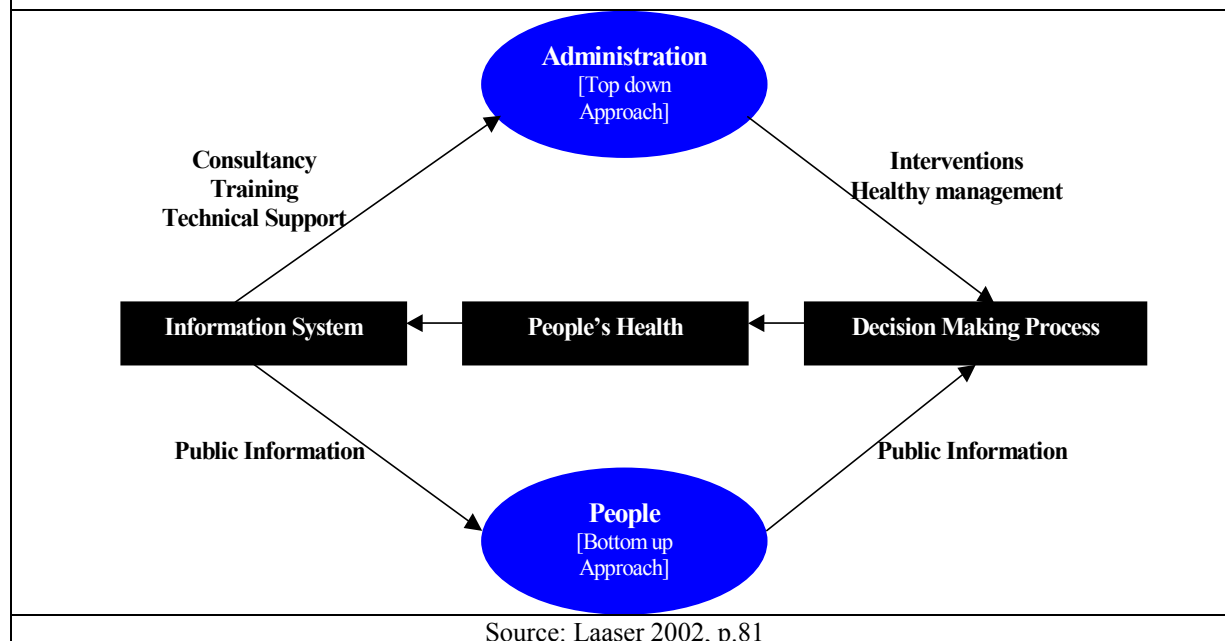


Figure 13: An operational approach to improve people's health



The lack of interdisciplinary “modern” public health institutes and health science academies in Yemen is to be considered a constraint for implementing health insurance on a large scale. Higher education regarding the understanding of population health and all health insurance relevant skills is needed. Thus, international donors should support the Ministry of Education and other stakeholders to set up health sciences, health economics, management, and other related academies in the country and to support specialised out-of-country training of teaching and research personnel. At the same, international lecturers and consultants should complement the national academic staff and participate in regular teaching activities. WHO and other donors should make available additional input for existing programs like the hospital management course at the University of Aden, and initiate or promote the implementation of further academic programs.

The Centre of Health Insurance Competence is recommended to search intensive contact and co-operation with institutes and universities in and outside the country. It might initiate and support a Centre for Health Strategy Studies (like the one implemented in Damascus), including a school of management and institutes for public-health, population, and health economics. Additional donor funding is likely to be available for enhancing academic strength and scientific back-up of a health insurance system. The support given by the European Committee to build up a structure and network of health science institutes within the scope of the Stability Pact in South East Europe might be an example of how to support public health schools and establish scientific collaboration in the region.

## 6. Summary

### 6.1 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 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.

## 6.2 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.

### 6.3 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.

### 6.4 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.

## **6.5 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.

## **6.6 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.

## **6.7 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 the next two years.

## **6.8 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.

## **6.9 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.

### 6.10 Towards a national health insurance system in Yemen

The following table confronts the main sectors of Yemeni workforce with health financing options.

Optional components of a national health insurance system in Yemen					
Health financing options by households' main employment sector	Workforce (rough and rounded estimates)	Health financing options			
		Payroll tax contribution insurance	Self- employed insurance	Community participation schemes	Tax-based public services
Government	420.000	37.5 %			
Military	350.000				
Polices	150.000				
Public companies	70.000				
Mixed companies	10.000				
Formal private companies	500.000				
Better-off self-employed	500.000		12.5 %	↑↑↑↑↑↑↑↑	
Poor self-employed	1.000.000			10 % ↓↓↓↓↓↓↓↓ Expansion strategy	50 %
Unemployed and poor	1.000.000				
Households in Yemen	4.000.000	37.5 %	12.5 %	(~10 %)	50 %
Population in Yemen	22.000.000	37.5 %	12.5 %	(~10 %)	50 %

Sources: own estimates and calculations

The tabled social health insurance law proposal could cover 1.5 million employees with pay-roll deducted contributions shared by employers and employees. For the better-off self-employed businessmen an appropriate scheme has to be developed, yet. For the at least 50% of the population that is poor, unemployed and underemployed, taxes and other government revenues have to be used. Community based health insurances will need re-insurance by the government, to cover more and more the poorer families, especially in rural areas. In view of this comprehensive vision three alternative options towards a national health insurance system in Yemen were designed, discussed and analysed: (a) a full speed and big-push option for the formal employment sectors, (b) incremental alternatives and (c) the building up of an essential institutional prerequisite for a rational and social national health insurance system.

### 6.11 Health insurance option A: Big push

The Deputy Minister of Civil Services and Insurances (MoCS&I) announced in a meeting with the study team that by July 2006 the time of health insurance will begin for all employees of the public sector. Planned salary increases for the civil sector offer a unique opportunity to start very soon with deducting health insurance contributions from the salaries. This reflects the idea of about three quarter of interviewed opinion leaders: health insurance should start very soon, and it should start in the public sector. If those private companies, which are legally obliged to contribute to pension schemes, would also be included, a total number of 1.5 million employees could be covered together with their families of approximately 7 members. This approach could benefit half of the population of Yemen.

Wage-related contributions of 6% (employers) and 5% (employees), as proposed in the social health insurance law, would generate 58 billion Yemeni Rial per year, if about 200,000 pensioners were also included. That would increase the current health spending in Yemen by 40%.

What can be bought by this money in the hands of a health insurance authority? A well appreciated health benefit package is provided by the Telecommunication Corporation to its employees and their families. If this benefit package would be provided for all 1.5 million enrollees, their families, and the pensioners, a deficit close to 50 billion YR per year would emerge. What can be done to reduce this deficit?

- Cost-sharing of patients would be difficult to maintain since health insurance wants to shift out-of-pocket spending into prepayment
- Reduced benefit packages are feasible and pay off, if treatment abroad would be excluded, especially. A “small for all” health insurance option would offer a considerably smaller benefit package that comes close to the current expenditure pattern in Yemen. This might be feasible in financial terms.
- Contribution rates can not be increased, since a 6%/5% share is already very high in the Arab context, and the salaries of workers and employees are really meagre.
- Employees without their families could benefit first, but this might be debatable according to Yemeni values.
- Chronic and catastrophic care could be provided by the government and not by health insurance, which would reduce drastically the deficit.
- Rational drug use has to be introduced anyway, i.e. a revolving and trustful drug fund has to be reinvented.
- Provider prices could be negotiated by the power of the economies of scale involved.
- Careful provider selection and control should accomplish the cost-containment strategy.

Furthermore, additional funds for health and health care have to be discovered and mobilised, for example

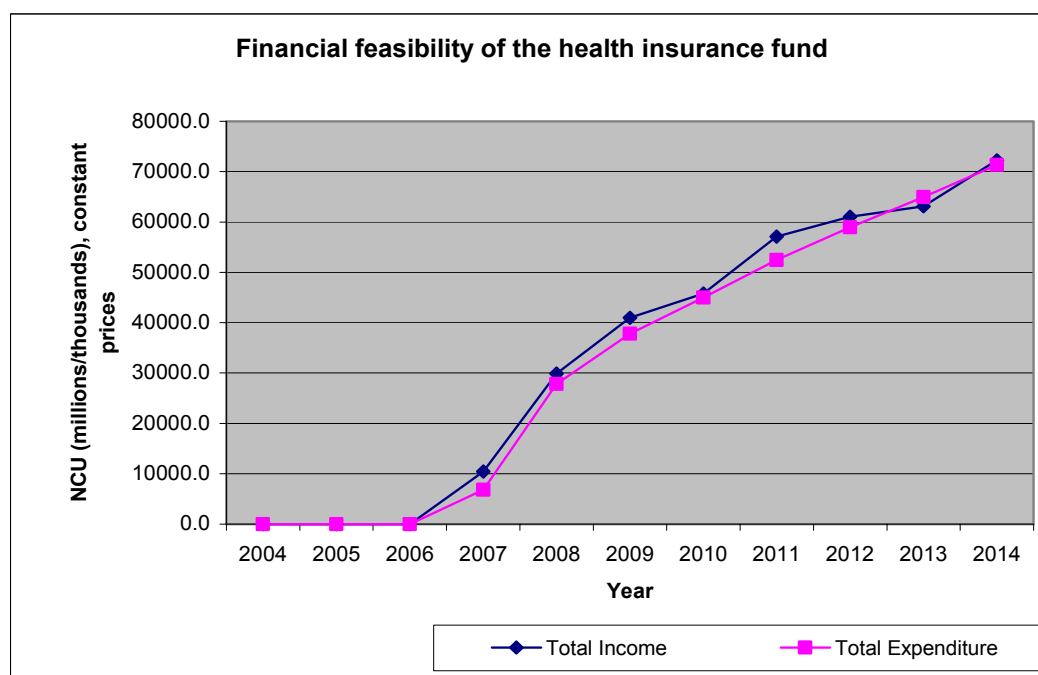
- Additional government funds for health provided to assure at least the coverage of the running costs of public facilities – a doubling of funds would be better and fair
- Earmarked “sin”-taxes and other taxes, e.g. on cigarettes, qat, big equipment, petrol
- Zakat funds and endowments for the benefit of the health of the poor and the vulnerable, to pay for health insurance contributions of those who are to be exempted from contributions
- Appropriate enforcement of existing tax laws and strengthening of progressive taxation.

In case of a clearly committed political willingness, the money-constraint of the big-push option for health insurance might be overcome. However, one of the essential prerequisites is even more difficult to implement: an autonomous and trustful health insurance authority. One option is to follow the pattern of the Social Development Fund or the Public Works Fund. In addition, the lack of sufficiently trained and experienced professionals is also a major constraint for implementing health insurance in a short term, and immediate capacity building and human resources development should be accomplished by importing temporarily foreign experts. Some other obstacles remain: high quality providers to be contracted by health insurance are not available in many parts of the country, data and information on

patterns of risks and demands are not available, either. Currently, most of the essential prerequisites for health insurance are not met.

Nevertheless, the big-push strategy would be an excellent opportunity for the urgently needed radical improvement or even revolutionary change of the health system. If government or charitable funds would pay contributions for the poor and if a rational and national and not-corruptible health insurance authority would take the lead, then just the best providers could be contracted for cost-effective care for anybody in need. This could lead to a more efficient and effective health care delivery that is urgently deserved by Yemeni population. However, a “big-push” strategy towards a national health insurance system is reasonable but hardly feasible under the given conditions.

One of the sub-scenarios of the big-push strategy is mentioned explicitly because this is the only scenario that would not lead to financial deficits in the long run, as shown in the figure to follow.



Although eventually covering the whole population and requiring no subsidies, there are a number of caveats to this scenario: The benefit package that can be offered at a cost equivalent to current spending levels in the country as a whole means that benefits will be lower than and different to those that some employees in the formal sector are getting today. With the inclusion of the poorer and rural population, the benefits offered must take into account the overall health needs of the population, especially primary and preventive services as well as maternal and child health. Formal sector staff not wanting to forego some of the benefits they enjoy now (such as treatment abroad) would be able to buy supplementary private insurance. With contribution rates that undercut the amount that these employees are willing to pay and the inclusion of the self-employed and poor this may be attractive. Of course, a big caveat here is that the scenario uses low utilisation rates and may therefore not be realistic.

## 6.12 Health insurance option B: Incremental evolution

An incremental introduction or strengthening of health insurance can be done

- bottom-up by improving, harmonising and networking existing health benefit schemes, as they exist in public and private companies or as they are initiated by international donors in the form of community based health insurance schemes and/or

- top-down by supporting those public sub-sectors that are willing and ready to embark in social health insurance, as for example the military and the educational sector.

Concurrently, government must achieve a full cost-effective coverage of health services for all poor.

Military, police and security police with about half a million employees are ready and willing to have a health insurance scheme, since years. It is a good number for starting a reasonable pooling, needed for social health insurance, if – as declared – police and security police would have a joint venture with the army. Political willingness and a management structure supportive for a health insurance fund are given. All three sub-sectors have experiences with pension insurance funds. Based on their political power, all would avail of sufficient back-up funds and re-insurance by government. As a limiting factor appears the fact that engagement in health insurance is essentially oriented to finance expansions of the military and police hospitals, e.g. for getting an oncology department and for improving cardiology and other specialties not sufficiently available. Soldiers and policemen would not get any additional benefit since they receive – in principle – free health care for themselves and their families in the health facilities of their employers. Furthermore, they are exempted generally from cost-sharing and cost-recovery in public health facilities. Additional government subsidies for introducing health insurance for these groups would give further privileges for a privileged group. However, if military and police hospitals would fulfil the presidential order to waive cost-sharing for pregnant women and chronic ill people, and to exempt the poor from cost-sharing, that would provide many good reasons to get military health insurance started soon. Then, relevant experiences will derive from the military scheme that might enrich the discussion about a national health insurance system. The President himself could and should guarantee that this public sector would be increasingly beneficial for more and more poor people in need.

In the case of the Ministry of Education representing close to a quarter million teachers, the options are not as clear as with the public security sectors. However, backed by the stewardship of the President and the Prime Minister, the educational staff could be a good starter for social health insurance. Leadership and commitment exist at the high political level within the ministry. Undoubtedly, the scattered working places of the teachers, mainly outside the larger cities and even outside smaller towns, reduce the options to contract and control quality health care providers, for the time being. The implementation strategy must be gradual therefore: first in Sana'a, then in selected bigger cities, then in selected governorates. It would be difficult but with a good political and financial back-up it could be a good investment. A 'small-scale' national health insurance authority would have to support this social experiment. International donors are welcomed to join and to help during a decade. A centre for health insurance competence is needed for back-up and guidance. A health insurance supervisory agency and a re-insurance guarantee of the government are two essential prerequisites.

Networking, strengthening and expanding existing health benefit schemes of public and private companies is a third element of the incremental expansion strategy towards a national health insurance system. Many experiences are available, many more can be discovered and shall be analysed. There is such a rich potential available in Yemen, that it is astonishing, that it was not yet utilised before. Workers unions and employers associations are committed stakeholders. It has to be guaranteed, nevertheless, that they would not be deprived of their privileges by a national health insurance scheme. As stated above, it would produce deficits, to replicate their schemes at the national level. This is not the case with eventually emerging community based health insurances that deserve the full support of public services and public funds. International professionals and funds should be attracted to foster such schemes, including any kind of micro-insurances.

### **6.13 Alternative C: Work and network**

There is a host of adverse circumstances against a national health insurance system in Yemen:

- A wide-spread mistrust with regard to public or publicly run funds
- No visible and strong political support and leadership in government and political parties
- Nearly insurmountable difficulties in covering the rural population in need

- The huge sector of poor, un(der)employed and self-employed at the margin of survival
- The fact that health insurance is rather a middle class topic
- The reduced scope and quality of health care offered in the country
- The absence of any quality management and control in the various sectors of health care
- The generalised commercialisation of public, private and informal health care
- The fleeing of Yemeni health care by seeking treatment abroad
- The priority needs of the health system for prevention, promotion and primary health care

It is not easy to overcome these deficiencies, bottlenecks and obstacles. It needs awareness campaigns, motivation and mobilisation measures, training, education and many promotional activities to justify a priority given for health insurance and to assure that a “new” social health insurance can be trusted in. This has to be based on facts and figures and on the selling of a good product that can be demonstrated as good or best practice. It requires reliable data and information on epidemiology, demand and supply of public, private and informal health care. It requires an effective and efficient supervision of health care in all Yemen and systems for appropriate licensing, accreditation and re-accreditation as well as penalty systems and its enforcement. It requires improvement of managerial qualifications and a performance oriented systems of incentives and disincentives. A training and capacity building offensive is urgently needed. All the many prerequisites of good management need strengthening – not just for introducing health insurance but in view of good governance in sustainable and credible institutions: money, mastermind, mechanics, motivation, mobilisation, manpower, measurement, monitoring and the many more “Ms” of good management. Health insurance would be only one of the beneficiaries of such a drive towards a modernised management, towards a good management culture.

#### 6.14 An assessment of alternative options

Several preconditions are needed for starting or implementing the various alternatives and sub-alternatives. In the following table they are resumed and briefly assessed.

Assessment of alternatives					
Preconditions		Big push	Small for all	Incremental	Wait work
Money	Sufficient financial resources?	-	+	~/+	+
Mastermind	Leadership and willingness?	-	~	~/+	+
	Clear concept and idea?	+	~	+	+
	Powerful leaders back-up?	~	~	~/+	~
Mechanics	Appropriate management?	-	~		~
	Government back-up?	-	~	~	~
	Donors back-up?	-	~	~	~
	Sufficient anti-corruption control?	-	-	-	~
Markets	Sufficient high quality providers?	-	~	-	~
Manuals	Enforcement of laws and regulations?	~	~	~	+
Manpower	Sufficient qualified cadre?	-	~	-	~
Motivation	Knowledge, awareness, excitement?	-	~	~	~
	Consensus of stakeholders?	-	-	~	~
	Solidarity support for the poor?	-	+	-	+
	Trust?	-	-	-	-
Measurement	Sufficient data and information?	-	-	-	~
Summary assessment		-	~	~/+	+

It is advisable to start with the last mentioned alternative, especially with a Centre for Health Insurance Competence and to engage step by step in supporting incremental endeavours towards a national and social health insurance system in Yemen.

### 6.15 A think tank for social health insurance

A Centre for Health Insurance Competence (CHIC) will be helpful to support the creation of an improved management culture and the incremental health insurance implementation. Such a centre would have a series of tasks

- Discovery and further analysis of solidarity schemes, including the awarding of the best solidarity schemes, the replication of best practices and the consultation for existing and intended solidarity schemes in the context of a massive awareness campaign, that such schemes are needed for strengthening the social capital of Yemen that is so much needed for social and economic development
- Observation and analysis of company health insurances in the public and in the private sectors, including consultations and technical advice for such health insurances and a networking of such schemes into an association or federation of company schemes. The voluntary implementation of a re-insurance of company schemes could become an additional important task for enlarging the risk pool, reduce the individual company risk, and allow for stepwise extended benefit packages.
- Follow-up and guidance and consultancy of community based schemes, and implementation of re-insurance for community-based schemes. In this regard lobbying and awareness generation has to be done to improve the feasibility of community based schemes, especially those with indigenous roots in Yemen and “made in Yemen”.
- Permanent advocacy and lobbying towards a national social health insurance system by proposal writings, research, communication and policy designs and a push for harmonisation of health insurance schemes and their integration into one national system, that safeguards a pluralistic multi-tier approach.
- Training in many forms: training of potential health insurance staff inside Yemen: information technology, English, health and health insurance related issues; training of potential leading health insurance staff outside Yemen: health financing, health policy, health insurance, etc.; repeated workshops with international specialised staff and consultants in Yemen; promotion of participation of “masterminds” in international seminars and conferences; partnership with the Centre of Strategic Health Studies in Damascus and similar institutions elsewhere; et cetera.

GTZ has initiated and is supporting Centres for Health Insurance Competence in various countries. A networking and mutual learning of such centres would be very fruitful.

Committed local funding should demonstrate first and firmly the political willingness to engage in a social and national health insurance system in Yemen. Furthermore, the implementation of a national Centre of Health Insurance Competence could be supported by international agencies and mainly by the consortium on social protection in health built by GTZ, WHO and ILO in order to co-ordinate efforts and to join forces. For setting up a CHIC, a legal framework is needed that allows such a competence centre to open activities in the national market and to act as a franchising company. Technical support for creation and setting up a CHIC will initially require international expertise and equipment, but on the long run external consultancy is supposed to be withdrawn according to the growing capacity and autonomy of Yemenite stake-holders. If sustainability of the CHIC is guaranteed, the centre will be able to give long-term support for any emerging and performing health insurance scheme. This might be a crucial contribution to implement a national health insurance system in Yemen. Step by step, CHIC could be converted into a National Health Insurance Authority.

The CHIC could also take over the role of a think tank on the national level. Performance and scope of a competence centre are potentially unlimited, and further tasks might develop according to the implementation strategies and success. However, the study authors would like to stress the fact that a Centre for Health Insurance Competence will be a very important prerequisite for all health insurance options considered in our study. The priority activities will certainly have to be adapted to the ever chosen country strategy for implementing a national health insurance system. While the “Big push” and the incremental options will require both training and technical support, the “wait and work” strategy will focus more on capacity building. If the Yemen Government decides to make a brave step towards a national system that offers universal coverage from a very early stage, CHIC will be needed

for preparing and advising the technical staff of the one national insurance fund and for supporting the existing company as well as the emerging community based schemes. In the incremental strategy, a major task for the HIC will be the assessment and harmonisation of existing and/or emerging insurance schemes. And in the most cautious option, the CHIC will have to focus firstly on capacity building and assessment.

For the implementation of a Yemenite CHIC, several options are possible. However, if the MoPH&P will be the leading agent for setting up a national health insurance system, it should also be a major partner of the competence centre. As a viable strategy appears the creation of the CHIC as a joint venture of the MoPH&P and other concerned stakeholders, i.e. the Ministry of Finance, Ministry of Civil Services and Insurance, other Ministries, the health insurance fund or funds, representatives of company and community-based schemes, health care providers, academic staff, civil society organisations and specialised consultants. The CHIC could develop or be converted into a kind of think tank of an emerging Health Insurance Authority.

### 6.16 International support

International technical and financial support is needed and welcome in Yemen. Workshops, studies and consultancies, legal support, capacity building, designs of various options for social and national health insurance, national and international networking – all this deserves international cooperation. It is recommended that an advisory council or steering committee should be appointed *immediately* by the Prime Minister composed mainly of

- ministries, especially those responsible for finances, health, social affairs, civil services, endowment, and those that might adopt health insurance soon, e.g. defence, interior, education,
- solidarity schemes, health insurance projects, employers' and employees' associations or unions, civil society organisations, universities, women organisations and other outstanding experts, partners and stakeholders, including Al-Shura Council, parliament and parties.

This Council has the following objectives:

- to develop, based on the GTZ-WHO-ILO study, a policy paper on social health insurance
- to provide a policy forum on all related aspects, including on the redrafting of law proposals
- to mobilize necessary human and financial resources for implementing social health insurance
- to advise the preparation and implementation of social health insurances
- to carry out a social marketing of the social health insurance program.

This council will be converted later on into a permanent advisory board of the national health insurance authority.

A technical secretariat of the steering committee shall be put in place *immediately* by reassigning local and international professionals and it will be technically supported by WHO and GTZ offices in Yemen. As soon as possible, an independent and autonomous centre for health insurance competence should be build up with (a) a presidential or cabinet decree for instituting it, (b) a yearly budget of 400 million YR given by the Republic of Yemen, and (c) with additional international support, e.g. from World Bank funds. This Centre shall be converted step by step into a national health insurance authority that replicates the good experiences of the Social Development Fund and adapts them to an independent, credible, accountable and transparent public non-profit institution for social health insurance. This authority will guide the incremental approaches towards social and national health insurance in Yemen.

### 6.17 Outlook

In some countries it took a long time to cover all population with a mandatory social health insurance. Some developing countries – even poor ones – did it relatively fast. Yemen will not need decades to accommodate fairness of health financing with good health care for all. If there is a clearly increasing political willingness and commitment for a social and national health insurance system in Yemen and

if international technical support could be mobilised, then Yemen could offer all its citizens in a foreseeable future good health care in case of need and not only according to their ability to pay. This is, what social health insurance intends to achieve.

## 7. Literature<sup>22</sup>

1. Agyemang-Gyau, Peter (1998): The Ability and willingness of people to pay for their health care - The Case of Lushoto District, Tanzania. Department of Tropical Hygiene and Public Health, University of Heidelberg.
2. Al-Serouri, Abdul W. et alii (2001): Cost sharing for primary health care in the public sector of Yemen. Sana'a (Oxfam, MoPH&P)
3. Al-Serouri AW, Al Sofeani B (2005): Quality Management Consultancy Report. Sana'a: MoPH&P.
4. Arhin-Tenkorang, Dyna (2000): Mobilizing Resources for Health: The Case of User Fees Revisited. CMH Working Paper Series, Paper No WG3: 6. Washington DC ([http://www.cmhealth.org/docs/wg3\\_paper6.pdf](http://www.cmhealth.org/docs/wg3_paper6.pdf)).
5. Arhin-Tenkorang, Dyna (2001): Health Insurance for the Informal Sector in Africa: Design Features, Risk Protection, and Resource Mobilization. CMH Working Paper Series, Paper No WG3: 1. Washington DC. ([http://www.cmhealth.org/docs/wg3\\_paper1.pdf](http://www.cmhealth.org/docs/wg3_paper1.pdf)).
6. Baraldes, Carmen; Carreras, Lucas (2003) Willingness to Pay for Community Health Fund Card in Mtwara Rural District, Tanzania. Dar-es-Salaam.
7. Bärnighausen, Till; Sauerborn, Rainer (2002): One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries? *Social Science & Medicine* 54, S. 1559-1597.
8. Carrin, Guy (2002): Social health insurance in developing countries: a continuing challenge. *International Social Security Review* 55, 57-69, ISSN: 0020-871X.
9. Carrin, Guy (2005a): Structure of the SimIns basic simulation model. No publication place indicated
10. Carrin, Guy (2005b): Structure of the SimIns plus simulation model. No publication place indicated
11. Carrin, Guy and Chris James (2005): Key performance indicators for the implementation of social health insurance. In: *Appl Health Econ Health Policy* 2005, 4 (1) 15-22
12. Carrin, Guy et alii (2003): National social health insurance strategy. Comments and suggestions of the joint WHO/GTZ mission on social health insurance in Kenya. June 3-13, 2003. Nairobi
13. Driss, Zine-Eddine El-Idrissi (2005): Consultation on National Health Account. Preliminary Results of a short-term consultancy on national health accounts in Yemen. WHO/EMRO.
14. Huber, Götz; Hohmann, Jürgen; Reinhard, Kirsten (2003): Mutual Health Organization (MHO) – Five years Experience in West Africa. GTZ, Eschborn.
15. Hurrelmann, Klaus, Laaser, Ulrich (1995): Health Sciences as an Interdisciplinary Challenge: The Development of a New Scientific Field. In: Laaser, Ulrich, de Leeuw, Evelyne; Stock, Christiane (Eds.): *Scientific Foundations for a Public Health Policy in Europe*. Juventa-Verlag, Weinheim, pp. 104-131.
16. Kwon, Soonman (2002): Achieving health insurance for all: Lessons from the Republic of Korea. Geneva (ILO)
17. Ministry of Public Health (2002): Ministerial decree no. (53/3) 2002 on free of charge deliveries for women who can not afford. Sana'a (MoPH&P).
18. Normand, Charles; Weber, Axel (1994): *Social health insurance: a guidebook for planning*. World Health Organization/ILO, Geneva.
19. Tarmoom, Abdul Aziz (2003): Critical analysis of the application of the decentralized district level health care financial and accounting system: a case of Alqatn district health system. Sana'a

---

<sup>22</sup> A full list of literature is included in part 1 of our study report.