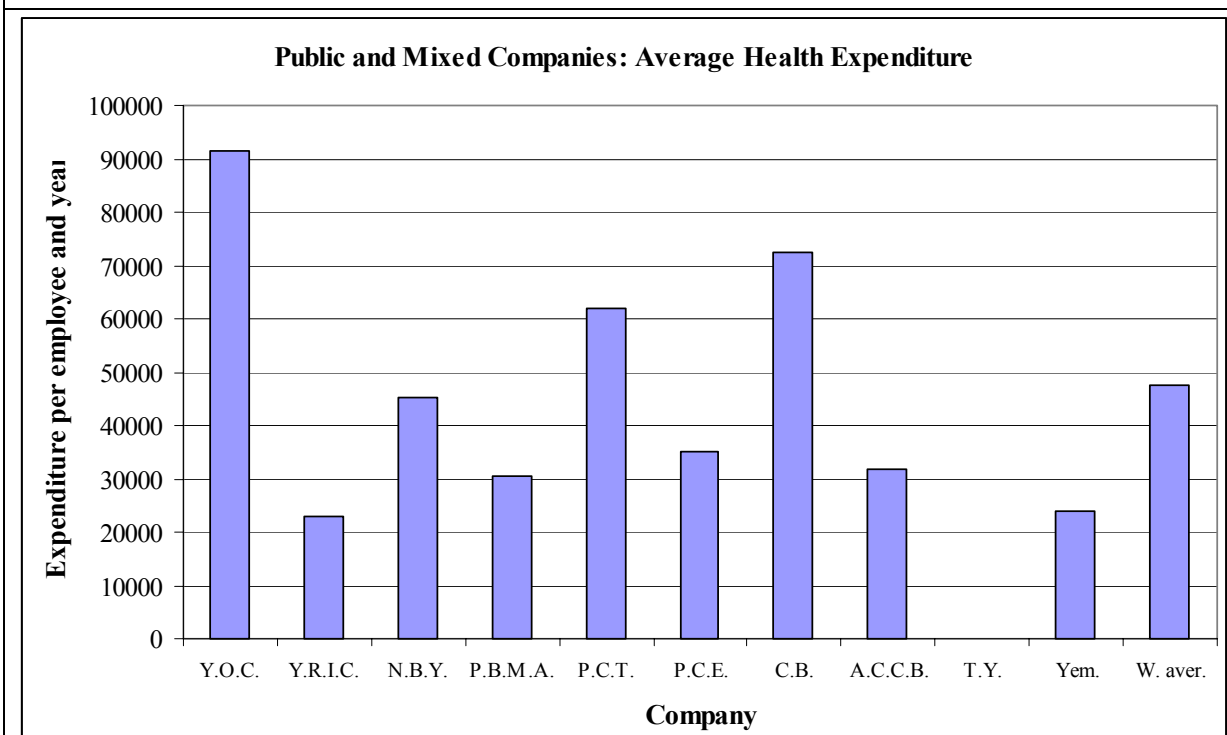
With regard to the design of administrative and managerial modalities as well as the scope of coverage, the assessed health benefit schemes show a broad variety. While some companies restrict support for health care to fixed allowances – either as general topping up of the salaries or according to medical or pharmaceutical bills presented by the employees – others reimburse their staff a part or all health care expenditures, and some even provide comprehensive coverage including out-of-country treatment. Administration relies mainly on human resources personnel, sometimes on contracted company doctors, and the budget uses to be allocated according to regular expenditure or adapted continuously to the upcoming need. In general, control and fraud detection are not performed in a systematic way, and confidence to often personally known people plays an important role in the selection and payment of providers. Thus, steering mechanisms, risk management and cost-containment strategies are applied randomly and are mostly underdeveloped.

The largest company group employing almost 9,000 people, however, is to be considered an exceptional case. In the mid 1990ies, the largest company group in Yemen started to implement its own health insurance scheme financed by income-related contributions shared between employer (2 %) and employee (1 %). Including the company's contribution to the health insurance, the company medical personnel costs and expenditures for treatment outside Yemen, Hayel Saeed's yearly health care expenditure per employee is 7,250 YR, while employees' average contribute is approximately

3,900 YR per year. Thus, the per capita amount spent for health care is slightly above 11,000 per year. Starting from the basis of 8 household members and 7 dependents per employee, and assuming similar health care need of all potential beneficiaries, the extension of coverage to family members would imply an estimated average company expenditure of 58,000 YR per employee and year. A series of risk management and cost-containment strategies are in place in order to reduce moral hazard and to prevent financial shortfalls. The Hayel Saeed Insurance Fund restricts coverage to employees only; family members of persons working in one of the group companies in Taiz are not entitled to benefits. Coverage of their health care expenditures relies on the family's breadwinner or on voluntary financial support from the company's charity organisation. A series of exclusions, e.g. treatment of chronic and expensive diseases, limited access to benefits, and a 5% co-payment have been implemented for reducing misuse and expenditure.

In general, public company schemes assessed during the Study on a National Health Insurance system in Yemen spend more money for health care of their employees. One out of 9 public sector enterprises invests only 23,000 YR in health, two are slightly above 30,000 YR, but most of the larger companies dedicate 60,000 YR and more for health care of employees. In the public company sector, the average of per-capita payment is 43,471 YR (range 23,000 – 91,385 YR, standard deviation 27,768 YR); and the weighed average taking in account the relative impact of different company and benefit schemes is even 47,565 YR. The next figure illustrates the per capita amounts spent for health care provision for employees working in public enterprises, including the average spending on health care provision.

Figure 5 Average health expenditure in public and mixed companies



Source: Public company schemes cover the whole and sometimes the extended family; thus the per capita spending is supposed to cover the health needs of the employee and his/her dependents. The data rely on own calculations according to information provided by personnel responsible for the health benefit schemes (for abbreviations see list of abbreviations or table below).

Detailed information was also available from one mixed company, Yemenia – Yemen Airways (51 % Yemeni, 49 % Saudi-Arabian). In the first half of the year 2005, Yemenia provided health care for its 3,897 employees and dependents (spouses and children) for YR 43,520,614. This corresponds to spending YR 22,335 per year per employee. Assuming a lower than average family size of six, this

would correspond to a health expenditure of YR 3,722 per capita per year for a rather generous health benefit scheme for Yemeni standards.

To a large extent, the observation regarding administration, management and performance of private sector company schemes is also valid for public enterprises. However, in all cases coverage includes the whole core family and often also the employee's parents living in the same household. Mainly larger companies are applying a series of mechanisms to contain health care expenditure and to reduce misuse, and most of them have introduced ID with photos of all beneficiaries. Only a minority of assessed schemes limits support for health care to fixed allowances paid for drugs. While some schemes reimburse their staff a variable percentage of health care expenditure, various public schemes provide comprehensive coverage including out-of-country treatment. Larger companies have specialised administrative and medical personnel for health care. A majority has contracted preferred provider(s), and in most cases beneficiaries do not have to make any payment as far as they receive services after prior approval by the company. Very few schemes have implemented a partly effective mechanism for controlling and fraud detection, and various modalities of claim processing and provider payment are in place. However, risk management, cost-containment, and other insurance strategies demand for further development. Obviously, most schemes are undergoing repeated reforms and adaptations according to observed problems and upcoming challenges. Sometimes, the innovations in one company are given up in another enterprise. Thus, a more detailed evaluation of existing schemes and mainly of ongoing reform processes is needed in order to make use of the accumulated experience.

Altogether, public and private company schemes underlie methodological constraints regarding health insurance related managerial capacity, and apply a limited array of purchasing and provider payment methods. Nearly all companies pay providers according to a fee-for-service mechanism, and financial negotiations are seldom. In addition, financial transparency and administration seem to be weak, and paternalism drives many of the benefit schemes. A major problem the study team was confronted with during assessment was the fact that the staff responsible for health benefit schemes was aware only in exceptional cases of what the company was spending on medical care of employees. Itemised data of expenses for drugs, out- and inpatient treatment, hospitalisation and out-of-country treatment was difficult to get so that a differentiated analysis of expenditure according to the various levels of health care was close to impossible. In addition, a series of health-related costs were not mentioned by the personnel and appeared only if the study group asked explicitly for items like company health professionals, extra allowances, and additional funding in special cases. Thus, company health care costs presented here will be generally underestimating the real expenditure that will be higher if all types of health-related support given to employees were reported and taken in account.

The general lack of financial transparency is also attributable to the fact that only a part of the benefits covered by the schemes imply the right of an employee to get them in case of need. Accessibility and mainly the scope of a series of health benefits rely on a case-by-case decision of company directors. Several companies have defined a margin of decision and condition the volume of financial support to work performance, using health benefits as an additional incentive for employees. This reflects the generalised paternalistic pattern of labour (and other social) relationships in Yemen and opens space for arbitrariness with regard to health insurance benefits.

Last not least a fundamental gender difference with regard to the coverage of dependents should be mentioned. All evaluated schemes except Hayel Saeed Insurance that restricts entitlement to employees only, declared to cover family members including several wives and many children. However, this is only true for male employees, while none of the schemes provides health care to the husband of female employees, and coverage of children remained unclear. The concept might reflect the prevailing conditions in Yemen where a male breadwinner sustains usually a family. However, the high unemployment rate (that affects also male workers), and the stepwise changes of traditional social patterns question seriously the discrimination of female employees with regard to health care coverage. To overcome gender inequalities should become a central concern of any approach towards a national health insurance system in Yemen.

The following table resumes the findings about existing company schemes in Yemen. It includes also the complete company name and the number of employees, and thus it allows for drawing some conclusions with regard to the absolute coverage and impact of each benefit schemes on the population level. Assuming the average household size, the assessed schemes that are covering all family members stand for more than 200,000 people or 1 % of the Yemeni population. For further details, please see chapter 16 of part 3 of our study report.

Company	Staff	Total expenditure for health (YR)	Expenditure per employee and year
<b>Private company schemes</b>			
Arab Bank (A.B.)	310	32,140,850	103,680
Arab Insurance (A.I.)	40	1,350,000	33,750
Hayel Saeed Group (H.S.G.)	8676	62,918,234	7,252
Hunt Oil Company (H.O.C.)	1083	49,000,000	45,245
Mareb Insurance (M.I.)	138	3,825,200	27,719
Tadhamon International Islamic Bank (T.I.I.B.)	400	8,750,000	21,875
Watania Bank (W.B.)	300	7,500,000	25,000
Watania Insurance (W.I.)	50	1,750,000	35,000
Yemen Islamic Insurance (Y.I.I.)	30	1,080,000	36,000
Yemeni Islamic Bank (Y.I.B.)	373	8,900,000	23,861
<b>7</b>			
Yemen Oil Company	5,400		
Aden Branch	1,300	118,800,000	91,385
Yemen Re-Insurance Company (Y.R.I.C.)	200	4,600,000	23,000
National Bank of Yemen (N.B.Y.)	683	30,855,000	45,176
Public Corporation for Telecommunication (P.C.T.)	5700	353,000,000	61,930
Public Electricity Corporation (P.E.C.)	10,000	340,000,000	34,000
Public Board for Meteorology & Aviation (P.B.M.A.)	2,300	70,000,000	30,435
Central Bank (C.B.)	2,100	145,000,000	69,048
Sana'a Headquarter only	1,100	115,000,000	104,545
Agriculture Co-op Credit Bank (A.C.C.B.)	1,100	38,000,000	34,545
TeleYemen (T.Y.)			
<b>Mixed company schemes</b>			
Yemenia (Yem.)	3,897	93,000,000	23,865

#### 4.4 Private health insurance companies

A review was also undertaken of private health insurance companies operating in Yemen. Obviously, private health insurance has a very short history in Yemen. A recent study had stated that there was no healthcare insurance policy marketed within Yemen (Constable 2002, p. 6). In the meanwhile, at least two out of the 12 private insurance companies that are working in Yemen - three more will start in the near future - offer health plans in Yemen. All of them started business providing third-party insurance by international companies, mainly by BUPA (British United Provident Association), IDI (International Danish Insurance), Munich-Re and some others. For instance, Watania Insurance offers health insurance according to various portfolios for Arab-Re (Lebanon) and Egypt-Re (Egypt). Individuals in Yemen or expatriates employees of major companies may purchase, or have purchased

on their behalf by their employer, healthcare insurance cover with international re-insurers at an average cost of 800 US\$, including 350 US\$ which is paid to the world wide rescue organisation SOS International. All third-party contracts entitle the policyholders to benefits in Yemen, Jordan, Egypt or European facilities.

On a national level, only private health insurance is sold to individuals, but the major purchasers are employers for their employees as part of the employment benefit package. Arab insurance started to implement private health insurance plans in 2002, and Watania insurance followed in 2004 offering two own health insurance packages re-insured by the British United Provident Association in London. Thus, private insurance market is very recent, and experiences are preliminary so far. Nonetheless, it is clear that the market share for private health insurers is very limited in a country like Yemen where household income per capita was YR 3,367 (=21 US-\$) in 1999 (World Bank 2002a (I), p. 25). The total premium volume of the whole insurance market in Yemen is estimated in less than 30 million Euro; and medical insurance promises not more than 300,000 US-\$.<sup>32</sup>

Although private health insurance companies cover the wealthiest and thus healthiest population share, they face the typical problems of very small risk pools. Until now, a Yemeni re-insurance scheme is lacking, but risk pooling on a national level is planned and negotiated between various stakeholders around the Medical Insurance Specialised Company (MIS). Private insurance companies feel recently encouraged by the MIS that acts as third-party agent and supports private insurance companies. Furthermore, managers of private companies perceive generally major problems for (private) health insurance in Yemen, mainly the lack of experienced manpower and information technology, bad quality and qualification of providers, inexistence of quality and price control of drugs, unregulated health sector prices and absence of professional federations.<sup>33</sup>

In Yemen, the Ministry of Trade and Industry is responsible for the supervision and control of all insurance companies including private health insurers. The Insurance and Re-Insurance Law regulates the private insurance market. The Ministry of Public Health and Population cannot and does not interfere in the activities of the private health insurance market, and no sector-specific supervision and controlling is in place, until now. So, the Ministry of Health is not entitled to revise the epidemiologic appropriateness nor enforce certain benefit packages in order to guarantee rational coverage of enrollees.

With regard to the implementation of a NHIS, some private insurers propose that public and private employees should be covered by private health insurance companies.<sup>34</sup> Recently, the Ministry of Interior was interested in contracting the Yemen Islamic Insurance for granting health benefit coverage to the 100,000 – 120,000 policemen and civil employees; however, the premium to cover the employee only (without family) would have been around 200 US-\$ per year. This was unacceptable for the Ministry that had calculated a contribution of approximately 20 US-\$ per year and enrollee. This example shows clear differences between public sector estimations and actuarial calculation by private insurance companies. Another problem mentioned by representatives of the Public Electricity Corporation refers to the concentration of private health insurance in bigger cities and the lack of branches and contracted providers in a series of governorates and in rural areas. Thus, private health insurance is not attractive for any company that is working nationwide and in remote areas.

In some countries, private health insurers have developed essential services packages, which give access and treatment for the most commonly presenting health problems. And, various stake-holders propose that a national health insurance system should rely on private insurance companies and on market driven competitiveness.<sup>35</sup> In Yemen, however, health insurance coverage is focussing strongly on hospital care, and all existing private companies look for competitive advantages by offering out-

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<sup>32</sup> Communication by Mujib Abduljabar Radman, General Manager of Watania Insurance

<sup>33</sup> Oral communication of Mr. Saleh Baddar, General Manager Yemen Islamic Insurance Company.

<sup>34</sup> Oral communication of Mr. Saleh Baddar, General Manager Yemen Islamic Insurance Company.

<sup>35</sup> Dr. Ahmed A. Al-Hamdani, Chairman Watani Bank; Yahya Mohammed Al-Khalani, President of the General Federation of Workers' Trade Unions Yemen.

of-country treatment. Contributions are very high compared to the purchasing power in the country, and palpable deductibles increase out-of-pocket expenditure in health.

None of the for-profit private insurance companies plans to develop or to offer any product that would be affordable for a broader population share. Such a benefit package is not to be expected on a national level because even in the private sector managerial capacity is relatively low, and co-operation with the public sector does not appear to be a viable option. Moreover, managers of private insurance companies say that they cannot cover the poor, and the Government should care for them. The few private insurance packages available within Yemen are focussing mainly on high quality care and out-of-country treatment. Thus, they are far away from meeting the most relevant epidemiologic patterns and health care needs of the country.

A special role plays the company initiated Hayel Saeed insurance fund located in Taiz that can be considered as a non-for-profit, private health insurance company. The largest company group in Yemen created its own insurance scheme in the mid 1990ies in order to cover health care expenditure of the staff. Enrolment is mandatory for all employees working in one of the companies involved, and financing is shared between employer and employees and relies on automatic payroll deductions. A series of risk-management and cost-containment mechanisms are in place, and the fund is co-operating with a closely linked, company-owned preferred provider for almost all kinds of services. Recently, the Hayel Saeed insurance fund has started to extend its restricted market segment establishing contracts with other companies and institutions, so far with a colour producing company and the University of Taiz. By this, the insurance fund located in the Al-Saeed Hospital in Taiz has achieved a 15% increase of beneficiaries, and further contracts with other companies in the Taiz area are planned. The fund appears to be flexible with regard to financing modalities, e.g. contributions of the university staff are per capita flat-rates and, thus, not wage-related. As the Hayel Saeed insurance fund is linked to the formal economy and to the most successful private company group in Yemen, lessons learned for a national health insurance system underlie the same limitations as mentioned generally for company based schemes. However, this kind of non-for-profit health benefit schemes deserves further observation and assessment in order to evaluate the potential to contribute to universal coverage. This is especially true because in the case of Hayel Saeed Group, overlapping efforts can be observed with company-run charitable organisations. The consortium has acquired experience with scaling up health insurance with additional funding through donations, religious taxes and welfare benefits, and has proved that contribution-based schemes can be complemented with other earmarked resources.

#### 4.5 Public sector programmes

Public sector attempts to implement health insurance have a relatively long history that started practically since the unification of both Yemeni states. In fact, government interest in health insurance appeared latest since 1992. However, sustainability of the various initiatives and proposals was difficult to achieve because they were highly depending on persons and discontinued always when the responsible personalities disappeared from the political scene. The following list gives an overview of the various initiatives and law proposals started since 1990.

Year	Initiative
1990	1990 first endeavours for HI. A delegation went to Tunisia. Dr. Ahmed Mhd DG of Al Thawra and former Minister Luqman were promoters of health insurance ideas during that time, backing was given by socialist Prime Minister. Study of C. Ross Anthony (USAID) recommending social insurance to start with government employees; contribution according to per capita flat rate.
1990/91	Initial health insurance project for the public sector only: proposed contribution rate 3 % (employee) plus 4 % (Government = employer), financing via payroll deduction, relative comprehensive benefit package, but limited to the employer, no family membership.

Table 31 Public sector initiatives on health insurance	
Year	Initiative
1991	Introduction of a 2% salary deduction for health insurance.
1994	Health insurance proposal for a pilot test in Al Thawra Hospital: Comprehensive coverage (in the first 3 years treatment abroad not included), inpatient treatment in Al-Thawra free of charge, 20 % co-payment for out-patient care. Coverage of dependents for additional flat-rate contribution (75 YR per woman, 50 YR per child) thought as incentive for family planning.
1995	Recovery of the discussion about Health Insurance in Yemen on the political agenda was coincident with the implementation of cost-sharing. Development and first presentation of an Army health insurance project to the parliament and the cabinet: Proposed contribution rate for soldiers 2 % and for officers 3 % of the salary.
2000	Visit of Health Director from Sudan (Fadaak 2005); second presentation of the military health insurance law proposal to the cabinet.
2001	Preliminary assessment of the feasibility for establishing a health care system based on social health insurance with support from WHO (Farzin 2001); conclusions and recommendations were refused since they dealt mainly with income generation and not with parallel improvements in quality and quantity of care. Third presentation of Army law proposal to the cabinet
2002	On the 1 <sup>st</sup> of March, the Deputy Prime Minister asked the MoPH&P in the name of the Cabinet to establish a social insurance fund and requesting a time table by the end of the same month. A survey of the existing health insurance schemes was conducted with assistance of Support to Health Sector Reform, European Commission (Constable 2002). It included a survey of private health insurance companies, public sector insurance schemes, hospital-based health insurance, pre-paid schemes, company health insurance, and other schemes. Background notes on development of National Health Care Financing Strategy were suggested and a training workshop for health care financing and associated healthcare reforms was recommended. In April, MoPH&P backstopped by Support to Health Sector Reform, European Commission organised a four days training workshop titled “ <i>Concept and Operation of Health Care Financing and Health Insurance in Developing Countries</i> ”.
2003	WHO consultation carried out in October concluded in a Social Health Insurance Law proposal. The draft law overall provides a good framework for the development of Social Security, including health insurance for civil servants and employees in the formal sector. The health insurance law was drafted in a committee composed of MoCSI, MoF, MoSAL represented by pension authorities, and MoPH&P. Labour unions and other partners were consulted as well as Al-Shura council. Recommendation was given to the president and by the prime minister to start implanting the law. A National Commission of Health Insurance was created with the participation of the MoPH&P, MoF, MoSAL, MoCSI, the Workers Union, the Chamber of Commerce, and others.
2004	Proposal of a Health and Work Insurance Law is presented to the cabinet, but the cabinet refused to agree, postponed it for further reflection, and conditioned approval to a prior study; especially the MoF and the MoSAL feared that Yemen is not yet ready for health insurance. Part of the government, mainly in the Ministry of Finance, shared this view. Fourth presentation of an adapted version of the Military Health Insurance Law to the cabinet, now with contribution rates of 3 % for soldiers and 5 % for officers. Ministry of Interior was interested in contracting the Yemen Islamic Insurance for granting health benefit coverage to the 100,000 – 120,000 police and civil employees. However, the premium to cover the employee only (without family) would have been around 200 US-\$ per year - too high for the Ministry that had expected a contribution of

Table 31 Public sector initiatives on health insurance	
Year	Initiative
	≈ 20 US-\$ per year and enrollee.
2005	Study “Towards a national health insurance system” decreed by the Cabinet and commissioned by MoPH&P. A law proposal for a Police Health Insurance Scheme is planned and currently discussed in the Ministry of Interior, but not yet available even as a draft.

Political discontinuity is a major problem and aggravates the other existing obstacles for decisive social policy in Yemen. Several proposals have not overcome the status of paper written documents disappeared in the many drawers of underused offices. For instance, the demonstration project with the fund purchasing services from Al Thawra Hospital on a capitation basis contained very detailed aspects and was submitted to the Ministry of Public Health and Population by the current Vice Dean of the Faculty of Medicine at Sana’a University, amongst others. However, every time the administration or the minister changes, all former attempts and ideas seem to be buried, and institutional memory is not developed in a form that would allow the maintenance and further development of concepts and proposals.

Obviously Yemen can look back to an impressive richness of public initiatives and proposals to implement a national or social health insurance system. It may well be that the proposals will bear re-examination in the current situation while the country is still looking for suitable approaches to implement health insurance in Yemen. The general legal framework does not represent a major obstacle, and in deed, the Labour Law that became effective in the mid 1990ies foresees health protection for dependent staff. However, it is not applied systematically and benefits granted depend mainly on the criteria of employers.

#### 4.6 Other initiatives

Public sector companies have developed a broad array of benefit packages oriented towards social protection in health, but all of them are small-scale schemes implemented on company level. However, they are still far away from building a public program and have to be considered rather as public enterprise initiatives. In the same way, many private enterprises have implemented the Labour Law offering health care benefits to their employees (see 4.3). Undoubtedly, company-driven health benefit schemes have the potential to become important elements and focal points of a national health insurance system. During the last years, private insurance companies are slowly discovering the national market for health insurance offered traditionally only by third-party representatives of international companies. The cautious attempts to develop a national health insurance market in Yemen have been backed recently by the Medical Insurance Specialists (MIS) offering expertise and potentially re-insurance for private insurers in Yemen.

It seems to be still premature to talk about community-based health insurance as a public program. However, planning and design of community schemes is on the way, and the concepts are waiting to be accepted by local stakeholders and to be implemented in the field. In addition, a broad array of solidarity schemes or practices exists in the country, mainly in rural and remote areas, but also in urban settings, e.g. in a neighbourhood, workplace context and societies. In this context, the investigation initiated by Oxfam in 2001 in the field of informal social protection is a highly valuable attempt to analyse the features and pattern of deep-rooted solidarity and mutual support in Yemen. The NGO-team was able to reveal and assess a series of community based solidarity concepts and practices that should be taken into account for the planning and implementation of health insurance in the country (see 4.1). However, further initiatives might appear and should be investigated in order to enrich the national experience of mutual support and solidarity for the benefit of a national health insurance system.