

In terms of a feasible and reasonable choice it seems to be advisable to start working with the last mentioned alternative.

### 3. Implementation plan

#### 3.1 Prerequisites

According to the experiences of countries with health financing systems based on social health insurance like for example Austria, Costa Rica, Germany, Japan or the Republic of Korea it is evident that Yemen needs a transition period to achieve universal coverage. The period between the first law related to health insurance and a final law approved to implement universal coverage was never less than 20 years. Yemen might learn from those experiences and the transition period would not be that long but it will take some time nonetheless. Government stewardship is an essential facilitating factor in this process. The very first stewardship function is to address the principal design features of the scheme. These are:

- Milestones for the systematic coverage of the population or specific groups
- Definition of the contributors and beneficiaries
- Financing sources for health insurance contributions
- Allocation and substantiation of revenues
- Definition of methods for paying providers
- Organizational and administrative framework.

Analysing the “Draft of a Social Insurance Law” that had been presented to the government in February 2004 and also regarding further the “Draft Law of Medical Insurance for the Armed Forces” on the one hand, and considering the general political goals and objectives of the Health Sector reform in Yemen – this is adequate and universal access to health care services and equity in both the delivery and financing of health care – on the other hand, it is necessary for the public stewardship to reassure and to adapt some of the features. This is very important for further implementation steps. Some of those questions that should be answered are:

- How to get all parts of the Yemenite population involved into the insurance system? What about health insurance for the big group of unemployed people in Yemen? Should other systems and laws like the Social Welfare Fund be expanded and cover them further on? What is an optional and realistic timeline to cover other groups of the population besides the public sector (including the ministries)?
- What is definitely to be covered by the benefit package? One of the central functions of health insurances in industrialised countries is to ensure a continued pay in the case of sick leave. In Yemen this is part of the employer’s responsibility. To bring this into the benefit package could strengthen employers’ engagement for the health insurance and make Yemen’s economy more attractive for (international) private investment. Is there a political willing to add disability income insurance into the benefit package?
- The financing of the health insurance will work only on the basis of employers’ and employees’ contributions. A model calculation of the health insurance’s monthly budget based on the stipulations of the Draft of the Social Insurance law demonstrated that probably about 60 % of the budget will have to be covered by public revenues (from oil income, taxes, donors etc.)<sup>11</sup>. Is there a political willingness and ability for refinancing such an amount? On the other hand: Are there optional alternatives of financing the system? What are other ways to increase the revenues (for example from the contribution side) on the one hand and to decrease costs on the expenses-side (providers, administration, staff) on the other hand?

Before the implementation of the Health Insurance these questions need to be answered, because they have got a direct impact on building up a project organization and for planning and realizing concrete milestones.

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<sup>11</sup> See chapters 2.2.4 to 2.2.6

### 3.1.1 Financial resources

Financial resources of the health insurance depend basically on the definition of the contributors, beneficiaries and the benefit package. In so far it is necessary to answer those questions first. On the other hand the experiences of existing international health schemes and also the results of model calculations might be helpful for answering some open questions within the Yemenite process of decision-making.

The financial frame of the NHIS will be determined by revenues on the one hand and expenses on the other hand.<sup>12</sup> There are the following sources of revenues to be taken into account:

- Employers' contributions
- Employees' contributions
- Pensioners' contributions
- Government's contributions for pensioners
- Other revenues from taxes and donors
- Yield of investment.

On the other hand there are the following expenses to calculate:

- Expenses for providers and medical treatment (hospitals and physicians)
- Expenses for drugs
- Expenses for costs of accidents and rehabilitation
- Sick leave/disability income insurance
- Administration/management/staff of the NHIS
- Expenses for infrastructure
- Expenses for training and external consulting
- Other expenses (for example for interest and credit repayment)

Due to the fact that there is currently no sufficient health insurance infrastructure in Yemen available it will be necessary either to invest into the basic structure from the government's side (this is costs for basic investment in infrastructure like buildings, data-warehouses, insurance card etc.) or to refinance the investment on the private market. The latter will increase the expenditures for interest and repayment.

The biggest position on the expenses' side will be the position for providers, medical treatment and drugs. The average expenses for treatment in hospitals amounts in industrialized countries to already more than 30 % of the total expenditures. The budget for administrative overheads, staff and infrastructure will exceed about 8 % of the total expenditure of a NHIS. In our preliminary model calculation the monthly expenses of a NHIS covering in a first step 11,5 million Yemenite people were estimated to be round about 9 Billion Rials. Based on the contribution rates of the Draft of the Social Health Insurance Law there was evidence that other revenues (from taxis, donors etc.) have to cover about 4 Billion Rials a month. There are different ways to increase the revenues and to decrease the expenses.<sup>13</sup> One way to expand the revenues is to increase the contribution rates. Another one is to expand the referred income basis, for example by taking additional private income into account. An option to decrease the expenses is to reduce the size of the administrative body. Another is to force cost management activities on the providers' side. There are many of such ways and means. Nonetheless there is evidence that Yemen will need a significant increase of public funds and investments to build up such a system.

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<sup>12</sup> See chapter 2.2.4

<sup>13</sup> See chapters 2.2.5 and 2.2.6

### 3.1.2. Human resources

The human resources that are needed to run a health insurance system in an efficient way include both: quantity and quality of staff. First of all it is necessary to have a look on the basic functions of the planned NHIS because they request special conditions and criterions for staff's quantity and quality. The responsible bodies of a NHIS will draw up a yearly plan of the administrative overheads, that means costs of staff both in a central headquarter with monitoring and pooling functions (that will be located in Sana'a) and the regional areas as governorates and districts. They will directly impact on the above-mentioned monthly and yearly budgets.

Yemen's National Health Insurance System will be based on a risk pooling of its members, in principle the majority or even further on all of the population. The system is based on pooling the contributions of its members and other stakeholders. Referring to a National Health Insurance Act contributors are the households, enterprises and the Yemenite government. The NHIS has to set the right financial incentives for providers, based on contracts, so to ensure that *all* beneficiaries have access to effective public and personal health services. The NHIS and eventually its regional and local schemes are acting as independent as possible but will follow national targets of Yemen's health policy as there are:

- To generate sufficient and sustainable resources for health
- To use these resources optimally
- To ensure that the defined beneficiaries have accessibility to health services on an acceptable standard and of a qualified level.

Referring to the fact of a necessary transition period the implementation would start with some crucial parts of the public and private sector. On the long run the NHIS seeks to enrol the whole population and is therefore from the very beginning to be run on a compulsory basis for the defined groups and sectors. The NHIS will be based on a professional management system. The functions of the schemes could be differed in primary external management processes that refer to clients and providers on the one hand and in supporting processes that focus on internal organization and administration on the other hand.

The five external processes are:

1. Benefit processes (include all questions of benefit packages and services)
2. Members'/Employees' processes (memberships, data-collection, campaigns for new memberships)
3. Contributions' processes (collecting and controlling contributions, reminding, summary proceedings)
4. Employers' processes (memberships, data-collection, employers' consulting)
5. Providers' processes (data-collection, contracts, negotiations, quality management, monitoring)

The four internal processes are:

1. Personal processes (human resources management, training, employment, dismissals, salaries)
2. Administrative processes (infrastructure, buildings, procurement, data-warehouses)
3. Financial processes (current accounts, budgeting, reinvestment, payments, transactions, pooling processes)
4. Management processes (setting goals, controlling, delegation).

The bodies of the NHIS will have an organization that covers the external and internal processes in different departments with qualified specialists. The necessary qualifications will include customer advisors, public health managers, insurance economists, administrators, physicians, pharmacists, health economists, contract specialists, lawyers, information and informatics specialists, health educators, marketing specialists, et cetera. Preparing the implementation of the NHIS in Yemen, it will be necessary to hire (international) specialists and to train Yemenite professionals in the above-mentioned fields. A very intensive training campaign is needed, inside and outside of Yemen. On the other side there seem to be a number of specialists available in Yemen who returned back to Yemen

after several years of specialization abroad. They have to be discovered and used as trainers and/or employees.

As to the quantity of the staff it is necessary to have more detailed information about the sectors in which the NHIS will start working. This is to have information about the need for customers' advising and the already both available and suitable Yemenite staff. A more detailed analysis of needs and requirements should be one task of the project organization and/or of the Centre of Health Insurance Competence that has to be installed preparing the implementation of the NHIS.

The human resource needs of a NHIS might be underlined using some references from health insurance schemes in industrialized countries though a comparison is always questionable on the background of some rather different demographic and social structures between Yemen and European countries. Anyway a short model calculation might demonstrate the questions that will have to be answered calculating the human resource need for a health insurance in Yemen. Some of the big European health insurances have a personal reference number of 2 full-time insurance's employees per 1.000 insured people. If the NHIS in Yemen started with 1,5 million insured members (public and private sector) with an estimated average family size of 7, plus 200.000 insured pensioners and their wives/partners there would be already a number of close to 11 million of Yemenite people insured. Calculated on the basis of the mentioned reference number the NHIS would have to employ about 22.000 people, even a reference number only based on members (1,5 million of insured employees and 0,2 million of insured pensioners) would still request a size of 3.400 NHIS-employees. This example underlines that the NHIS will be one of the biggest Yemenite employers in the future. In any case it is necessary to define special reference numbers that take the special need of the Yemenite system into account. This might also be a task of the project-management that has to be installed for implementing the NHIS.

### 3.1.3 Material resources

The question of needed material resources includes two aspects. The first is to make or to have a basic infrastructure available as there are suitable buildings, computer infrastructure, office furniture, transport fleet etc. There will be an investment in new infrastructure necessary. Yemen will have the chance to use modern equipments to build up an effective *and* efficient system based on valid data. A crucial instrument for this will be to start working with an insurance card for all beneficiaries that guarantees valid data-transfer, good quality of medical service and that prohibits misuse. This needs an investment in the hardware both on the side of the health insurance and the providers. An exact calculation of the costs for this investment requests valid data as to available infrastructure, number of beneficiaries, size of staff, needed specialists etc. To prepare this should be the task of a special project-organization, e.g. the nucleus of a health insurance authority.

The second aspect deals with the current expenses. The material expenses are – besides the staff costs – part of the administrative expenditures. In average the material costs can be calculated as a third of the expenses for staff costs, a reference number that might be used for further model calculations and different scenarios. This should also be the task of the special project-management.

### 3.1.4 Legal preconditions

The above discussed and defined design features of the NHIS need to be addressed in a Social Health Insurance Law. Let us review the final draft of a Social Health Insurance law that was already presented to the government:

- It might be considered to begin the legal framework with some guiding principles, for example that NHIS shall contribute to the Vision of the Yemenite President to create an environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Yemenites. The guidelines might also underline the basic principles of solidarity, community- and company-participation, independency and self-responsibility of the NHIS

- The group of beneficiaries might be enlarged regarding international and also Yemen's national health goals and in principle all Yemeni populations might be included with differentiated health financing schemes. This should be mentioned already in the law proposal.
- It is necessary to specify the benefit package at least in the sense of acceptable, medically indicated health care for all Yemenites or in the sense, that only cost-effective treatments will be financed based on internationally available evidences and meta-studies.
- The benefit package might or might not include besides an employment injuries insurance an insurance for continued pay of income in case of sick leave
- A harmonisation of laws related to health and insurance is necessary. This refers essentially to the Labour Law and to the Pension Law.
- The codification of a penalty-system should be considered and the chosen avoidance strategies related to graft, misuse and corruption. This law should be an example for a "good governance" law.
- Depending on the preferred option it is necessary to codify and specify the risk pooling in the case of a management via multiple funds. This might be included into modifications of the law after several years of an existence of one health insurance fund as the starter.
- To guarantee the independency of the NHIS it should be considered to separate the function of an external supervisory body (ministries in charge of the NHIS and responsible for inspection of the NHIS) from a more internal Board of directors that consists mainly of stakeholders from companies, trade unions and donors. Task of the latter would be to "hire and fire" the professional management of the scheme that should work on the basis of limited contracts (for example four years, with optional prolongations).<sup>14</sup>

### 3.1.5 Willingness and ability of stakeholders

In general terms, political willingness for health insurance remains unclear and appears to be rather weak at the level of decision-makers. All political parties the study group had the opportunity to contact during data collection expressed a certain interest and a potential support to a national health insurance system, but commitment seems to be limited and clear support for such a project a less important issue on the party agendas. The Parliament backs health insurance in Yemen, but refers to the Minister of Finance who has the power in the Cabinet and is hardly to be influenced by the majority in the Parliament. Thus, it remains to be seen if the Parliament will play a relevant role in promoting, asserting and getting through the political steps needed for the implementation of a health insurance system. Some members of the Al-Shura Council seem to be in favour of health insurance.

The commitment of the Government and ministries is also ambiguous and varies from one institution to another. As described especially in the presentation of the step-by-step approach (Alternative B, see 2.3), the Ministry of Defence and the Police have proven their interest and commitment, while in the Ministry of Education only single representatives seem to be ready to start health insurance. In other ministries the readiness is even more limited and no clear expectation regarding health insurance has been expressed so far. Neither the Prime Minister nor the President has made so far a clear declaration about the priority need and political importance of health insurance. However, some presidential decrees concerning cost-free treatment of chronic diseases and the priority attention of maternal and infant health call for improvement of social protection in health. Commitment and willingness of the Prime Minister and particularly of the President seem to be highly needed for the start of a national health insurance system.

Employers seem to be highly interested in creating a national and also a social health insurance system in Yemen. For employers health insurance has the potential to free them from a series of costs they have to cover on their own and without participation of employees. Currently employers use to be the only payers of health benefits granted by most companies. Thus, employers declare to be willing to pay even higher contribution rates for health insurance than workers and employees. If sick leave payment becomes a health and work insurance benefit, the readiness of entrepreneurs to contribute to

<sup>14</sup> Further aspects were mentioned in Table 12 and 13

health insurance will certainly increase. On the other side, employees are willing to pay at least relatively small contribution rates, what means around 2 or 3 % of their salaries. However, other social partners like women organisations stress the fact that other problems than health should be a priority concern, such as nutrition and access to education.

Community involvement and participation in implementing cost sharing was largely missing, except in very few donor-supported schemes, and only as long as the donors are present. Several studies have shown that although there is willingness to pay for services, there is a lack of trust in health providers and in traditional leadership. At hospital level there is minimal or no input by users to ensure that their priorities are taken into account. In addition, there is no evidence of any facility audits, and decisions about the use of revenue rely exclusively on the hospital director or his deputy. In Dhi-Sufal, decisions about the income use are met by the District Health Council including just one community representative. In Hodeidah, 13 committees representing the communities and the health facilities have been set up (Al-Serouri 2002, p. 15f). The findings of the study team in Shamayatayn (see chapter 4.2 in part 1 of our study report) showed also an obvious lack of transparency and community participation and, thus, confirmed former observations.

With regard to the ability of stakeholders to initiate, promote and participate actively in the implementation of a national health insurance system in Yemen, some constraints are to be admitted. General understanding of the concept of health insurance is weak not only in the population, but also at the level of stakeholders and decision-makers. Most interview partners the study-group has met during the three-months investigation were not used to distinguish clearly between health care financing and provision, and health insurance was often mixed-up with hospital care. In fact, most insurance schemes are directly linked to providers, with offices in hospitals, and relying on hospital personnel. However, the priority tasks of health insurance are health care financing, administration, management, controlling, and supervision, but not provision of medical care. A better understanding of what health insurance means and how it ought to be organised in order to fulfil the mentioned tasks will be needed for the upcoming political discussion and decision processes that are indispensable for giving the necessary support and backing of stakeholders to the ambitious project of a national health insurance system.

### **3.1.6 Willingness and ability to pay of recipients**

Users' willingness to pay in developing countries is often underestimated because it is mixed up with the ability to pay that is often clearly restricted. Especially poor people have a clear feeling that they are continuously running the risk to lose a high amount of money for health care, mostly in expensive private facilities. Meanwhile, a series of studies in various developing and also in least developed countries have shown that even the poorest are willing and able to save and lay aside some money for health care expenditure (Agyemang-Gyau 1998, p 65, 76; Zeller/Sharma 1998, p 20; Arhin-Tenkorang 2001, p 37; Baraldes/Carreras 2003, p 17; Asgary et al. 2004).

In preparation for cost sharing, the MoPH&P conducted a survey to find out people's expenditure for health care, the services they pay for, and the willingness to afford higher expenses in the future. Most expenditure was destined to drugs and laboratory tests. Roughly half of the interviewed users (46 %) declared to be willing to pay up to five percent of their monthly income for health care, especially for drugs and laboratory tests where they were used to spend most of the money for (MoPH 1992). A more recent study realised in a rural area of the Sana'a Governorate, 77-100 % of respondents were willing to pay for curative services, 26-86 % per cent for immunisation, and 0-45 % for maternal and child health services (Dorman 1995). The fact that even public health services have never been free in many areas, with patients being required to pay formally or informally to obtain treatment, may explain the high willingness to pay.

These findings were confirmed in two studies. The study conducted in rural Sana'a cited above found that only 0-26 per cent received free care (Dorman 1995). A second study was conducted in Dhamar, and indicated that health care in public facilities was almost never free, mainly because drugs and

laboratory services were not available and had to be obtained from private pharmacies and laboratories (Qassim/Beatty 1995). People may be much more willing to pay small amounts for publicly provided services rather than for much higher-priced private services. Availability of services in nearby public facilities can also reduce the cost of transport associated with reaching private services, which are often concentrated in the cities. Nevertheless, it should be stressed that people are willing to pay for health care only if it is of good quality, or in areas where there has not been extensive provision of free services recently (Al-Serouri 2001, p. 14).

The apparently high willingness to pay is likely to reflect the fact that people in Yemen are highly used to pay for health care in all types of facilities, and that there is no alternative than to accept payment in public facilities (Al-Serouri 2001, p. 83). The fact that even public health services have never been free in many areas, with patients being required to pay formally or informally to obtain treatment, may explain the high willingness to pay (*ibid.* p. 14). In daily life, many people are obliged to look for coping strategies in order to get medical care in the moment of need. That might increase the willingness to pay for any kind of prepayment scheme even of those citizens who have only a very narrow understanding of health insurance.

Women seem to have a higher willingness to pay at least for good quality drugs (46 % of women, 29 % of men). Men tended to oppose payment for drugs more often than women due to fear of the misuse of revenue collected in the drug fund, while women stressed the irregular supply as a reason for reluctance (Al-Serouri 2001, p. 38). The same study revealed that poor people express in general a higher willingness to pay than the better-off (*ibid.* p. 39). One reason therefore might be that they have access to the public facilities only, and are thus more seriously affected by the funding shortages. However, poor respondents are much more as likely as to be unable to pay than the better-off because they simply cannot afford it. Unsurprisingly, unwillingness due to unaffordability hits mostly the poor, and it was mentioned slightly more often by women (*ibid.* p. 39).

As quality of care is essential for willingness to pay, any potential future scenario will require a clear-cut exemption system and strict supervision in order to create trust in the system, and thus improve willingness to pay. Incidences of arbitrariness and illegal charging by staff are likely to hamper not only the operation of cost sharing, but also the willingness to pay of health care users (*ibid.* p. 90). However, there is a direct interdependence between willingness to pay and quality of care. Thus, peoples' declared interest regarding contributions to a health insurance system reflects always their current experience as well as their expectations towards health care delivery. Thus, improved health care availability and quality, with an adequate supply of affordable drugs and services being the most important factors, is very likely to increase the willingness to pay and to attract also the better-offs whose contributions might cross-subsidise health care for the poor.

### **3.1.7 Mobilising all prerequisites**

For starting the implementation of a national health insurance system a complex array of conditions and prerequisites have to be met. When the country initiates its long way towards a health insurance system that has the potential to cover most and potentially all Yemeni, it faces a high risk to fail and to produce disappointment if things are not well planned and prepared. At first, the general understanding of what health insurance means and what health insurance can do has to be developed in Yemen. Only if politicians, decision-makers, stakeholders and citizens can be sure that they are talking about the same thing health insurance can emerge in a satisfactory way and help to solve the priority health needs of people in Yemen. Otherwise, the implementation process is running the risk to lead to a partial and scattered solution.

Other essential prerequisites that have to be met or at least faced in an early stage refer to the financial, material, human resources and legal conditions. Financing is not the only task of health insurance, but it is one of the most important that has to be assured for any kind of health insurance activity. Thus, the defining income resources and implementing reliable and transparent forms of payment are crucial points. That means that contributions from employers and employees, but also subsidisation from

general or earmarked taxes as well as from donations, zakat, endowment and other sources, have to be calculated on the basis of the expected expenditure for health care of the insured. The availability of resources has to be assured, and financial transfers and flows are not a minor task in a country where not everybody has a bank account and cheques use to be the most important form of financial transaction.

Regarding material requisites it has to be clear that the implementation of a national health insurance system is a huge challenge and a major task for a country that lacks any prior experience and can count neither on pre-existing infrastructure nor on necessary human resources. Independent from the implementation strategy applied the starting schemes will need offices, equipment, computers and specialised information technology that allows for performing at least the most basic tasks of health insurance. Step by step, the system will have to build up branches in all regions, governorates or even districts, and the need of infrastructure and technology will increase according to the expansion of the system and the inclusion of population groups.

Closely linked to the demand on physical space, workplace equipment and computer technology is the increasing need for qualified personnel that will arise because a relevant number of well trained staff for dealing with the various tasks of health insurance will be required. Currently, human resources seem to be a major challenge as even the private insurance sector claims for qualified staff covering a minimal market segment. A nationwide system will require thousands of people who have reasonable computer knowledge and can realise the various tasks like member affiliation, management, claim processing, accountability, controlling, fraud detection and many others in a confidential and reliable manner. At the same time, hundreds of health economists, insurance experts and other specialist will be needed for running a national system that achieves financial viability and sustainability. And, last not least, a number of highly qualified top managers will be necessary in order to run health insurance and to assure accountability as well as good performance.

On the political level, clear declaration of high-ranking representatives and further commitment concerning a national health insurance system in Yemen will be indispensable. The democratic parliamentary system in Yemen is not accompanied by a deep-rooted culture of civil participation and responsibility. Obviously, most citizens are used to wait for signs and steps “from above” and hesitate to take initiative even when they are highly interested in some issues. On the other hand, people have also had the experience that bottom-up initiatives came to an abrupt end when the Government or public sector organisations were involved or even took over. Both factors make evident that pronounced and clear-cut political commitment at the top level will be an essential prerequisite for a national health insurance system in Yemen.

### **3.1.8 Project-organisation**

We recommend to establish a professional project organisation – in the form of a Centre for Health Insurance Competence (see chapter 2.6) – in order to prepare the building up of the National Health Insurance. Basic success factors of such a procedure are:

- Clearness of project’s goals and a systematic approach
- Presidential or Cabinet decree for institution the Centre
- Sufficient financial budget from local funds, e.g. 200 million YR per year, to run it independently from international support
- Hiring a local professional with very intensive international experience in the field of health insurance and health financing and highly credible references or – for the beginning – an international project manager
- Adequate basic infrastructure (for training included)
- Building up a task force of professionals as an advisory board to this Centre (see chapter 5.6.1)

For a realistic perspective it is necessary to describe the different tasks of the project organization, to integrate the stakeholders into a professional project structure, to establish priorities and to define the concrete milestones and steps of realization. Examples for basic tasks are given in the following table.

Table 26 Project organization tasks		
Management	Implementation	Support
Establish political support	Building up the administration	Marketing
Detailed planning	Selection and hiring of staff	Documentation
Controlling	Establishing financial and pooling system	Financing / budget
Evaluation	Defining pilot regions and implementing the system	Project assistance
Project organization	Building up a training system	Data analysis
Managing projects' staff	Training of managers	Controlling
	Project expansion	

For preparing and implementing the NHIS it is necessary to hire a task force of at least 25 experts, 15 Yemenite professionals and 10 international health insurance experts, some of them to be financed from international funds. It will need at least 12 months of preparation to have the administrative body of the Health Insurance on work. In any case it should be kept in mind that the Yemenite professionals working in the project organization should be part of the later management of the health insurance body. Hiring has to be done in view of the criteria mentioned in table 12.

Government's stewardship is a basic prerequisite and a crucial factor for the success of the process. The implementation plan should therefore include a professional structure to manage the further reform steps. Building up this structure it should already be considered to get those stakeholders involved that will be part of the later supervisory body of the NHIS. For the beginning we recommend an advisory board composed of the main health insurance experts of the country, various civil and non-governmental organizations, supported by the ministries involved in health insurance. (see chapter 5.6.1)

### 3.2 Regulation and quality enforcement

The enforcement of high quality medical services is and needs a continuous back up. The main challenge is to get transparency on the services provided. Without reasonable transparency it is nearly impossible to strengthen high quality in the provision of services. These are possible approaches:

- Enhancement of available data: Basic is to avail of reliable and valid data e.g. about diagnostics and treatments
- Introduction or / and improvement of documentation standards: Only documented services can be evaluated. Some experiences show, that already the introduction of simple documentation standards (e.g. in hospitals as an condition to get their bill paid) improves the quality of the treatments.
- Payment incentives: Outcome oriented payment systems are adapted to set the right incentives in direction of quality. Capitation fees or lump sums should be preferred to expensive fee-for-service-payments: they promise better quality (in the long run) and lower prices.
- Setting minimum standards: In many countries authorities define and dictate minimum standards for various treatments. Often they are developed by organisations of physicians. Sometimes they are defined by the government. In any case: to make them work, the acceptance of the standards is absolutely essential. Therefore it is compulsive to work them out together with representatives of those, who later have to fulfil the standards. These standards can - in a longer run - lead to guidelines.
- Guidelines: Especially high developed countries are actually trying to enforce the improvement of quality by setting guidelines. In some countries treatment guidelines are obligatory; in others guidelines have just an advisory character. Although the first experiences with implemented and elaborated guidelines in developed countries are promising, at the moment they do not seem to be the first choice in developing countries for quality enforcement. The same as with minimum

standards, guidelines need a high acceptance by doctors. It is unthinkable to create them without practising physicians.

In the staff of a centre for health insurance or a health insurance authority specialists in quality assurance are essential. They have to be experienced in the many endeavours that are undertaken in this domain worldwide. Quality assurance needs quite some investments in human capital and in networking between health insurance, health experts and providers. A link to Faculties of Medicine has to be established, as well.

### **3.3 Staging, planning and managing the implementation process**

The most important elements of staging the implementation of health insurances

- for an eventual full speed implementation of health insurance or
- for selected public servants – e.g. military and teachers – or
- for pilot regions – e.g. Sana'a and Aden – or
- for the networking of existing health insurances and/or
- for the building up of project management and a centre for health insurance

were mentioned already in various chapters before. The forth-following chapter will add to it some more details with reference to various scenarios for optional health insurances. With regard to the implementation plan of various health insurance options we have to refer first, nevertheless, to a modification of the meaning of (implementation) planning during the last decades, characterized by a shift from health planning to health system management.

Health planning was a major concern of health services management in the last century. Originally it was masterminded by the Semashko model of planning health services in the Soviet Union, whereas Beveridge and Bismarck types of health services opted since long for managerial processes of problem solving. Nevertheless, health planning ideas found their way into Western health care systems, too. By and by and all over the world, it was superseded by a more flexible and pluralistic approach of coordinating health policies of various partners in the health sector, where each partner within his own area of responsibility had his own micro-planning and management procedures. After the fall of planned economies and the globalisation of market approaches, health planning started to change its basic character. Step by step, governments concentrated more and more on their basic functions of regulating and supervising the health sector composed of many different partners. In various Western countries the notion of a government as a provider of health services was outdated since long. Transition countries followed this trend gradually. At the turn of the millennium the international discussion started pinpointing at the value-driven stewardship role governments have to play in favour of the public interest.

This is why an implementation plan for health insurances in Yemen needs one essential component: continuous dialogues among the stakeholders (proponents, partners, providers, patients and any other group that might be affected or could give support and guidance), hopefully driven by the stewardship of a value driven Ministry of Health or by any other agent of the public interest. Implementation planning for health insurances, therefore, should be driven by the new meaning of health planning, which is briefly and analytically described in the following table and which best can be supported by creating a “planning group”, or “advisory committee”, or “steering committee”, etc. We recommend a Centre for Health Insurance, supported by a strong, experienced and committed advisory committee.

Health planning proper	Needs assessment	Identifies health and health services needs, problems and opportunities and their social and economic context
	Consultation and participation	Consults with authorities, providers, and other actors in the health sector on their needs, problems and opportunities;
		Involves citizens in needs assessments and assesses preferences and demands of consumers
	Goals and strategies	Clarifies goals, objectives, targets and priorities of all partners involved and develops justifications for assigning priorities
		Describes and recommends opportunities for changes, services, projects, programmes and policies and recommends tactics
	Coordination, partnerships and negotiations	Coordinates and gives guidance for health planning activities of various partners of the health system
		Identifies potential collaboration of other partners and of funding sources
		Assists in negotiating joint or coordinated activities of all relevant partners involved
	Analyses and evaluations	Assesses advantages and disadvantages of various proposed options, e.g. in terms of costs and effectiveness
		Monitors and evaluates the implementation of plans, projects and programmes and their accomplishments, e.g. in meeting priorities of the Ministry of Health
Decentralization	Supports regional and local health planning and delegates – if possible – planning processes to lower levels in the sense of participatory planning	
Tools and training	Updates regularly health planning tools and supportive resources, e.g. data, methods, and gives feedbacks on health planning tools	
	Trains staff in health planning skills	
Information	Prepares evidence-based background documents for planning meetings and as background papers for policy making	
Health policy support	Compilation	Compiles policy papers of partners of the health system and identifies needs for modifications of government policies
	Scenarios	Maps the direction for possible health policy changes
	Role setting	Assesses and/or defines the roles of various actor in the health system, e.g. the private and the public sector, for financing and provision (WHO 2000, p 121)
	Instruments	Identifies policy instruments and organizational arrangements required in both the public and private sectors to meet system objectives (WHO 2000, p 121)
	Capacitation	Sets the agenda for capacity building and organizational developments (WHO 2000, p 121)
	Guidance	Provides guidance for prioritizing expenditure, thus linking analysis of problems to decisions about resource allocation (WHO 2000, p 121)
	Alliances	Supports sector wide approaches for coordinating all relevant actors and initiates policy debates
	Consultations	Solicits expert opinions and consults with health services researchers and managers
	Risks	Assesses risks and potential direct and indirect implications of (potential) policies
	Analyses	Identifies major concerns of health policies, e.g. goodness, fairness, responsiveness, equity

Health stewardship support	Regulation	Supports setting the rules and ensuring compliance (WHO 2000, chapter 6)
	Knowledge	Supports exercising intelligence and sharing knowledge (WHO 2000, chapter 6)
	Strategies	Supports assessing and designing strategies, roles and resources (WHO 2000, chapter 6)
	Performance	Supports improving performance (WHO 2000, chapter 6)
	Excellence	Supports the discovery and promotion of best practices

We assume that a more detailed plan for the implementation of health insurance would not be needed for the time being, or even worse, would be misleading. Setting up health insurances is not an engineering task like the building of a road or an airplane. Setting up health insurances is a social process of interacting partners in their institutional contexts. Theoretically it seems to be important to define the rules of the “game” they are playing driven by their social and economic roles they are expected to perform. But even the setting of rules of a game might be overtaken by power-plays. All stakeholders involved will act according to their interests or how they might perceive them – right or wrong. It is like a soccer game without referee and arbitrator and even without a clearly defined field to play on. Managerial skills are needed much more than planning skills. We can not anticipate the future of social processes, but we can keep the processes going on and into the right direction. Therefore we suggest – in the public interest – to build up and support a new institution – a centre for health insurance – that participates actively and value-driven in a social process towards social health insurances to benefit all Yemeni citizens. This is the core element of the implementation plan.

In spite of all these caveats we submit to discussion the following implementation plan and timetable, which has to be reviewed repeatedly and adjusted to circumstances and opportunities. There is an old Latin proverb from Roman times: *carpe diem*, i.e. grab each opportunity. This should also be the motto of the health insurance evolution in Yemen.

Year	Health insurance milestones	Institution building	Advise
2005	Review of study and planning Budgeting for CHIC	Secretariat	Steering committee
2006	Approval of military HI law Military pilot-testing in Sana’a Approval of civil HI law Project designs for teachers Dialogues between existing schemes Support by CHIC starts Support for micro-insurances MoPH&P increases pro-poor coverage International auditing and evaluation Increased international support	Centre for Health Insurance Competence (CHIC1)	Advisory board & Donors

Table 28 Milestones for health insurance evolution in Yemen			
Year	Health insurance milestones	Institution building	Advise
2007 2008	Support by CHIC intensifies Approval of HIA law Expansion of military scheme Joint venture with polices designed Pilot-testing for teachers Support for micro-insurances Pilot-testing for self-employed MoPH&P increases prevention programmes MoF pays contributions for the poor International auditing and evaluation Increased international support	Centre for Health Insurance Competence (CHIC1)	Advisory board & Donors
2009 2010	All security schemes (SS) are unified SS tests contracting of external providers HIA supports security schemes Teachers HI in Sana'a and Aden Voluntary scheme for self-employed Harmonization plan for company schemes Support for micro-insurances MoF pays contributions for the poor MoPH&P increases prevention programmes International auditing and evaluation Increased international support	National Health Insurance Authority  &  CHIC1 splits into think tank of HIA and independent centre for HI training, research and consultancies	Supervisory board  &  Advisory board & Donors
2011 2012	Evaluation studies on experiences Full review of HIA Teachers in one entire Governorate SS at national level MoF pays contributions for the poor Micro-insurances strengthened Company schemes for all private sectors International support diminishes	National Health Insurance Authority  &  CHIC2	Supervisory board  &  Advisory board
2010 2014	Gradual expansion of all schemes MoF pays contributions for all poor MoPH&P increases prevention programmes Throughout audit and evaluation International support review	National Health Insurance Authority & CHIC2	Supervisory board & Advisory board
2015	Review and planning – participatory approach of all partners and clients		

#### 4. Macro-financial projections of the proposed National Health Insurance<sup>15</sup>

##### 4.1 Introduction

A number of financial projections were made using the WHO-GTZ health insurance simulation model SimIns-version 2<sup>16</sup>. SimIns is a health insurance simulation tool that analyses the basic mechanisms of health insurance. It projects the development of incomes and expenditures under certain assumptions over a 10 year period. Its principal use is in the financial forecasting of social health insurance (SHI) schemes, but it can also be used for community-based health insurance (CBHI). Key variables in health insurance - population coverage, incomes, health insurance contributions, co-payments, health

<sup>15</sup> Prepared by Guy Carrin, Ole Doetinchem and Belgacem Sabri, WHO

<sup>16</sup> See G.Carrin & C.James (2005). *SimIns health insurance simulation model (Eschborn: GTZ and Geneva: WHO)*, forthcoming..