

Regarding the proposed division of labour between government and health insurance there is a relatively clear opinion of the leaders related to basic health care, including prevention and vaccination, MCH and PHC, which should be in the hands of government. Related to chronic and catastrophic conditions, there is a mixed feeling, whether government or health insurance should be the lead agent. The main domain of health insurance is seen in the area of curative health care.

Table 33 Opinion leaders' proposed division of labour between government and health insurance		
Health programmes	Government %	Health insurance %
Mother and child health care	93	9
Vaccination programmes	92	6
Prevention of diseases	91	5
Treatment of infectious diseases	89	12
Primary health care	85	10
Promotion of healthy life styles	82	12
Life threatening emergencies	76	33
Very costly and catastrophic diseases	65	59
Treatment of chronic diseases	58	54
Secondary health care	51	51
Drugs	45	77
Diagnostics	38	73
Accidents (fractures, traumatism etc.)	37	75
Outpatient treatment	34	75
Specialized or tertiary health care	32	75
Sorted according to government responsibilities, first Source: GTZ&EC survey of opinion leaders, 2005		

A more comprehensive review is given in part 3 of our study report. It is recommended, that such studies are undertaken with opinion leaders in rural areas, too, so to avail step by step of a more representative picture of attitudes and opinions. A full analysis of the results will be done by the partner of our study, especially regarding deviations of certain groups of opinion leaders from the mainstream of opinions.

6 International experiences

Options for health insurance can be developed theoretically as is the case with the many publications on this issue written by health economists and public health specialists. Their insights and theories are very helpful for designing health insurance options. Some relevant documents will be included in the electronic attachment to our study report. Another option for developing health financing options is to look at the historical development in specific countries or at a cross-sectional comparison of various countries. We will look first at countries in the Eastern Mediterranean and North African neighbourhood of Yemen, present then very roughly lessons from other developing countries around the world³⁷, and finally we will discuss some remarkable trends of the long term historical trends in Western Europe.

³⁷ More details will be given in various chapters of part 3 of our study report.

6.1 Experiences in neighbouring countries

The Eastern Mediterranean Region of WHO covers 22 countries with a population of 500 millions. The region has shared societal values stemming from common history and culture such as social justice, equity and solidarity. The right to health and health care is recognized in many constitutions and all countries have signed the Alma Ata declaration calling for health for all through primary health care. Social protection is secured through tax-based health financing systems, social and private health insurance and through very limited schemes of community self-help.

However the EMR is also quite diverse with respect to income, health spending, health standards and levels of health system development. The GDP per capita in the United Arab Republic (UAE) is 100 times that of Somalia, health expenditure per capita in Afghanistan is about 10 US \$ and low income countries are at early stages of epidemiological and demographic transitions. Because of these variations countries of the region are divided in three groups: high, middle and low-income.

High-income countries

They represent 8 % of the total region and are mainly represented by oil producing countries including Gulf countries and Libya. In these countries, social protection is quasi universal as access is secured almost free of charge through government budget. During the last decade and following financial constraints caused by the consequences of Gulf wars and drops in oil prices, ministries of health have initiated some form of cost sharing at time of use which are meant mainly to reduce moral hazard. Also government spending was restricted and efforts were made to exclude the expatriate population from the government system by creating health insurance schemes for them directed mainly to use private services through user fees arrangements. Such policies are to be interpreted in the political and social context which is moving towards a growing role of the private sector in both financing and delivery of health care services. Some national health account analysis reflect an increasing share of households in total health expenditure.

As the expatriate population represents in some countries between one third to two thirds of the total population, WHO has advocated maintaining it is the national scheme while developing cost sharing mechanisms through their employers in order to reduce the pressure on government spending. It seems that the pressure to develop special health insurance for the expatriates is coming for the aggressive private health sector and echoed by privatization policies. Also private health insurance is used in some gulf countries particularly for some big companies. The efforts to develop co-operative health insurance are under way for about 6 million expatriate workers in Saudi Arabia and some forms of social and private health insurance are developed in both UAE and Kuwait. Studies are carried out in Bahrain with the help of some private companies.

Middle-income countries

This group represents 42 % of the total EMR population. Health care is financed through a mix of tax-based social protection and self-paying systems. Social health insurance has started in the early sixties with the wave of independences and is evolving gradually according to the political and economic environment.

In Morocco, though social health insurance has started in late sixties, the present coverage is about 17% of the total population. Coverage includes 90% of civil servants and families, big public companies and 30 % of workers in the private sector and their families. A new compulsory insurance scheme has been developed in 2005 for both public and private workers which will bring the coverage to 34 % of the total population. A particular focus is put on providing social health insurance for the poor through a special scheme financed by taxes and charitable donations.

In Lebanon half of the population is covered by social health insurance; including civil servants, workers in private sector, military and police. Figures may eventually be revised downwards in view of perceived duplication of registered population. The reform process will also try to expand coverage

to some categories of self-employed.

In Jordan recent reform has expanded coverage by social health insurance to 60 % of the population though data is relatively scarce in this respect. The insured population includes civil servants, workers in public and private enterprises, military and the Palestinian refugees which represent approximately one third of the total population.

Egypt has started social health insurance in early sixties for workers in public and private sectors without covering their families. The health insurance organization has developed an extensive network of facilities including health centers and hospitals of various levels in big cities. Contracts were also made with private providers. In 1995 coverage was extended to students and recently it was also extended to children under one year of age considered to be a vulnerable group. At present coverage is about 51 % of total population. However private out of pocket household expenditure is about 58 % and the reform program is targeting universal coverage.

Tunisia has initiated social health insurance for civil servants and workers in the private sectors in early sixties while the poor and vulnerable group are covered by government free of charges. Health insurance services are provided through 2 schemes: Social Security Fund for workers in the private sector and their dependents, Social Protection Fund for the civil servants and their dependents. Insured patients get their services free of charge from public health facilities though some co-payment has been initiated since 1982, from some health centers belonging to the Social Security Fund and from private providers through some special arrangements. The new health insurance reform program has developed a common sickness fund which will operate for all the insured patients and which will open more to the expanding private sector. Presently 90 % of the population is covered and in most schemes supplementary insurance is provided through mutual and private health insurance.

In the Islamic Republic of Iran, coverage by social health insurance is almost 90 % of the total population. However, the recent national health account analysis and studies on catastrophic spending have showed an increasing inequity in health spending as 53 % of total spending is born by households and that 2 % of households are suffering from catastrophic spending. The reform program is focusing on reducing inequity, on increasing government spending on health and on achieving universal coverage.

Low-income countries

In low-income countries, the formal sector is very limited which explains the low coverage by social and private health insurance. Government spending in these countries is low and shrinking in many cases leading to high and unacceptable rates of out of pocket spending up to 75 %. Even essential public health functions are not well financed in government sectors. Some countries have scattered employment-based small insurance schemes covering some time the beneficiaries only.

In Djibouti, a limited scheme is covering civil servants with their families. Military and police are having special coverage for themselves and their families. The health sector reform program is planning to improve social protection through extension to formal sector employees.

In Sudan, social health insurance has started in early nineties and the present coverage is about 22 % of total population including civil servants, students, veterans and families of martyrs. Efforts are being made to assess the feasibility of developing community-based health insurances. Plans are made to initiate training on CBHI with technical support from WHO and ILO using the STEP training materials.

In Pakistan, there is no formal social health insurance scheme though workers in private and public companies are having special insurance schemes using the private sector services. Efforts are being made to develop some form of social health insurance for workers in the formal sector and studies are carried out by WHO to implement community based and micro insurance schemes.

Conclusion

The goal of universal coverage and improvement of social protection is high on all reform agendas in the various income groups. Countries are committed to improve equity in financing and to reduce catastrophic spending and to harmonize the coverage by various insurance schemes to avoid duplication and fragmentation.

However the main challenge for low-income countries remains the low level of total spending on health. As the prospects of economic growth are not very promising, that some low and middle-income countries are crippled with wars and political strives and as the debt burden is heavily straining public spending on health, efforts should be made to increase regional and global solidarity for health development. WHO, ILO and all concerned partners should support national and regional efforts aimed at improving social protection while advocating investment in health as recommended by the WHO Commission on macro economics and health.

6.2 Other international experiences

Experiences of other countries can hint at opportunities and pitfalls. In chapter 20 of part 3 of our study report health insurance examples from Asia are presented, especially those countries at a similar level of economic development as Yemen when they started introducing health insurance. Chapter 21 of part 3 of our study report presents examples from three countries of Latin America and draws conclusions for Yemen. Chapter 22 of part 3 of our study report reports on health insurances in Egypt, Algeria and Syria from a German viewpoint. Such examples might benefit the discussion on health insurances in Yemen.

Table 34 International health insurance lessons for Yemen	
Country	Lessons for Yemen
Algeria	Avoid drastic decreases of GDP for health
	Social health insurance funds cross-subsidize health care for the poor
Chile	Universal coverage is possible.
	Segmented health systems – state-run, social health insurance and private health insurance – are inefficient.
	Private insurance and insurance markets need strong and effective regulation.
	The poor have to be covered without discrimination.
	Linking tax-financing for the poor with national health insurance is possible.
	Good exemption mechanisms are necessary to protect people from impoverishment.
Egypt	Avoid too low contribution rates
	Do not allow companies to opt out
	Substitutive voluntary insurance schemes to be discouraged
	Avoid health care privileges that decrease solidarity
El Salvador	It is a long way towards universal coverage.
	Closer collaboration of public and non-public institutions needed.
	Improvement in public health care provision is of utmost importance.
	Detection and assessment of all existing health financing schemes is a crucial starting point.
	Co-ordination of various funds will promote solidarity and equity.
	Linking up might improve health outcomes.

Table 34 International health insurance lessons for Yemen	
Kenya	Allow for time to develop a strategy, an implementation plan and legislation - start early.
	Include all stakeholders in the planning process
	Address all concerns before presenting the final package for approval, especially those from the Ministry of Finance
	Start working on capacity building, efficiency gains and better management now – you do not need to pass a law first
	Do not assume that anyone will freely and readily give up any benefits that they currently enjoy
Paraguay	Government initiatives towards social health insurance can work out.
	Special professional groups can take leadership in social security.
	Teachers belong to the most active groups with regard to health insurance.
	Administration and adequate management are crucial for health insurance.
	Claim processing and provider payment are relevant for cost-containment.
Philippines	Include a programme for the poor
	Government pays contributions for the poor
	It is difficult to cover the small scale self-employed
South Korea	Start with a programme for the poor
	Do extensive health systems research
	Do it gradually in the private employment sector
	Avoid too low contributions
	Give subsidies for the self-employed
	Provide only cost-effective interventions
	Control drug prescriptions and prices
Syria	Health benefit schemes of ministries are quite different within and between MENA countries
	Teachers are often the driving forces for instituting health insurance
Thailand	Give free medical care for the vulnerable, incl. school children
	Support voluntary community schemes with re-insurance
	Add a 100 YR flat rate programme per illness episode for the uninsured
Sources: Chapters 19 to 22 of part 3 of our study report and also part 4	

These short summaries of experiences in other parts of the world show, that Yemen can learn from many countries. There is no health insurance that can be replicated 100% in another country. But there are quite a number of similarities, that have to be dealt with. The problem of covering or including the poor and the unemployed is one of the basic issues. Another issue is the difficulty to cover and include the self-employed. Division of labour or cooperation between health insurances and government services is a topic that can be studied in all countries with health insurance. It would be uneconomic and not reasonable to disregard experiences from social experiments in other countries, wherever they might be located. For health systems research and management there is no better way of learning than looking carefully into other countries and into their histories. This is a real eye-opener and can avoid reinventing the same mistakes.

6.3 Criteria for proposing and choosing options

There is never one option only. Economics is the science of options. Health economics is an art to develop, discuss and defend options and to try to find the best one for improving the health of the people. Opportunity costs are those costs that we have to pay if not choosing the best alternative or option. This is why we have to be very creative in developing, discussing and defending options and to look into all their advantages and disadvantages, direct and indirect costs, tangible and intangible

costs. It does not matter, how options are borne. They can be bastards. The fittest option shall survive. Therefore we do not need criteria for proposing options. Everybody can propose any option. The more, the better.

We need criteria for choosing options. If we have a clear vision and objective and if this vision and objective were measurable as well as the main characteristics of the options, than we could mathematically chose the best options. In real and social life, this is not the case. Therefore we have to gather all available evidences, arguments, data, opinions, estimates from the point of view of the proponents of the options as well as from those benefiting or eventually being harmed by the options. It is a social dialogue that is needed to deal with the options and a rational weighing of advantages and disadvantages for various sectors of society. In terms of health insurance a dialogue between government, workers, employers, health experts, civil society and all involved parties is needed to chose the best option. It is not the decision of the government. It is a social process. A forum for discussing the various options with representatives from all concerned parties and from the society is a must for developing a health insurance system. It will not be engineered at a desk. It has to be submitted to social processes of weighing advantages and disadvantages from the most different points of view of all proponents, partners, patients and the poor. A dialogue forum is an essential step towards a rational national health insurance system.

6.4 Preconditions to start a national health insurance system

6.4.1 Historical preconditions

Looking into the history of Europe we can try to find out, what preconditions exist to start a national health insurance scheme. Health insurance schemes were started, when many populations still were very poor. Even after wars health insurances were reinstated in various countries. Health insurance is not just a luxury good of rich countries. Almost all European countries now are covered by far reaching non-profit health insurances within a broader context of social insurances. The extension of the coverage of social insurance including health insurance in Europe followed more or less this pattern that was detected by a quantitative policy science analysis (Alber 1985):

- (1) from workers to nations, i.e. it was an incremental approach starting with salaried workers
- (2) from accidents to unemployment insurances, i.e. work accident insurance was followed by health insurance. Unemployment insurance came late
- (3) from voluntary to compulsory insurance, i.e. it started with solidarity schemes that were harmonized step-by-step and integrated into more comprehensive networks
- (4) from control to confidence and right, i.e. there were tight controls at the beginning
- (5) from cash to kind, i.e. benefits were given increasingly in kind and not as cash; cash benefits during sick leave were given first to cover the basic needs of the families; health care came later
- (6) from workers to the self-employed, i.e. that the self-employed entered health insurance late, as it is experienced now in many developing countries, too
- (7) from poor to rich, from weak to strong, i.e. that the coverage of the poor was a main goal for social health insurances in Europe. This differs from health insurance approaches advocated by some authors from the United States of America
- (8) from self-help to institutions, i.e. solidarity schemes were converted step by step into larger institutional settings
- (9) the state played a rather unclear role, i.e. it was not necessarily the driving agent for change, sometimes it were the workers and the employers playing a more active role
- (10) political parties played a rather undetermined role, i.e. that the political colour of the parties involved as driving forces did not matter so much for designing and implementing health insurance in Europe
- (11) socio-economic factors were not decisive, i.e. that in some countries it started in poor and in others in better-off situations
- (12) diffusion was not a mayor factor, i.e. that experiences from abroad were consulted but were not the decisive in patterning national and local health insurance schemes.

The main message is: a national health insurance system can start under very different conditions. What is needed most is an awareness, a political willingness and an opportunity.

6.4.2 Empirical preconditions

There are several prerequisites for the set-up of health insurance schemes, which emerged during the interviews and discussions with partners from various organizations and institutions in Yemen. The following listing, therefore, is a reflection of a set of doubts and questions of Yemeni partners, rather than an analytical and academic array of issues to be considered.

- The idea: First of all it is crucial that the idea is clear and shared that health insurance is beneficial, due to its principle of small prepayments to cover big and catastrophic risks. It is not enough that the experts are convinced. It is important that this idea is shared by certain groups of society, and that there are examples of solidarity schemes and (even small scale) health insurance projects stemming from the sharing of this idea by a number of stakeholders. Dissemination and replication of this ideas is not feasible just by marketing but by the marketing of a good product, which is acceptable in various cultural and religious settings. The principle of solidarity alone will not suffice, to convince people and partners. Enlightened egoism will accept, too, the principle that health insurance has to be mandatory for many, to save money individually in case of an unpredictable need. Motivation and mobilisation has to foster the spreading and sprouting of the simple basic idea of health insurance
- Power: If this idea is backed up by powerful and influential people, small scale endeavours can expand into a broader scheme, what is necessary for a good pooling, i.e. for involving many members so to be prepared for covering rare risks. Power alone, nevertheless, is not sufficient. It has to be combined with leadership, i.e. with a powerful personality who personally promotes and pushes the principles of a social health insurance. This leader has to be able to convince sceptical partners and stakeholders, e.g. the Ministry of Finance. She or he has to have the capacity in sharing the excitement on health insurance with others. One or more shining stars are needed. We can call it a mastermind what is needed, somebody who cares for his brainchild called social health insurance.
- Principles: The basic idea of health insurance rests on various pillars.
 - A social health insurance can not survive on its own. There has to be government aid to support the production of health by promotion and prevention and the provision of basic health care. This can be done either directly by public providers or it can be contracted out. The important thing is that it is done rationally, i.e. that efficiency of all undertakings is strictly implemented and that effectiveness concerns address for example a rational drug use campaign and a referral system by a trustful and trusted gatekeeper. There has to be government aid in the form of re-insurance for emerging or smaller health insurance schemes, too.
 - Another principle is that the poorest have to be supported by the better-off, either through the tax system or through a subsidised or even free participation in the scheme or by both. The same applies to small-scale self-employed subsistence farmers and traders with meagre returns, to the unemployed and those affected for a certain time by specific vulnerabilities or shocks. Clear and feasibly enforced exemption rules of paying for health care or health insurance are a must.
 - A third principle is that there should be no losers, if possible, when introducing health insurance into an existing set-up with already operational health benefit schemes for selected and lucky workers and employees. Acquired labour rights deserve safeguarding. The same holds true for some stakeholders who started already with health insurance project proposals, as for example the armed forces and the police.
 - A fourth principle seems to be simple: health insurance has to benefit its members in a noticeable way. This means, that pre-payment is and should be pre-payment, i.e. there

should not be a confounding with post-payments in the form of cost-sharings and co-payments, except in cases where such is needed for moral hazard handling.

- Governmental back-up: Institutional power has to back-up the dissemination and replication of the health insurance idea and has to give it sustainability.
 - First of all, assigning some priority to basic health and basic education as the drivers of economic development is a mandate to be followed by a rational national government; health insurance leadership has to convince government leaders on the intrinsic relation between macroeconomics, health and education.
 - Adjustment of existing financial, pension and labour laws is a second important back-up as well as the drafting and more-partite discussion and revision of them in periodic intervals so to learn from experiences.
 - A third and very fundamental issue is the channelling of funds earmarked for health to health uses. This was not always the case in the past in Yemen. It means that there shall be a clear division of labour between a health fund or various health funds and the government. Government should not intermingle with funds that are run according to the principles of a rational public health minded decision making.
 - Government has to exert stewardship to back it up and to strengthen it. A clear-cut division of labour in this regards has to be installed and maintained.

- Management: A state-of-the-art management is needed with a high level of passionate professionalism and experience, not allowing routine practices and bureaucracy. Management has to be backed-up by an excellent and innovative think-tank, by institutionalised and influential dialogues with the patients (e.g. self-help groups of diabetes patients, civil society organizations), partners (e.g. the labour sector), providers (public and private) and competitors (other health benefit or health insurance schemes). A goal should be to achieve step-by-step a mutual learning and a gradual harmonization of schemes and a better pooling and risk sharing. Repeated evaluations of goal achievement are needed.

- Trust: Trust in funds got lost in Yemen. Graft and corruption were mentioned again and again in all interviews. Transparency, accountability and credibility might be achieved best by independence from government and by an ongoing internal, civil and international advise and auditing. In view of transparency simple procedures and clear financing and benefit rules should be introduced with clear definitions of rights and obligations of clients and providers and a clear and true information for all partners involved, including the media. Trust can be regained only if the clients see value for their pre-payments. High quality health care is still rare in Yemen, Yet, there are examples and ways to improve it through selective contracting of the best providers and a permanent and sustainable drive towards quality assurance.

- Control: Collateral to increased transparency is the enforcement of rules and regulations by a strict and compassionate system of checks and controls. Trying to avoid corruption, parasitism, free riders, double-jobbers, ghost clients, ghost employees and ghost providers requires a lot of intelligence, intuition and imagination. A central intelligence agency will have to be built up inside a health insurance authority for increasing efficiency, so to avoid opportunity costs and to spend the scarce resources for the purposes of health insurance rather than for private profits. Clear and drastic penalties have to exist and a judicial system that can and will and is willing to enforce them. Health insurance is not an island in Yemen – it has to face the realities surrounding it and the intelligence of people trying to benefit from it. This is one of the most important challenges and threats. Potential profiteers are not just individuals but also institutions where funds might disappear and be channelled to other uses, as it is experienced widely in Yemen. It is by no means an easy task.

- Good start: It seems to be vital to have a good demonstration project at the beginning. A project that can match the best intentions of health insurance with best implementations and best practices. A similarity with the excellent but misused drug fund hast to be avoided. A modelling after the pension funds has to be done carefully, since they are not regarded by many as best

examples. A similarity with the social development fund would not be bad which relies on strong international back-up and an outstanding personality as manager, indeed. A good start is needed with an easy to administer group or segment of the population. In case of political willingness and support the start has not to be too small and slim.

6.4.3 Further preconditions

A number of further conditions need to be satisfied and some key questions answered before Yemen can embark on the establishment of a Social Health Insurance. Some of the questions relate to the political consensus and willingness, others to the economic situation and the labour market. Last but not least there are many technical and administrative questions to answer. The fact that there was already a draft of a Health Insurance Law presented to the Government in February 2004 indicates that there have been some steps taken to answer some of those questions. On the other hand the codification of the Health Insurance Law was postponed because parts of the Government thought that Yemen was not yet ready for the reform. This underlines that it is necessary to update and concrete the political goals, to analyse the situation regarding the basic preconditions, to assess concrete impacts of the planned reform and also to assess optional alternatives. First of all it needs to have a broad consensus of the stakeholders to implement such a reform. This is a “*conditio sine qua non*” for any further steps of implementation.

The general preconditions of starting a NHIS are the following:

- Consensus in the group of Yemen’s political decision-makers and stakeholders, support from the President and the Prime-Minister
- Support from international stakeholders and donors (for example the World Bank, WHO, ILO etc.)
- Openness and comprehension for the reform among Yemen’s population
- Minimum of insured people in the beginning
- Sufficient management capacities
- A basic technical infrastructure, at least a sufficient budget to build it up
- Openness for external support and implementing the system by a professional project management
- Sanction/Penalty system
- Willingness for both: codification by law (legal framework) and reviewing/updating existing laws.

Besides these preconditions (see specifications further on in part 2 of our study report) it is necessary to answer the question if there is an acceptable health care infrastructure in place that will be able to provide the health services that will be part of the health insurance benefit package.

On the background of these preconditions some important findings from our interviews and analysis of documents might be mentioned:

- Corruption in Yemen’s society was a main issue in most of the interviews.
- In August 2005 there seemed only partly to be a consensus of building up a National Health Insurance that follows the criterions “transparency”, “accountability” and “credibility”
- Existing laws like the Labour Law for the private sector do have some good stipulations as to company-based health care and service insurances, other regulations, for example the continued pay in the case of sick leaves don’t suit to a modern National Health Insurance law and should be revised and adapted. This is also because they are not attractive for private investment in Yemen’s economy.
- On the one hand many of Yemen’s health indicators are pretty bad, on the other hand there are hundreds of professionals (doctors, pharmacists) unemployed and underemployed. Only building up a National Health Insurance can not solve this problem, but it needs a public investment in facilities and staff, a professional distribution of resources and the implementation of a penalty system.
- There is lot of good practice within existing health schemes, especially in the private and public company sector, but there is also an amazing variety of different benefit packages, financing and

mobilizing revenues and health care procedures. Variety is also an advantage, that's why good practice should be kept and can give an orientation for further reform steps. So it is necessary to integrate good practice into the reform by a nation-wide comprehensive strategy.

6.5 One theoretical option: Tax based health provision

In contrast to most countries with social health insurance, where the goal of universal coverage has been stated fairly recently, universal coverage has been a central feature of countries with tax-financed models (Busse et al. 2005). In New Zealand the main policy objective to provide “free care for all” dates back to 1938. The UK followed with the creation of the National Health Service (NHS) in 1948 – “universal, comprehensive, and free at the point of delivery”.

In Northern European and Australasian tax-financed health care systems, entitlement to health care services is based on residence, such as in the UK, Australia, New Zealand or the Scandinavian countries - independent of citizenship. The population not covered in these countries is accordingly very small and basically limited to illegal immigrants. Compared to these countries, universal coverage is a more recent phenomenon in Southern European tax-financed countries, but by 2002 all countries with a National Health Service in Southern Europe had also achieved near-universal coverage.

In Italy, a National Health Service with the objective of universal coverage was introduced in 1978. Before 1978, 93% of the population was covered by public health insurance, although under markedly varying conditions. The 1978 reform changed the principle of health care financing: solidarity within professional categories was discarded in favour of intergenerational solidarity, which backed the introduction of universal, free coverage for all Italian citizens. Non-Italian residents were at first not included under this legislation. Only since 1998, legal immigrants have the same rights as Italian citizens. Measures were also taken to provide some care to illegal immigrants, who now have access to a limited range of health care services, in particular treatment for infectious diseases and health care schemes for babies and pregnant women (Donatini 2001).

According to the last National Health Survey in 1997, 94.8% of the Spanish population was covered under the obligatory affiliation to the National Health System; 4.6% of the Spanish population – civil servants and their dependents – took out insurance with a non-profit mutual fund. If individuals are not covered by the national scheme, this is usually on the grounds of membership in an alternative, employment-linked insurance program and not on the basis of inability to contribute. The small group of the Spanish population formally not covered by either the National Health System or a mutual fund, consists mainly of those who are not obliged to join the social security system and, simultaneously, do not qualify for access through the non-contributory scheme for the poor. This excluded group is basically made up of self-employed liberal professionals and employers (Rico 2000). Access to health services in Spain is connected to the ownership of the *Tarjeta Sanitaria Individual* (TSI), an individual electronic health card. Since 2001 the TSI is available for citizens as well as for foreign residents. There is no difference between Spanish citizens and migrants even if they are considered “illegal”. A new initiative in Catalonia aims at extending the group of migrants owing a TSI irrespective of their legal status, thus being able to access the public health networks. By offering information and facilitating the access, improved knowledge about services included in the TSI and strategies for marginalized populations shall be achieved (Velasco-Garrido 2005).

In Portugal, in addition to the National Health System which covers 83.5% of the Portuguese population, 10% are covered by substitutive private insurance schemes and 6.5% by mutual funds. Generally, the benefits received under private insurance or mutual fund schemes exceed those provided within the NHS. However, in both subsystems the employer and employee contributions are often insufficient to cover the full costs of care and consequently a significant proportion of costs are shifted onto the NHS. This was caused by enrollees of these funds not declaring their membership when receiving treatment within the NHS, thus exempting the funds from responsibility for the full costs of their members' care. The relationship between the NHS and the subsystems was explicitly

addressed by legislation in late 1998. A scheme of systemic controlled “opting-out” was devised, by which the financial responsibility for personal care in the NHS could be transferred to public or private entities by means of a contribution to be established in a contract with the Ministry of Health. Three agreements have been made between the Ministry of Health and subsystems. The State transfers annually to those entities a capitated amount for each beneficiary and in turn, the corresponding subsystem pays the whole price of NHS hospital services and ceases to benefit from NHS co-payments in drug dispensing. The benefits of the improved articulation between the NHS and the subsystems are unquestionable. However, there is striking evidence of a discrepancy between the ease of financial transfers from the Ministry of Health to the subsystems and the difficulty NHS services have in invoicing and billing the services rendered to the subsystems’ beneficiaries (Bentes 2004).

There are 13 countries among the 25 countries reviewed in the report by Busse (2005) which mainly derive their health care expenditure from tax payments. They derive their tax payments as direct taxes, e.g. personal and corporate income tax, or as indirect taxes, e.g. value added tax. Some of these countries, especially Iceland, Finland and Sweden, do additionally rely on social health insurance contributions, although these are minor compared to tax payments.

Spain and Iceland have moved away from social health insurance and managed the transition to tax payments as the main financing mechanism. In both countries the major reason for this change has to be seen in the perceived higher progressivity of the tax payment mechanism, although social health insurance contributions, if designed accordingly, could have possibly achieved a similar level of progressivity as actually achieved by the change in Spain (i.e. from regressive in 1980 to neither pro- nor regressive in 1990).

Table 35 The transition from social health insurance to tax-financing in Iceland and Spain

In Iceland, more than 60% of health expenditure was financed by flat rate insurance contributions to sickness funds until 1972. Since these contributions were perceived as too regressive and as health expenditure was rapidly rising at the same time it was decided to shift to tax payments. In the transition period from 1972 to 1989, sickness funds still remained but received their funding completely from tax payments, 80% from the state and 20% from local governments (Halldorsson 2003).

Spain also mainly relied on social health insurance contributions. In the mid-1970s, the social health insurance contributions contributed about two thirds to the total health care expenditure, while the remaining third was covered through tax payments. In 1986 with the introduction of a National Health Service a major shift towards tax funding was initiated. By 1989, the previous pattern was reversed for the first time, with tax payments constituting 70% and social health insurance contributions dropping to about 30% of the total. Throughout the 1990s, the role of social health insurance contributions has been steadily decreasing (Rico, Sabes 2000).

Source: Busse 2005

In contrast to Spain and Iceland, the decreased level of tax financing led to a relative (albeit minor) increase in the percentage of social security contributions in Finland. The share of tax payments decreased from 66.1% of total health expenditure in 1975 to 59.7% in 2002, while social security contributions increased from 12.6% in 1975 to 15.9% in 2002. This shift is mainly due to the economic recession Finland was faced with in the nineties (Järvelin 2002). Canada and Norway experienced even more dramatic slashes in the share of taxes as percentage of health expenditure – in favour of more private financing mechanisms. However, this development did not necessarily reflect a decrease in available taxes (as in Finland) but a massive slash in health spending from general revenue, revealing the vulnerability of tax payments to changes in political priorities.

Instead of deriving tax payments as direct or indirect taxes for general revenue, some therefore suggest an ear-marking of taxes for health expenditure. Strangely enough, such taxes do not exist in countries which are mainly tax-financed (though in the case of Sweden it could be argued that the provincial taxes are *de facto* earmarked as the vast majority of them is used for health care). Instead, ear-marked taxes have been introduced as a source of complementary financing in countries with mainly social security financing. In France, 3.3% of the total health revenue is raised as earmarked taxes on car usage, tobacco and alcohol consumption. In addition, the pharmaceutical industry is required to pay an earmarked tax on advertising accounting for 0.8% of total health revenue (Sandier 2004). Germany raised its taxes on tobacco consumption by almost €1 per pack in three steps by 2005 which is channelled into social health insurance to stabilise contribution rates.³⁸

The common assumption is that tax payments mainly play a role within tax-financed health care systems and SHI countries rely predominantly on wage-related contributions to fund their health systems. However, in Austria, Belgium, Switzerland and Japan more than 10% of their total health expenditure are raised through taxes – up to 30% in the case of Austria (Busse 2005). Additionally, and more confusing, in international statistics it is often unclear whether expenditure through taxation includes tax subsidies to sickness funds or whether these are included as SHI resources. With other words, in some countries the stated share of tax payments might underestimate the actual amount of resources collected via taxes, since these possibly include a reallocation of resources.

6.6 A second theoretical option: priority coverage of catastrophic cases

A different financing mechanism which evolved during the eighties is the approach of Medical Savings Accounts (Busse 2005). Under this approach an anticipated amount of money needed is saved up *ex ante* by each individual in a special account set aside to cover health care expenses. In contrast to tax payments and social health insurance contributions the collected resources are not pooled, and are therefore combined with some form of health insurance against high financial risk from illness. The reimbursement of health costs in the framework of this high-risk insurance is limited either to the costs of precisely defined treatments, especially those which potentially expose the insured to high financial risk (e.g. in the case of severe or chronic diseases), or takes effect only in excess of a certain deductible, which is limited to a specific amount per year. This high-risk insurance cover can be provided by a tax- or social health insurance-based system or by private health insurance (Schreyögg 2004).

As compulsory social health insurance contributions Medical Savings Accounts require the individual each month (sometimes shared by the employer) to pay a fixed amount or a percentage share of his gross income into a Medical Savings Account on a compulsory basis. The compulsory nature of Medical Savings Accounts, in contrast to a private bank account, guarantees that the individual does, in fact, create capital reserves that he can fall back upon in case of illness.

Should the account be exhausted and services and not reimbursed by high-risk insurance, expenses incurred must be paid by overdrawing the account or by private means (Nichols 1997). If the funds in the savings account have not been exhausted by the end of a given year, the remaining funds will be saved in the individual's account to cover future health expenses subject to a defined rate of interest. Depending on the organization of the system, reserves can also be created as old age reserves for the time when the individual is no longer gainfully employed. Persons that are no longer gainfully employed are then no longer obliged to pay contributions to the Medical Savings Account. Furthermore, it is also possible for the account holder to bequeath any funds saved to his descendants.

The three main reasons for the introduction of Medical Savings Accounts as financing mechanism are, to prevent moral hazard in spending by linking health care resources to individual responsibility, to set

³⁸ The tax on tobacco consumption was labelled as earmarked tax by the German Government although earmarking is actually not possible in the framework of the German tax system.

aside reserves for old age and to achieve a higher affordability of voluntary health insurance premiums by providing means to cover deductibles. There are currently two different approaches to Medical Savings Accounts in high income countries used by Singapore and the USA.

Singapore formerly had a largely tax financed system with tax payments contributing 51% of total health expenditure in 1965. At the beginning of the 1980s, a distinct increase in the proportion of elderly in the population and an accompanying rise of health care expenditures due to medical advances were anticipated. It was predicted that a health care system financed mainly by taxes in an environment of rising health care expenditures and falling tax revenues as a result of a declining labour force would no longer be a suitable method of funding in the long run (Phua 1991). A reformed system was therefore intended to solve the anticipated demographic problem and, at the same time, to create incentives for acting economically, while respecting the provision of health care services as a scarce resource. By creating a new structure of financing Singapore moved towards a mixed system based on social health insurance contributions (7%), payments into Medical Savings Accounts (8.5%), tax payments (26.5%), voluntary health insurance premia (15%) and out-of-pocket payments (43%) (Schreyögg 2003).³⁹

In spite of its advantages the system of Medical Savings Accounts in Singapore raises a number of equity issues due to its regressivity and is therefore not suitable for every country (Nichols 1997). In contrast to Singapore the objective of the approach in the USA is focused instead on cost containment, expansion of insurance coverage to include the 15% uninsured and thus serves primarily to finance a high deductible in order to reduce premium payments.

Table 36 Medical savings accounts in Singapore

Initially, in 1984, a system of Medical Savings Accounts, called Medisave, was introduced in Singapore. In this system, every gainfully employed citizen of the State of Singapore is obliged to pay a 6-8 % share of his income – according to his age – into an individual account managed by the state. Funds saved in the accounts are invested in the capital market by the government and interest is paid at the current market rate (Asher 1995). In case of illness, the individual can pay for his treatment and that of his dependents from the savings in his Medical Savings Account. However, only hospital costs and certain selected out-patient costs approved by the state in a catalogue of services may be financed by the Medical Savings Account. Citizens receive regular statements of account, showing the current status of their savings account. As soon as a Medisave Account shows a balance of € 30.000, all amounts paid in over and above this amount are automatically transferred to the building savings account of the respective individual, an account which every employed citizen of Singapore is obliged to maintain in order to save money either to purchase real estate or to invest into the education of their children. This system was supplemented by a high risk health insurance scheme (called Medishield), being paid from contributions depending on age, which can be financed from individuals from the respective Medical Savings Accounts and intended to finance both expensive hospital treatments as well as out-patient treatments for chronic diseases. In addition a fund (called Medifund) is used to support individuals with low incomes who do not have a Medical Savings Account at their disposal or who are unable to set aside sufficient savings. Medifund is financed by the state from general taxes.

The implementation of the system of Medical Savings Accounts in Singapore has not yet been fully completed, because the generation entering into retirement before 1984 was not able to accumulate capital stocks and is therefore financed by family members or by state assistance. For this reason, full implementation of the system will not be achieved until the

³⁹ Shares for voluntary health insurance premi and social health insurance contributions are estimates. All other shares are based on data of the Ministry of Health Singapore (2002) for the year 2000.

Table 36 Medical savings accounts in Singapore

year 2030. Apart from medical savings accounts the low share of health expenditure as % of GDP of 3.7% (2002) may also be attributable to the young population and an incentive scheme of hospital classes. However there exist a number of indications on the basis of different studies that they have at least made a considerable contribution to this low share (Prescott/Nichols 1998; Schreyögg 2004a). Beyond this, the accumulated assets of all Medical Savings Accounts already amount to ca. € 13.1 billion (2001), thus constituting an important source of capital for investments in Singapore's national economy (Asher 2002).

Source: Busse 2005

6.7 Third theoretical option: rather comprehensive benefit package

6.7.1 Experiences from other countries

Since the highly considered World Development Report 1993 "Investing in Health", the concept of a package of essential health care, based on services that have been shown to be cost-effective, has been adopted in principle or in practice by a large number of countries (World Bank 1993). In the meanwhile, many multi- and bilateral donors have encouraged or promoted their adoption. However, the package concept was not that new and reflects the idea that comprehensive primary health care proposed e.g. at Alma Ata in 1978 is too expensive for many developing countries (Ensor 2002, p. 247). However, much of the literature on basic and essential services packages focuses, on the one hand, on the design and implementation and, on the other hand, on methodological tools for measuring the economic benefits, achieved life years and related problems. Relatively little attention has been given to the evaluation of the strategy in the field and on the impact on health and other social indicators (ibid. p. 248).

In most countries that have decided to follow the pathway towards implementing basic health care include the following health benefits:

1. Reproductive health care - including safe motherhood (essential obstetric care, ante-natal and post-natal care), family planning, other reproductive services including sexually transmitted diseases;
2. Child health care - including acute respiratory infections, diarrhoeal diseases, vaccine preventable disease and adolescent care implemented through an integrated management of sick child approach;
3. Communicable disease control - including tuberculosis, leprosy, malaria, filarial, kala-azar and emerging diseases;
4. Limited curative care - concentrating on first aid for trauma, medical and surgical emergencies, asthma, skin diseases, eye, dental and infectious ear diseases;
5. 'Behaviour change communication' is being implemented as a way of influencing health behaviours and health-care-seeking practices across all of the ESP components (Ensor 2002, p. 249).

Recently, a series of initiatives have started in Latin America to overcome social exclusion in health and to improve coverage of social protection in health. The enforcement of social policy measures by international donors (HPIC-Initiative, MDG) was a strong motivation for governments to create targeted insurance plans with a limited benefit package dedicated mainly to maternal and infant health problems. Bolivia was one of the first countries to start the implementation of a mother child health insurance schemes on the national level.

The Bolivian Basic Health Insurance (Seguro Básico de Salud - SBS) was born in 1999 as a social policy program that was supposed to develop into an insurance scheme. Source of financing are national tax resources channelled via the municipalities according to a capitation flat rate. The SBS

focussed on the poor population in rural and suburban areas. Enrolment is free of charge, and services are granted free of co-payment. Provider payment relies on the municipalities, and health care provision mainly on public facilities. The SBS offered a well-defined package of benefits according to the most important epidemiological problems and health needs concerning maternity and early childhood diseases. In the meanwhile, the SBS has developed into the Unitarian Mother Child Insurance (SUMI) that is offering a broader benefit package including chronic infectious diseases except HIV. Membership is formalised by an insurance card delivered by the local authority, and affiliation to the SBS is higher in rural areas. However, reliable data about the number of actually affiliated beneficiaries are extremely difficult to explore.

Total population	8,808,000
GDP per capita (Intl \$, 2002)	2,568
Life expectancy at birth m/f (years)	63.0/67.0
Healthy life expectancy at birth m/f (2002)	53.6/55.2
Child mortality m/f (per 1000)	68/64
Adult mortality m/f (per 1000)	247/180
Total health expenditure per capita (Intl \$, 2002)	179
Total health expenditure as % of GDP (2002)	7.0
Source: WHO 2005b; figures for 2003 unless indicated.	

The SBS benefit package is designed according to the country's most important health needs. The volume of covered benefits depends basically on the financial situation of the general treasury and obeys to economic and epidemiologic reasons, following the logic of a strict cost-effectiveness-relationship. The 76 services included in the SBS-package cover 56 % of the necessities to deal with the most relevant epidemiological problems, giving priority to maternity and early childhood disorders. The benefits cover of the epidemiologically most relevant causes for morbidity and mortality in Bolivia and represent an amplification of the pre-existing Mother-Child-Insurance.

The SBS-package is limited to maternity- and childhood health problems and some epidemic infectious diseases; thus, most other diseases and their treatment are excluded. The SBS-scheme does not grant any non-obstetric or orthopaedic surgery, no treatment of chronic or acute diseases except the selected infections, and no specialised treatment. The benefit package does not offer any option of choice for providers and enrolees. Promotional activities are practically limited to family planning. Prevention appears mainly in form of different vaccinations including a triple antiviral (MMR), OPV, BCG and DPT extended to Hepatitis B and Haemophilus influenzae B. Immunisation indicators are relatively high in most parts of the country (coverage rates between 87.01 and 94.78 %; total vaccine coverage: 80.88 % of the children until 1 year).

The SUMI scheme is currently covering the following benefits:

1. Children under 5 years
 - Health care and nutrition
 - Comprehensive child vaccination
 - Nutritional promotion and feeding
 - Treatment of the most relevant killer diseases including acute diarrhoeas and respiratory infections
2. Health care of women in fertile age
 - Periodical prenatal control, delivery and post-delivery care
 - Prevention and treatment of pregnancy complications
3. Family Planning and treatment of endemics
 - Information, education and family planning services
 - Diagnosis and treatment of tuberculosis
 - Diagnosis and treatment of diseases of sexual transmission, except AIDS treatment

- Diagnosis and treatment of malaria
- Diagnosis and treatment of cholera

Essential benefit packages are designed for improving access to affordable health care for the most vulnerable population groups. They target to increase the use of health facilities by the poor, to offer effective services for diseases endured mostly by the underprivileged and to make selected health care available in rural areas. In fact, evidence from several studies suggests that the essential benefit package approach has been successful in enhancing public financing of primary levels of care, in channelling resources into vital health service delivery and to shift attention from hospitals to health units and centres (Ensor 2002, p. 254). The last point seems to be of utmost importance in the case of Yemen where a high degree of medicalisation (compare Chapter 3.2.1) is to be observed “health insurance” often seen as equivalent to hospital. Therefore, organisational, institutional and, last not least, also political constraints and rigidities that inhibit regional and local resource flows have to be overcome in order to make an essential benefit approach viable and effective.

6.7.2 Options for Yemen

The socio-economic situation and the conditions of health and health care in Yemen have a series of similarities to Bolivia. Certainly, some indicators appear to be worse in Yemen, but the pattern of diseases and the epidemiologic challenges are roughly the same. Facing the Millennium Development Goals (MDG), the Bolivian Government decided to make a serious attempt to improve the most worrying health indicators by investing public resources. Bolivia offers a universal essential benefit package designed especially for the needy. Financing the SBS and the SUMI through general taxes, the Bolivian State has proven his willingness to pay for the poor.

According to recent estimations, Yemen could provide universal primary care according to an essential benefit package at an annual cost of between 8 – 15 billion Rials assuming a contact rate of approximately 1 visit/ capita/ per year (Rhodes 2004, p. 17). In spite of the general lack of data and information in Yemen, some rough estimations are available with regard to the potential costs of implementing an essential benefit package covering mainly maternal and child health as well as the most important infectious diseases. According to a recent study, the overall size of investment required to achieve the MDG-related targets of the health investment plan and to deliver the interventions in the priority areas amount to \$ US 14,133,763,450 or \$ US 53.52 per capita for the period 2006 – 2015. Most of the challenges set by the MDG are closely linked to a reasonable essential benefit package for Yemen so that the following estimations give an idea of the costs to be expected.

Table 38 Estimated expenditure for an MDG-oriented essential benefit package in Yemen		
Type of intervention	Total cost of EBP (US-\$)	Cost per capita and year (US-\$)
Maternal health	755,890,409	2.83
Child health	1,324,589,359	4.91
Malaria	621,494,461	2.28
Tuberculosis	92,549,568	0.34
HIV/AIDS	364,453,504	1.32
Total	3,158,977,301	11.34

Source: Compennolle 2005, p. 22; it has to be taken into account that according to own investigations and comparisons to other countries in similar socio-economic conditions the prevalence of tuberculosis seems to be generally underestimated in all available statistics.

Regarding the overall epidemiologic situation in Yemen, an essential benefit package should not focus on achieving the MDGs and reducing poverty only. In addition to the persistence of typical poverty-related patterns like malnutrition and communicable diseases, the social and financing burden of “modern” diseases is increasing. Although no reliable epidemiological data for the whole population are available, a series of surveys and specific studies reveal that the prevalence of hypertension,

diabetes mellitus, cardio-vascular diseases and malignomas is relevant in Yemen.⁴⁰ In view of the scarce resources and financial restrictions, an essential benefit package has to focus on prevention, early detection and adequate treatment in order to avoid or, at least, postpone pathological consequences.

With regard to high blood pressure and cardiac diseases, for instance, theoretical considerations confirmed by clinical and epidemiological trials suggest that qat-chewing is a relevant risk factor (Hager 1996). The negative effects on health are enhanced by the increasing use of chemical pesticides and fertilizers producing chronic intoxication of long-term qat-chewers (Date 2005). Thus, preventive measures should stress the relevance of reducing the widespread use of qat-leaves mainly for younger people. As restrictions often lack effect, this appears to be a strong argument for introducing a special qat-tax earmarked for health in order to raise additional funds for a national insurance system. Early diagnosis of treatable diseases depends to a large degree on access to affordable health care, and the current practice of cost-sharing prevents many citizens from contacting providers in time and in an early stage. Thus, a national health insurance system has the potential to reduce overall costs by reducing the necessity of expensive complications of generally low cost diseases.

In order to cover also the upcoming civilisation diseases, a study demanded by the MoPH&P and performed by an expert of the European Commission parallel to the study on health insurance, proposes to extend the MDG-based scope with a series of other services that ought to be included in an essential benefit package. With regard to treatable infectious diseases, leprosy,⁴¹ helminthiasis⁴² and bilharziasis also deserve a concerted action and available drugs in case of need. The essential package should take into account the probably underestimated prevalence of hypertension, focussing on early diagnosis and treatment.⁴³ The problem is costing hypertension diagnosis and treatment because the prevalence is difficult to calculate and might be highly under-estimated. In addition to the above mentioned patterns of disease, the EC-study suggests to include also primary eye care, medical and surgical emergencies (injuries, animal bites, shock, burns, acute abdomen etc.), and minor surgery (circumcision, drainage or incision of abscesses, etc.) (Neu 2005, p. 12).

Independent from the decision to be made about the most adequate essential benefit package for Yemen, it has to be said clearly that additional efforts will be unavoidable for implementing and guaranteeing the availability of such a package. Mainly Health Units and Health Centres have to be improved and adapted to the necessities of effective service delivery. Besides the scale-up of facilities and human resources, other investments will need to be made for improving the system's ability to plan, finance and deliver high-quality health services. Essentially this includes strengthened management capacity, improved monitoring, evaluation, and quality assurance, enhanced community demand and access to essential interventions, better health information systems and research as well as improved access to affordable essential drugs (compare Compernelle 2005, p. 19f).

6.8 Résumé

For health systems research and health systems management there is no better source of evidence and inspiration than international comparisons and a review of historical developments in health systems abroad. This is a principle on which international organizations dealing with health systems are being

⁴⁰ According to a study performed between 2000 and 2001, 18 % of hospital patients suffered from high blood pressure (oral information given by Prof. Mohammed Y. Al-Noami, Minister of Public Health and Population). Statistics of Al-Thawra Hospital show 665 cases of hypertension and 1774 patients treated for chronic or acute ischemic heart disease.

⁴¹ According to data published during an international conference on leprosy held in Sana'a in early September of 2005, at the beginning of 2005 the prevalence was 286,063 cases, while in 2004, the incidence was 407,791. (Yemen Times, 12th Sept. 2005).

⁴² Especially *Echinococcus* seems to be epidemiologically relevant, as statistics of Al-Thawra Hospital refer to 57 cases of hydatod cysts that underwent surgery in 2004.

⁴³ With regard to the costs of various treatment modalities, the more traditional approach based on β -blockers and/or diuretics might be the most suitable and affordable scheme to cover the demand within a basic package; however, the first substance might raise resistance because it antagonises the effects of Qad. Anyhow, preventive measures like stopping Qad-chewing seem to be most likely to lower blood pressure and to reduce treatment costs.

build upon. A look into the neighbouring countries is quite useful. And it is understandable to prefer being compared with countries of a similar level of development. To be able to understand longer term trends it is nevertheless essential to observe historical developments in richer and more developed countries which – a certain time ago – had a less advanced development stage, too. When South Korea and Germany started with health insurance they were at comparable levels of development as Yemen is today. Learning from mistakes of others can save a lot of money and prevent frustration. Other countries did not go the way of health insurance. It is essential, to learn from them, too. All options have to be taken into consideration, to be able to decide rationally on choices for the best health financing system for Yemen.

7. Summary and preview

7.1 Introduction

More than half of the Yemenite population do not have access to health care. This is partly due to the lack of reachable provider facilities, mainly in rural areas where more than two out of three citizens are excluded from health care. The other relevant factor is the inability of the poor population share to pay for health care. Health insurance coverage is practically inexistent, and pre-payment schemes are very scarce and hardly affordable. People have to cover most expenditure from their pockets, so that many people are unable to pay for needed and adequate medical care in the time of need.

Some political initiatives have been raised in the past in order to overcome this situation by implementing social protection in health. Especially health insurance has the potential to lower the access barriers to health care, to prevent impoverishment caused by illness, and to overcome the exclusion of so many citizens from health. Collective funds are best for fair health financing, because individuals or groups can dedicate an affordable amount of money to acquire the right to receive financial support whenever the insured health risk occurs. Health insurance makes payment for health independent from the utilisation of clinics, hospitals or pharmacies, because people pay before falling ill and not only when we are sick, as most people have to do now with a very high share of out-of-pocket payment. And it pools different risks, since everybody pays and not only the sick or vulnerable. Cases of serious and costly illness that do not happen very often can be paid by a health insurance fund. We talk about national health insurance, when almost all citizens are obliged to join health insurance, especially the wealthy and the healthy, and when all citizens can enjoy the benefits of health insurance. We talk about a national health insurance system, when different health financing forms are combined to provide health care in case of need and not just according to the ability to pay.

7.2 Terms of reference

Based on a Decree of the Cabinet of the Republic of Yemen the German Development Cooperation (GTZ) was contracted to undertake a study on situation assessment and proposals for national health and insurance system. The terms of reference are:

1. Collect, summarize, and synthesize all relevant documents and data bases prepared for Yemen and provide an overview for a comparative analysis of the situation in Yemen with selected countries in the region and the World.
2. Identify important existing solidarity schemes in Yemen and analyze their structure, impact, and performance.
3. Review existing health insurance schemes in Yemen, including public sector programmes, private health insurance, community-based health insurance and company-based health insurance schemes.
4. Conduct and analyze a health financing opinion survey of politicians, Islamic leaders, citizens, development partners, local governments, ministerial officials, insurance companies, public and private health care providers, NGOs, workers' syndicates and the medical association.
5. Visit and interview the ministries and other central institutions, public and private health care providers, district local councils and health offices on governorate and district levels.