

# Towards a national health insurance system in Yemen

## Part 2: Options and recommendations

### 1. Background and assessments

#### 1.1 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.

#### 1.2 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.
6. Compare the present situation in Yemen with experiences in similar countries in the region and worldwide in order to determine which preconditions are required to start a National Health Insurance System.

7. Analyze and discuss in a workshop(s) all findings and suggested alternative health care financing options with major stakeholders and draw conclusions against background of the realities in Yemen.
8. Develop at least 3 alternative health financing proposals which assure the equity of health care provision. Each proposal should cover issues related to revenue collection, provider payment, choice and unit of enrolment, benefit package, pooling arrangements, contribution schedule & method and purchasing.
9. Propose an implementation plan with stages of regional, social and organisational expansion according to priorities, management capabilities, quality of existing health services, and preparedness of population groups
10. Prepare the National Health Insurance financing framework for each proposal as well as preliminary macro-financial projections for the first 10 years.
11. Identify areas of demand for future technical assistance for the establishment of a National Health Insurance system in Yemen.

### **1.3 Methodology**

The German study team was working in close cooperation with partners from the Ministry of Public Health and Population. Yemeni professionals participated in all stages of data collection and analysis as “twins” of all international experts in the spirit of mutual learning and capacity building. The team was complemented by specialist consultants from World Health Organization and from the International Labour Office. A comprehensive literature discovery and review was undertaken, and essential documents were translated into English. Interviews were conducted with more than 230 partners from national and local governments, parliament, Shura Council (second chamber), employers, unions, health insurance schemes, pension funds, civil society organisations, and donor agencies. More than 20 groups of opinion leaders shared their views on social health insurance with a multiple choice questionnaire. More than 30 public companies responded to a questionnaire on costs and benefits of their health schemes for employees and their families. Another survey shed light on afternoon jobs of civil servants and their willingness to join health insurance. Field visits in four governorates added to the knowledge gained. In a series of workshops interim findings were discussed, and a consensus of the study team and their Yemeni partners was build up for presenting assessments and options in a larger workshop on 11.-12.09.2005 with more than 80 participants. On 3<sup>rd</sup> October 2005 options and recommendations were discussed with members from Parliament, Al-Shura Council, political parties and the Ministry of Health. A presentation to the Cabinet is scheduled.

### **1.4 Background**

Most of the 20 million Yemeni live in mass poverty and lack government services. The population growth exceeds economic development. Oil reserves will dwindle in a foreseeable future. A sustainable development policy has to be designed and started yet. Human capital formation should be one of the major concerns, with health and education as drivers of economic and social development. Health is a macroeconomic investment. Human resource development has to be complemented by a diversified production strategy and a reversal of the increasing environmental degradation.

Most diseases and deaths in Yemen are avoidable at low cost. Prevention and promotion of adequate health seeking behaviours of families, however, are not priority in decisions on resource allocation for health care. In the strongly medicalised Yemeni society, primary care has a low status although it is highly cost-effective for avoidable diseases as well as for the increasing chronic and “modern” diseases. More than half of the population has no access at all to health care. Especially women are excluded and marginalized. This situation is aggravated by a very uneven distribution of public health facilities and by a significant underfunding of the running costs of public health facilities. Hospitals in the public sector are generally under-utilised and of doubtful quality. The private sector is not properly regulated and its quality is uncertain. There is a very high demand for treatment abroad in the case of severe diseases.

About 29% of total health expenditure in Yemen – from private pockets and public funds – is used for treatment abroad. Approximately every two out of three Rials spent for health care are paid by families and households as out-of-pocket payment in case of illness. Extremely high health care costs hit only very few people, diseases are unpredictable, and prices in the individual case widely unknown. As social protection in health is lacking, these conditions make quite a number of families impoverish by expensive treatments, catastrophic diseases and death of family members. Even for normal diseases they have to spend a lot of money. In spite of relevant presidential decrees and existing exemption rules for the poor, public health care is by no means given for free. Cost-sharing of patients finances 45% of the costs in the largest government hospital, Al Thawra. On top of this, most providers get informal payments. 84% of opinion leaders say, cost-sharing is not well organised; and 91% affirm that cost-sharing leads to postponement of treatments. Exemptions for the poor are only given to a very small extend. This is due to the underfunding of public facilities and the low moral of staff that did not increase by topping up their salaries from the cost-sharing income. In the afternoons, the same staff earns in the grey market or shadow economy of health care. An excellent programme for cost-recovery of drugs by means of a drug fund for essential drugs fell into the trap of mismanagement and corruption. The very good government cost exemption scheme for chronic and catastrophic diseases was not enforced properly. The result is a high private spending at the time of use

- high spending for avoidable diseases
- high spending for catastrophic cases
- high spending for treatment abroad
- high spending for drugs
- high spending for informal, under-the-table payments.

Health insurance intends to regulate and reduce out-of-pocket payment, and to shift the unpredictable high burden for a few persons into regular prepayment of all, so that health care can be given according to need, and not according to affordability, only.

### **1.5 Social security and protection**

A social safety net for Yemeni is a priority of the poverty reduction strategy of the government. A remarkable social fund for development was built up to mitigate the effects of economic adjustment programs. It could address some issues like “providing access to basic services in education, health, water and microfinance, as well as creating job opportunities and building the capacity of local partners”. Nevertheless, most families are left alone in case of structural or random shocks like flooding, fire, robbery, crop failure, inflation, currency adjustments, price increases, unemployment, accidents, famines, disabilities, long-term care needs i.e. all the “small” catastrophes that can destroy the existence of individuals, families and even extended families. Public risk management is not in place, neither. The only element of social protection addressed by the government is an insurance scheme for death, disability and pensions. It covers the military, police and government administration sectors quite well, but coverage of the private formal employment sector is very low. However, the implementation of pension insurance for about one million employees was an important achievement.

### **1.6 Existing health insurance schemes**

Yemen has a rich history of solidarity and local self-help initiatives. Most of them are small-scale and of limited coverage. Undoubtedly, this is a treasury of good ideas and best practices. They have to be further discovered, assessed, disseminated and replicated, wherever possible. This is a strong mandate for follow-up activities towards a national health insurance system in Yemen. Examples are teachers’ and hospital staff solidarity schemes reaching beyond health and health care.

Community based health insurance schemes are discussed and recommended internationally. They are mostly voluntary schemes linked to public or private health care facilities. Two of such endeavours are promoted in Yemen, in Taiz and Hadramaut governorates. Both are not yet ready to be implemented fully, and some doubts prevail regarding their replicability in other areas.

Company based health benefit schemes in the public and private sector do show very diverse and interesting features regarding benefit packages, membership, provider contracting and payment, as

well as risk-management and co-financing. Financial transparency and administration seem to be weak, and there is ample room for improving and strengthening such schemes, that on average cost about 45,000 YR (equals currently 234US\$) per employee (and family) per year. A national health insurance system might and should benefit from the various experiences and from the knowledge available on how to manage such funds. More in depth studies have to be realised on these and similar schemes.

### **1.7 Expectations regarding health insurance**

National and social health insurance is being discussed in Yemen since unification in 1990. Health insurance related salary deductions were already introduced shortly thereafter but not followed by the provision of health insurance benefits. Since 1995 the Ministry of Defence proposes a health insurance scheme for the armed forces, and a similar move is now existing to cover police and security police, altogether close to half a million employees. For the civil public and the formal private employment sector a law proposal of the MoPH&P was given several times to the cabinet, which decided in 2004 to contract a study for assessing proposals and alternatives.

The international community expects a sustainable and really social health insurance for all citizens, especially benefiting the poor, the vulnerable and women that are systematically excluded from access to fair and reliable provision of needed public services. Empowerment of the poor and of women, especially, has to be strengthened in this context. In view of preventing corruption, the building of an independent, transparent, credible and accountable health insurance authority would be the most important prerequisite for a health insurance that might assure accessible and high quality provision of health care for those in need.

Most of the interview partners of the study team did not appear that enthusiastic with regard to health insurance. Most pointed at the difficulties in setting up a trustful fund after repeated bad experiences with funds in the health and other sectors. Many interviewees mentioned other priorities related to the basic needs that are still not satisfied for the majority of the population. A questionnaire given to opinion leaders in Yemen brought a slightly more positive picture. They are quite uniform in rejecting the current practices of cost-sharing for health in public facilities, and nearly all of them advocate a social health insurance system covering the whole family. Health insurance should be mandatory, organisation would be best at the national level, and management should rely on an autonomous health insurance organisation. 77% of the opinion leaders would like health insurance to start immediately or within two years.

### **1.8 Experiences in other countries**

In neighbouring low-income countries, unacceptable high levels of out-of-pocket spending and shrinking government spending for health are as common as in Yemen. In Djibouti civil servants are covered and military and police have health benefit schemes. In Sudan, social health insurance covers 22% including civil servants, students, veterans and families of martyrs. In Pakistan there is no formal health insurance scheme. In the middle-income-countries of the region health care is financed through a mix of tax-based, social health insurance and self-paying schemes. In Morocco the social health insurance coverage reaches 17%, in Lebanon and in Egypt about half of the population, and in Jordan recent reforms have expanded coverage by social health insurance to 60%.

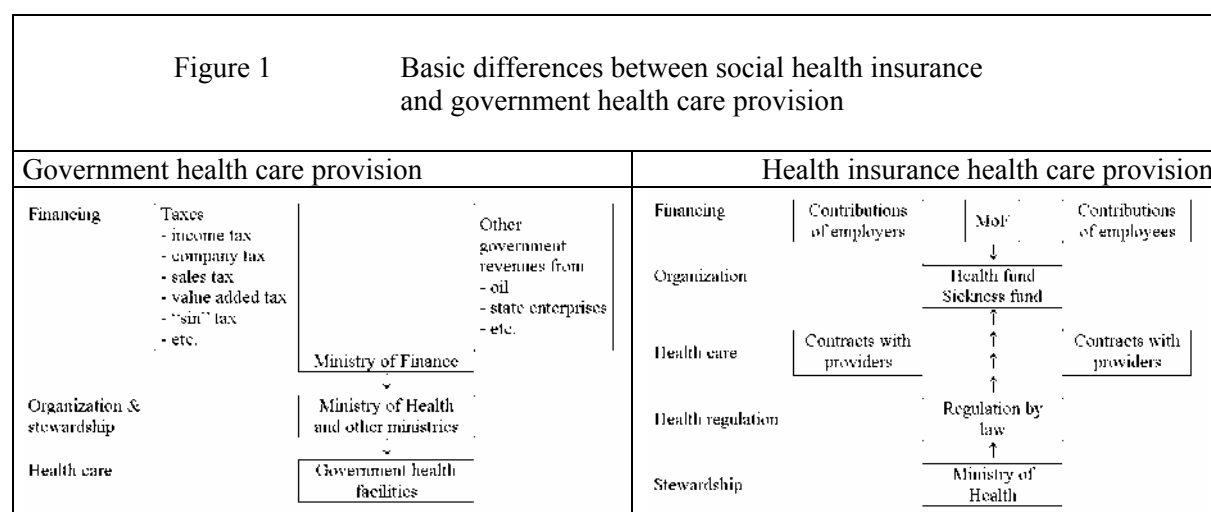
Experiences from other continents can be helpful for Yemen, too. South-east Asian experiences pinpoint to the need of special programs and government subsidies for contributions of the poor. Latin-American experiences indicate that targeted benefit packages are feasible even in precarious economic conditions and that it is essential to make sure that contributions for health insurance are channelled really to health benefits. Africa can give good examples of back-up strategies for emerging health insurance schemes in the form of centres of health insurance competence. Yemen does not stand alone attempting to introduce a national and social health insurance system. It can bank of the experiences of other countries, and should benefit from an appropriate networking with such experiences.

## 1.9 Preconditions for a national health insurance system in Yemen

Health insurance is not an easy concept, especially in the Moslem world. Awareness and understanding is not widespread. Motivation and mobilisation campaigns are needed to spread the basic ideas of a social health insurance and to stress linkage to the idea of solidarity shared by nearly all Arab people. Powerful decision-makers have to be convinced, too, and leadership is indispensable at various levels of policy decision-making. Social health insurance can survive only in close partnership and in a clear division of labour with the government, especially with the Ministry of Finance for funding and progressively taxing the healthy and the wealthy, and with the Ministry of Health for stewardship, prevention of avoidable diseases and promotion through health education for all. In Yemen it might be difficult to regain trust of the public sector and of opinion makers. Funds for health were mismanaged and abused by corruption. Health insurance deductions from salaries did not give any return in form of health benefits. For regaining lost trust, one unrenounceable prerequisite seems to be an outstanding independent management that is entirely bound to the principles of transparency, credibility, and accountability. A strictly professional approach is as needed as a staff that is knowledgeable in all the many specialised domains of health insurance and dedicated to the basic ethics of public service in the public interest.

## 2. Alternative health financing and health insurance proposals for Yemen

Health insurance differs significantly from government health care provision as it exists in Yemen. The following figure presents a simplified confrontation of both types of health care provision.



Between both types of health care provision there are fundamental conceptual and practical differences. In case of government health care provision organization, supervision, regulation and stewardship are tasks of the Ministry of Health. This generates typically an overlapping of diverse interests and decreases efficiency. In the case of a social health insurance, the Ministry of Health regulates, supervises and gives stewardship but is not a provider of health care; the most cost-effective providers are competing and they are contracted by the health insurance which is governed by employers and employees as payers, eventually joined by the government if subsidies are given. Check and balances are easier and better to be organized, if such a kind of clear-cut division of labour is done. There are many more reasons to opt for a social and national health insurance system.