Increasing Health Care Access in Yemen Through Community-Based Health Insurance

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MATTHEW FUSS*

ABSTRACT

This Note addresses the implementation of health insurance reform in Yemen. As a result of a system of user fees and a lack of health insurance, the current regime poses serious barriers to health care access for Yemen's uninsured citizens. When the dust settles from the ongoing conflict with Houthi rebels, the time will be ripe for replacing Yemen's health financing system. In order to rebuild trust and curb abuse in the public health system, legal reforms are required to implement health insurance through decentralized decision-making and accountability measures. The Welfare Regime Framework accommodates these general reforms through policies that reflect the particular circumstances of Yemen. The implementation of health insurance reform will require policy reforms that bring together local, national, and international stakeholders to finance and develop management capacity for community-based health insurance in Yemen.

INTRODUCTION

Yemen underwent a peaceful political movement in the aftermath of the Arab Spring of 2011, which resulted in the ousting of then-President Ali Abdullah Saleh in 2012.1 On February 21, 2012, Abd Rabbuh Mansur Hadi was elected the new president, to be followed by a two-
year transition period. However, by March 2014, President Abd Rabbuh Mansur Hadi had fled Yemen after Houthi rebels took control of the capital Sana’a. The ensuing conflict has caused a humanitarian crisis and an overall institutional failure of Yemen’s government. The regime that emerges in the aftermath of this turmoil will have to prioritize Yemen’s basic needs, including water, education, employment, and health care. Given the material effect of a nation’s health on its productivity and prosperity, Yemen should prioritize legal reforms to its health systems. While globalization has led to a thriving private health sector in Yemen, it has also encouraged reduced public expenditures and user fees at the point of purchase. Consequently, only those employees provided with employer-sponsored health insurance have benefited from globalization, while the vast majority of Yemeni citizens continue to have limited access to health care.

The lack of equal access to health care is particularly prevalent among the 70 percent of Yemen’s working population who are part of the “informal sector,” which is defined as the largely poor, wage-employed and self-employed workers not covered by health insurance programs. Within the informal sector, there are many Yemeni citizens unprotected from the financial risks of poor health resulting from Yemen’s system of user fees. The health system in Yemen also faces a number of other constraints, including limited health service coverage, lack of coordinated management, inadequate community involvement, and inadequate information and monitoring systems. These constraints

2. Helen Lackner, in WHY YEMEN MATTERS: A SOCIETY IN TRANSITION Why Yemen Matters, supra note 1, at xvi.
3. Dan Stewart, Yemen’s Neglected Disaster, TIME, Nov. 9, 2015, at 40.
4. Id. at 43.
8. See id. at 33; see also Aulaqi, supra note 5, at 248–50 (discussing future challenges in the effort to reform Yemen’s health system).
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are exacerbated by Yemeni citizens' distrust of both public and private health systems.\(^9\)

Unfortunately, efforts in the past to implement a national health insurance system never materialized. Even when sensible reforms to the health system were enacted, they ultimately failed because of poor implementation and underfunding.\(^10\) The void caused by this decrease in public expenditure on health has been filled by the private health sector, which is particularly problematic because most Yemenis have no health insurance.\(^11\) And even when public health care benefits are offered, they "are tailored to maximise cost-sharing revenues and revenues from informal payments."\(^12\) Rather than focusing on ability to pay, health insurance reform should promote a system of providing health care based on need.

The solution proposed in this Note is a community-based health insurance (CHI) scheme targeted to serve the informal sector. This approach requires legal reforms aimed at transforming Yemen's current system of user fees into one based on prepayment and risk pooling. Implementing reforms entailing prepayment, however, will require gaining the trust of the Yemeni public, which, given the history of government mismanagement and corruption, will be no small task. Accordingly, the new government should pass a framework law to create an independent national health insurance authority (NHIA). Creation of the NHIA should be paired with bottom-up reforms to implement CHI programs. Additionally, the NHIA should coordinate its efforts with international organizations that provide technical assistance and financial support to implement these CHI programs. Local, national, and international stakeholders should work within a Welfare Regime Framework. The Welfare Regime Framework would accommodate these stakeholders through top-down and bottom-up reforms. These reforms would address the practical issues of implementation, such as "who should be covered and how, the goods and services to be included in a benefit package, compulsory health insurance financing, and what entity should administer and oversee it."\(^13\) To address these practical issues, the NHIA would serve a stewardship role by financing,

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9. See Saleh et al., supra note 1, at 375.
10. See SCHWEFEL ET AL., supra note 7, at 41 (describing a public drug fund in Yemen that drastically reduced the prices for essential drugs but was shut down in 2005 due to corruption and poorly administered exemption policies).
11. See Saleh et al., supra note 1, at 372, 374.
12. SCHWEFEL ET AL., supra note 7, at 45; see also Aulaqi, supra note 5, at 243 (noting that the current health system in Yemen relies significantly on the private sector, which is driven by financial concerns rather than patient welfare).
decentralizing decision-making, and employing approaches that ensure accountability and quality in its network of CHI programs.

The balance of this Note is divided into four parts. Part I discusses global trends in health care reform and health policy in general as well as health care in the Arab world in particular. Part II provides an overview of Yemen's current health care system. Part III explicates the Welfare Regime Framework as a basis for social policy reform. Lastly, Part IV provides approaches for effectively implementing health insurance reform at the community, national, and international levels.

I. GLOBALIZATION AND HEALTH CARE POLICY

A. Global Trends in Health Care Reforms

National health systems are organized and limited "by the culture, resources, and values of a country, yet operate in a field of medical care and normative policies which is open to international exchange and learning." Likewise, health care reforms are often influenced by national concerns for protecting patients' and citizens' rights to health yet are still subject to the economic realities of trade liberalization and global integration that characterize globalization.

There are five current trends of globalization that influence health policy: (1) global competitiveness requires states to lower the costs of their health policies by moving to "a more contractual and competitive bidding to deliver services" as a means to limit the size of the public sector workforce; (2) innovation plays a key role in global competitiveness and requires greater engagement with the private and commercial sectors; (3) the pursuit of economic growth eventually replaces existing health policy priorities as health systems become a resource base for globalizing industries (e.g., telemedicine and advanced medical technologies); (4) the portability of benefits required by globalization results in health systems that accommodate increased migration; and (5) international agreements play an important role in delimiting national health policy domains.

Health care reforms in countries belonging to the Organisation for Economic Co-operation and Development (OECD) began in the 1980s and came in two phases. The first phase saw the splitting of purchaser

14. JONATHAN TITTER ET AL., GLOBALISATION, MARKETS AND HEALTHCARE POLICY: REDRAWING THE PATIENT AS CONSUMER 29 (Simon J. Williams & Gillian Bendelow eds., 2010).
15. See id. at 75.
16. Id. at 30-31.
17. Id. at 32-37.
and provider functions. These reforms led states to take on a purchasing role while entering into contractual relationships with private providers to plan markets and manage competition in order to lower cost and improve efficiency. While this first phase of health care reforms in OECD countries focused more on the supply side, the second phase focused more on the demand side by emphasizing patients as consumers and granting them rights to choose their service provider.18 In other words, the conception of health care among policymakers has shifted from a publicly-provided benefit to a consumer good purchased on the open market.

B. Global Policy Influences

Global policies that influence a state’s health care system can be grouped into the following policy domains: (1) the direct influence of global intergovernmental agencies through agreements with the state (e.g., the World Health Organization (WHO)); (2) the indirect influence of global intergovernmental agencies effected through changes of national policy resulting from non-health-care sector commitments (e.g., trade agreements); (3) the direct and indirect influences of global nongovernmental organizations; and (4) the influence of global ideas transmitted outside global agencies through research and consulting.19

Intergovernmental agencies have played a key role in influencing health care reforms. For example, the WHO and United Nations Children’s Fund (UNICEF) organized the Alma-Ata Conference, in which they formalized the “Health for All” strategy in 1978.20 This strategy emphasizes the importance of primary health care in any comprehensive health care reform and the inclusion of community participation in the planning and organization of primary health care;21 it also emphasizes cooperation with other public-sector actors within each country as part of a comprehensive approach to reforming national health systems.22

The entry of the World Bank into the dialogue on health care reform in the early 1990s marked a shift from the WHO’s “Health for All” strategy to one concerned more with equity, universal access, and sound

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18. See id. at 36.
19. See id. at 55.
20. Id. at 57.
21. See Guy Carrin et al., Community-Based Health Insurance in Developing Countries: A Study of its Contribution to the Performance of Health Financing Systems, 10 TROPICAL MED. & INT’L HEALTH 799, 800 (2005).
22. TITTER ET AL., supra note 14, at 57.
financing. This World Bank strategy contributed to health care reforms in developing and transitioning countries. The World Bank enunciated these policy priorities in the Ljubljana Conference of 1996, during which the World Bank also pushed to limit the privatization of health care systems.

The shift in focus to equity and universal access is consonant with the United Nations' (U.N.) stipulations on human rights: Article 12 of the International Covenant of Economic, Social and Cultural Rights "recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." In that 151 countries have signed this covenant, it serves as an authoritative source of the right to health. The right to health was perhaps most importantly defined in 2006 by Paul Hunt, the U.N. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health: "The right to health can be understood as the right to an effective health system encompassing health care which is accessible to all. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system." The right to health also entails "financial and physical accessibility to services in a non-discriminatory manner."

C. Globalization and Health Care in the Arab World

In line with the U.N.'s pronouncement on the right to health, the constitutions of many Arab countries protect access to health care. In the latter half of the twentieth century, the Arab world's health systems were dominated by socialist policies calling for a strong role for the state in the financing, provision, and organization of free universal health care. By the late 1980s, however, these policies proved to be financially unsustainable. Due to budget deficits, health facilities were left without necessary resources, and physicians were underpaid. As a result, countries like Egypt, Libya, Tunisia, and Yemen looked for ways

23. See id. at 32–33.
24. Id. at 58.
27. Saleh et al., supra note 1, at 376 (citing WHO & OHCHR, supra note 26, at 2).
28. See id. at 368, 371.
29. See id. at 371.
30. See id. at 372.
31. See id. at 371.
to supplement public financing for health care. This shift was accompanied by increased interest from international organizations like the World Bank and the International Monetary Fund to expand their investments in social development projects.\textsuperscript{32}

Development theories in the late 1980s promoted liberalizing trade and reducing the role of the state in general.\textsuperscript{33} In 1987, the World Bank called for user fees as a solution for recovering some of the cost of public expenditures on health.\textsuperscript{34} The reduction in public spending on health left public health services unable to meet patients' needs, which led patients to seek private care.\textsuperscript{35} Moreover, governments pursued robust privatization policies, including outsourcing the provision of health services to private providers altogether.

At the turn of the millennium, international agencies generally concluded that the system of user fees was inefficient and served as a barrier to health care access for low-income populations.\textsuperscript{36} In 2005, the World Health Assembly passed Resolution 58.33, which urged Member States to switch to systems of prepayment in order to finance health care. Nevertheless, many countries in the Arab world continued to reduce their public financing of health services while also leaving in place their systems of user fees.\textsuperscript{37}

\section*{II. Health Care in Yemen}

\subsection*{A. Historical Context of Health Insurance}

From 1967 to 1990, there were two Yemeni states: the socialist-backed People's Democratic Republic of Yemen (PDRY) and the Western-backed Yemen Arab Republic (YAR).\textsuperscript{38} Yemen's unification in 1990 coincided with increased liberalization of the health care system.\textsuperscript{39} Prior to unification, the YAR had allowed a private health system to develop alongside its publicly-funded system, while the PDRY maintained a strict socialist system that disallowed private

\textsuperscript{32} See id. at 372 ("This shift for investment beyond classic projects for economic growth (eg, transportation and energy) was encouraged by development theories that by the 1980s advocated the importance of meeting individuals' basic needs (eg, health, nutrition, and education). ").

\textsuperscript{33} See id. at 372.

\textsuperscript{34} See id.

\textsuperscript{35} See id. (describing the process known as passive privatization, whereby patients are indirectly pushed into the private sector).

\textsuperscript{36} See id. at 373.

\textsuperscript{37} See id. at 373–74.

\textsuperscript{38} Lackner, supra note 2, at xiii–xiv.

\textsuperscript{39} Saleh et al., supra note 1, at 372.
healthcare. After unification, health care in Yemen became an amalgamation of the YAR and PDRY systems. Starting in the mid-2000s Yemen began to encourage a market approach to health care, with its citizens increasingly turning to the private sector for care. This shift, in combination with reduced public health budgets and user fees, negatively affected Yemen's poorest citizens and its rural areas.

B. Political Context

As opposed to most of the regime changes that occurred during the Arab Spring of 2011, change in Yemen was peaceful. In the fall of 2011, Yemen's President Ali Abdullah Saleh stepped down under an agreement that called for elections in early 2012. On February 21, 2012, Abd Rabbuh Mansur Hadi was elected the new President of Yemen. A two-year transitional regime was expected to follow the presidential elections. Yemen is unique in the Arabian Peninsula, as it is the only republican regime with regular elections. Nevertheless, due to the rise of international jihadism, attention from the outside world has been focused more on security issues than on civil and economic reforms. Additionally, Yemen faces a number of political challenges, including "southern separatism, sectarianism in the far north, and miscellaneous class and tribal issues everywhere." Following the takeover of Sana'a by Houthi rebels and President Abd Rabbuh Mansur Hadi's flight from the country in March 2014, a coalition of ten Arab nations led by Saudi Arabia and supported by the United States began an air campaign against the Houthi rebels. Yemen is currently faced with a near collapse of its political institutions.

40. See Aulaqi, supra note 5, at 236–37.
41. See id. at 237.
42. See id.
43. See id. at 237–39; see also Helen Lackner, supra note 1, at 1, 14–15 (noting that roughly half of Yemen's population lives in poverty and about 70 percent live in rural areas).
44. See Lackner, supra note 1, at 1.
45. Saleh et al., supra note 1, at 374.
47. Lackner, supra note 1, at 12.
48. Lackner, supra note 1, at 2.
49. Id. at 2.
50. See Stewart, supra note 3, at 38, 40.
C. Health Service Access

Health care access and even distribution of health services have long been problems in Yemen, even though the Yemeni constitution guarantees the right to health care for everyone. Roughly 35 percent of Yemeni citizens do not receive access in times of need, and access to curative services is limited to 68 percent of the population, whereas 32 percent are without services entirely. This resource allocation in Yemen leads to inequitable results as 30 percent of total health spending goes to treatment abroad for a small number of patients: those who can afford to incur the travel expenses.

There is also geographic inequity in the distribution of access to health services—25 percent of rural areas have access, as opposed to 80 percent of urban areas. Moreover, because most Government Healthcare System (GHS) hospitals and private hospitals are concentrated in urban areas, some 70 percent of the total population does not have easy access to specialist care and would face great expense in traveling to urban facilities.

D. Health Services

1. Public Health Services

The public health care system in Yemen consists of four levels: (1) 2,929 primary health care units, (2) 184 district hospitals, (3) fifty-three general hospitals, and (4) two specialist referral hospitals. GHS hospitals often suffer from a lack of human resources and leadership, and some rural hospitals stay closed for months at a time because of insufficient staffing.

51. See generally Sharon Lambeth, Health Care in the Yemen Arab Republic, 25 INT’L J. NURSING STUD. 171 (1988) (outlining the Yemen Arab Republic’s five-year plan initiated in 1977 to improve access to and equalize distribution of healthcare and looking at some of the resource shortages that hindered that plan).
52. See THE CONSTITUTION OF THE REPUBLIC OF YEMEN Feb. 20, 2001, art. 55 (stating that “[h]ealth care is a right for all citizens. The state shall guarantee this by building various hospitals and health establishments and expanding their care.”).
54. Aulaqi, supra note 5, at 240.
55. See id. at 238.
56. Id. at 240.
57. See SCHWEFEL ET AL., supra note 7, at 13, 51.
58. Aulaqi, supra note 5, at 240.
59. See id. at 241.
To make matters worse, because of a lack of trust and confidence, patients often bypass first level primary health care units and seek care at governorate or national hospitals, which is an inefficient use of the available health resources and creates high health expenditures for patients. Additionally, inadequate public sector health care is estimated to cause 95 percent of patients to turn to the private health sector for care. In an attempt to address such issues, Yemen developed the District Healthcare System (DHS) in 2002, which delivered primary health care through community-based services by using mobile health clinics and district hospitals. In the absence of good management, however, employee absenteeism has undermined the program's effectiveness.

2. Private Health Services

Since unification in 1990, Yemen's private sector has thrived, having increased from 167 private hospitals in 2002, to 746 private health centers in 2012. Such growth in the private sector occurred as Yemen sought to mitigate the burden of financing a free public health system. While the private sector owes its success partly to committed owners and foreign investors, the private sector is mostly staffed by employees of the public sector. Such staffing often results in divided loyalties and disadvantages the public sector. These divided loyalties create perverse incentives for self-referrals to move patients from public to private care, where salaries are roughly five times higher than in the public sector.

E. Health Financing

Because of Yemen's weak economy, it has struggled to fund its health care system. In 2007, the total health care expenditure in Yemen was USD 1.14 billion, or USD 60 per capita, whereas the government

60. See MINISTRY OF PUB. HEALTH, HEALTH SECTOR REFORM IN THE REPUBLIC OF YEMEN: STRATEGY FOR REFORM 18 (2000) (Yemen); SCHWEFEL ET AL., supra note 7, at 34–35.
61. Aulaqi, supra note 5, at 241.
62. Id. at 244.
63. See id. at 244.
64. Id. at 246.
65. See id.
66. See id.
67. SCHWEFEL ET AL., supra note 7, at 33.
68. See Aulaqi, supra note 5, at 246.
69. Id. at 238.
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only contributed USD 463 million of this, or USD 20.22 per capita.70 Between 2007 and 2010, the private, out-of-pocket spending on health rose from 67 percent of the total health expenditure in Yemen to 71 percent, whereas the public budget for health spending fell from 4 percent to 3.6 percent.71 Moreover, patients who access public health care must pay user fees at the time of service and purchase prescribed medicines out of pocket, both of which result in immense burdens when patients need long-term care.72 Compounding this problem, "unofficial fees" are often claimed by health workers, who feel justified in so doing because they are underpaid and chronically underequipped.73

F. Proposed Health Insurance Reform

The government of Yemen sought to implement its "Strategy for Reform" between 1998 and 2001.74 While Yemen achieved 30 percent of the strategy's proposals, "its incomplete implementation resulted in much greater expansion of the private sector without the intended corollary of collaborating closely with and complementing the Government Health Service."75 In 2005, the Republic of Yemen issued a decree to contract the German development aid agency Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) to draft a proposal for a national health insurance system;76 however, no reforms were passed to implement this proposal.77

In June 2011, Yemen's Cabinet approved a National Health Strategy, which consisted of a five-year plan "to ensure sustainable preventive, curative and rehabilitative health services that are of high quality, ensure user satisfaction and respect equity in distribution of resources."78 Nevertheless, this plan did not include any reform to health financing. Since then, the government of President Abd Rabbuh

70. Id.
71. Id.
72. See SCHWEFEL ET AL., supra note 7, at 11–12, 32, 40.
73. See id. at 43–44.
74. Aulaqi, supra note 5, at 242.
75. Id. at 242–43 (internal quotation marks omitted).
76. See SCHWEFEL ET AL., supra note 7, at 6–8 (recommending three reform strategies: (1) a "full speed" approach for immediately expanding insurance in the formal sector to cover nearly half of the Yemeni population; (2) a three-step incremental approach to reform insurance in the formal sector while concurrently putting in place a full cost-effective coverage for the poor; (3) a think tank approach for determining the best practices of community and company-based health insurance).
77. See Aulaqi, supra note 5, at 243.
Mansur Hadi expressed support for strengthening health services in its commitment to social and human development.\textsuperscript{79} Such political support is key, because "implementation . . . of a social health insurance policy will be severely restricted if there is no strong and steady political support."\textsuperscript{80} Moreover, political opportunities for major reforms to health systems occur very rarely.\textsuperscript{81}

Since President Abd Rabbuh Mansur Hadi's flight from Yemen and the Houthi rebels' seizure of the capital in the spring of 2014, the ensuing conflict has created a humanitarian crisis, with "more than half the country's 25 million people . . . struggling to find food and almost two-thirds hav[ing] no access to health care."\textsuperscript{82} The government that emerges will need to enact policy reforms to address the dire state of Yemen's health care system.

III. WELFARE REGIME FRAMEWORK FOR HEALTH INSURANCE REFORM IN YEMEN

The Welfare Regime Framework accepts the global reality of "mixed" capitalism and acknowledges that markets, states, and communities must cooperate to meet human needs.\textsuperscript{83} Welfare states are typically defined as a system in which the state provides social protections and benefits in combination with labor-market regulation.\textsuperscript{84} However, in developing states, neither the state nor markets are sufficiently reliable to protect citizens against the insecurity of markets.\textsuperscript{85} Nevertheless, states that manage to mix the institutional domains of state, market, and community are able to achieve a more sustainable framework for well-being.\textsuperscript{86}

The welfare regime approach, as applied in the Global North, is premised on nine principles: (1) capitalism is the dominant mode of production; (2) class divisions arise from the division of labor between owners and non-owners of capital; (3) employment in formal labor

\textsuperscript{79}. See Saleh et al., supra note 1, at 376–77.
\textsuperscript{80}. Carrin et al., supra note 21, at 799.
\textsuperscript{81}. See Jeremy Hurst, Effective Ways To Realise Policy Reforms in Health Systems, 51 OECD HEALTH WORKING PAPERS 1, 27 (2010).
\textsuperscript{82}. Stewart, supra note 3, at 43; see also Crisis Overview, UNITED NATIONS OFF. FOR COORDINATION HUMANITARIAN AFF., http://www.unocha.org/yemen/crisis-overview# (last visited Mar. 17, 2016) (discussing the displacement of the Yemeni people and their need for humanitarian assistance).
\textsuperscript{84}. See id. at 1696.
\textsuperscript{85}. See id.
\textsuperscript{86}. See id. at 1697.
markets is the dominant form of securing one's livelihood; (4) an interclass political settlement results from the political mobilization of the working classes; (5) the state is relatively autonomous; (6) social interventions are circumscribed by the welfare mix of state, market, and family structures; (7) the welfare mix provides social services; (8) over time the welfare mix and outcomes reproduce the welfare regime; and (9) social policy takes place in the public domain and is intended to achieve welfare-oriented goals.

The term “regime,” in the legal sense, is the “set of rules, institutions and structured interests that constrain individuals through compliance procedures.” These rules may emerge formally from the top down or informally from the bottom up. Although the continuance of regimes tends to be recursive, regimes can be replaced in times of rapid change or crisis. The rights and duties that emerge in a welfare regime are shaped by the history of the interrelation of state institutions and the global economy. Such interrelations are bound by both non-state and global actors. In other words, social policy reform within a state's welfare regime takes place in a global context in which markets, states, and communities must act together to enhance well-being.

In the Global South, by contrast, welfare regimes can often be categorized as informal security regimes, which are “institutional arrangements where people rely heavily upon community and family relationships to meet their security needs.” Here, “community” refers to the informal sector in which subsocietal actors and civil society contribute in defining rights and duties (as compared to the formal rights defined by the state). In such regimes, international actors play important roles in the welfare mix by providing aid and foreign direct investment.

Social reform under the welfare regime requires a focus on “de-clientelization.” In terms of health insurance reform, de-clientelization
entails breaking down patients' dependencies on persons with intimate power over them.\textsuperscript{97} Reforms based on civil society, including the informal sector, contribute to de-clientelization.\textsuperscript{98} However, those in the informal sector, who are predominantly poor, will only trust social reforms if the processes for achieving improvements are effectively implemented or delivered.\textsuperscript{99}

IV. EFFECTIVE IMPLEMENTATION OF COMMUNITY-BASED HEALTH INSURANCE IN YEMEN

Establishing a national health-insurance system will help reorient the health system away from the patient as a client and toward need-based provision of health care. Such reorientation would be facilitated by implementing a prepayment system independent of the insured's risk and by identifying the right welfare mix. This welfare mix would require a bottom-up approach in order to create CHI programs as well as a top-down approach for creating a NHIA to steward the implementation of health insurance reform and coordinate international assistance.

The effective implementation of health-insurance reform can be enhanced by building trust at the community level, such as by building on existing initiatives that have already gained the trust of the population.\textsuperscript{100} At the national level, the government needs to ensure an independent NHIA, especially given Yemeni citizens' distrust of public health care.\textsuperscript{101} Lastly, international stakeholders would need to cooperate with community and national stakeholders to coordinate technical and financial assistance.\textsuperscript{102}

A. Community-Based Health Insurance

A CHI scheme for the informal sector and rural population can supplement the existing insurance already in place for the formal sector in Yemen.\textsuperscript{103} Establishing CHI programs in Yemen would be particularly beneficial because it would allow citizens to bypass any political or organizational difficulties during Yemen's time of political uncertainty. Community financing serves as a "mechanism whereby

\begin{itemize}
\item \textsuperscript{97} See id. at 1708.
\item \textsuperscript{98} See id.
\item \textsuperscript{99} See id.
\item \textsuperscript{100} Carrin et al., supra note 21, at 803.
\item \textsuperscript{101} See SCHWEFEL ET AL., supra note 7, at 8, 10.
\item \textsuperscript{103} See SCHWEFEL ET AL., supra note 7, at 63.
\end{itemize}
households in a community (the population in a village, district or other geographical area . . .) finance or co-finance the . . . capital costs associated with a given set of health services."104 CHI programs perform the functions of revenue collection and risk pooling.105

1. Revenue Collection

The target population for CHI in Yemen is the 70 percent of the working population in the informal sector that currently finances their health care through a system of user fees.106 The revenue collection in CHI programs entails a system of prepayments.107 By keeping track of prepayments, CHI will be better able to gauge accessibility by using the metric of ratio of prepaid contributions to health expenditure.108 Most CHI schemes are designed to cover the portion of out-of-pocket expenses comprising the prior fee-based system.109 Hence, CHI with a high enough prepayment ratio will prevent families from having to make excessive out-of-pocket payment when they need health care and will help reduce the incidence of catastrophic spending.110

CHI programs can increase enrollment through subsidies and building on preexisting programs. To subsidize patients' prepayments, CHI programs should identify additional sources of financing at the national and international levels.111 Because Yemeni citizens will be unlikely to participate in CHI until they have had time to trust and be convinced by the merits of the program,112 CHI schemes might gain more quickly their trust by building on preexisting programs already trusted in the community.113 One such program is the Child Development Project (CDP), which was initiated to help reach the Millennium Development Project's goal of reducing child mortality in Yemen.114 The CDP was designed to improve the nutritional health of

104. Carrin et al., supra note 21, at 800.
105. See id.; see also infra Part IV.B.1 (noting the third function of strategic purchasing that must be carried out in CHI programs; however, due to the amount of technical assistance required, this task is included within the stewardship provided at the national level).
106. Cho, supra note 6, at 29.
107. See Carrin et al., supra note 21, at 801.
108. Id.
109. Id. at 805.
110. See id. (citing a study defining "catastrophic spending" as occurring when patients spend more than 10% of their annual income on healthcare).
111. See id. at 801.
112. See id. at 803.
113. See id.
children by mobilizing resources at the community level through community-based management and community-based interventions.  

2. Risk Pooling

Successful CHI programs also include risk pooling, which allows “financial resources to be shared between the healthy and the sick.” Risk pooling serves as a metric for determining how fairly and equitably health insurance benefits are distributed by determining the percentage of the target population actually enrolled. But when such a system is based on voluntary enrollment, adverse selection is a risk. In other words, those with preexisting conditions would be more likely to enroll than healthy individuals. Such enrollment would negatively impact CHI by driving up the cost of prepayment. CHI schemes may also require higher contributions from higher-risk groups, which could lead those groups to be less willing to enroll. Lastly, risk pooling might be met with cultural resistance in Yemen, where the concept of insurance is considered haram, or forbidden by the Quran.

Three solutions are particularly relevant to resolve the pitfalls of voluntary CHI programs. Regarding adverse selection, CHI schemes can establish a qualifying period before individuals can take part in CHI to discourage individuals from enrolling only when they are ill. Whereas adverse selection can be resolved at the local level, CHI coverage in communities containing relatively high-risk populations will depend on subsidies from national and international stakeholders as a means of equalizing the risk. Using subsidies as an equalizing mechanism allows CHI programs to require more affordable contributions. Finally, although the concept of pooling risk is novel in the informal sector in Yemen, CHI programs should engage in information campaigns that describe CHI in a culturally relevant way. For example, CHI programs could explain risk pooling by relating it to traditional mutual-aid initiatives and zakat, an annual charitable tax comprising 2.5 percent of income. Yemeni citizens take this tax seriously, and, if

115. See id.
116. Carrin et al., supra note 21, at 801.
117. Id.
118. Id.
119. See SCHWEFEL ET AL., supra note 7, at 20.
120. See Carrin et al., supra note 21, at 808.
121. See id. at 807.
122. See id.
123. See SCHWEFEL ET AL., supra note 7, at 21.
the tax could be collected reliably, it would generate between YER 700 to 1,000 million per year.  

B. Stewardship at the National Level

Government support and stewardship will be necessary for the state to ensure the overall success of its health system, especially since a large number of CHI programs in rural Yemen would provide coverage in areas that would likely have sustainability issues resulting from low membership. The NHIA can do this by performing a number of tasks to help steer CHI programs to an eventual national health insurance system. These tasks include providing financial management, decentralizing decision-making authority, and monitoring the CHI programs to promote accountability and quality assurance.

1. Financial Management

While CHI schemes are premised on a system of prepayment, they do not exclusively have to rely on household contributions but rather can be subsidized by "central [or] local government, [and] national or international NGOs." This notion is supported by research suggesting that CHI schemes will not reach the most vulnerable unless their membership is subsidized. To raise funds for such subsidies, Yemen could levy "sin taxes" on cigarettes or qat or hypothecate the tax on oil or big equipment.

In addition to its co-financing role, the NHIA should engage in strategic purchasing, which consists of choosing the best benefits, providers, and payment methods. In choosing the best benefits package to offer through CHI, the NHIA will have to balance the most pressing health needs of the informal sector with the financial situation.

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124. Id.
125. See WHO, Community Based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives, 26, EIP/FER/DP.E.03.1 (2003) (Guy Carrin).
126. See id.; see also Carrin et al., supra note 21, at 805 (noting that CHIs can be used as starting points for scaling up to larger risk pools).
128. Carrin et al., supra note 21, at 801.
129. See id. at 804.
130. SCHWEFEL ET AL., supra note 7, at 106.
131. See Carrin et al., supra note 21, at 801.
of the country.\textsuperscript{132} Because of the geographic isolation of some of its citizens in rural areas, the NHIA should include transportation costs in its benefits package.\textsuperscript{133} Additionally, the definition of the benefits package should include strict gatekeeping and referral practices,\textsuperscript{134} which would prevent the inefficient practice found in Yemen today whereby Yemenis bypass lower-level primary care facilities and go directly to higher-level general hospitals.\textsuperscript{135} But shifting to a primary health care base would first require educating the public on the benefits of primary care.\textsuperscript{136}

To choose the best providers, the CHI scheme would be limited to the existing health care infrastructure in any given geographic area. In rural areas, for example, the national health insurance body will be limited to choosing the nearest public health provider, whereas in urban areas it can choose among the best public and private providers.\textsuperscript{137}

For ease of administration, the best payment mechanism for CHI programs is capitation, "where providers receive payment according to the size of the population served."\textsuperscript{138} With capitation payment, there is no incentive for overproduction; however, capitation does give rise to potential underproduction (that is, providers might have the incentive to use the least amount of funds received through capitation in order to pocket the unused part).\textsuperscript{139} While underproduction can be avoided by fostering competition in urban areas (because providers' income depends on the number of patients served), the same cannot be said for rural areas, where the best solution may be to capitate groups of providers together.\textsuperscript{140} Altogether, strategic purchasing serves as an indicator of access to cost-effective health care.\textsuperscript{141}

\textsuperscript{132} See SCHWEFEL ET AL., supra note 7, at 98–99.
\textsuperscript{133} See Carrin et al., supra note 21, at 802. But cf. Irene Akua Agyepong & Sam Adjei, Public Social Policy Development and Implementation: A Case Study of the Ghana National Health Insurance Scheme, 23 HEALTH POL'Y & PLAN. 150, 153 (2008) (citing research that suggests "quality of care and ability to pay may sometimes be more important barriers than geographic access").
\textsuperscript{134} Carrin et al., supra note 21, at 807.
\textsuperscript{135} For discussion of the Yemeni population's lack of faith in the lower levels of the public health system, see MINISTRY OF PUB. HEALTH, supra note 60, at 18 and SCHWEFEL ET AL., supra note 7, at 34–35.
\textsuperscript{136} WHO, Planning and Implementing Health Insurance in Developing Countries: Guidelines and Case Studies, 26, WHO/ICO/MESD 2.7 (Oct. 1993) (Aviva Ron).
\textsuperscript{137} See SCHWEFEL ET AL., supra note 7, at 50–51 (discussing the imbalance of facilities between urban and rural areas and noting that improving rural care is one of the highest priorities for a national health scheme).
\textsuperscript{138} Carrin & James, supra note 127, at 38.
\textsuperscript{139} See id.
\textsuperscript{140} See id.
\textsuperscript{141} Carrin et al., supra note 21, at 802.
2. Decentralization

Decentralization plays a key role in the effective implementation of CHI because "community participation in management, cost recovery, and the setting up of effective motivational systems cannot be implemented if the overall system remains centralized." For example, successful CHI schemes in Uganda delegated to local communities decision-making authority regarding community sensitization, collection of contributions, and monitoring for abuse, whereas financial management and monitoring quality of care remained centralized. A similar arrangement would be suitable for the CHI scheme in Yemen until the NHIA, with international assistance, is able to further develop management capacity at the community level. Ultimately, decentralization would help create greater community commitment to the system.

To rebuild trust in the health system, Yemen should find an entry point in communities that is already trusted by the population. For example, the Social Fund for Development (SFD) in Yemen already has experience providing both financing to community organizations to allow them to manage basic health services and technical assistance in developing management capacity. This strategy would promote a more comprehensive approach to addressing issues that go beyond health financing yet still affect the overall health of the population. Such cooperation would be familiar to the actors involved as Yemen’s Ministry of Public Health has planned to cooperate with the SFD to address the following issues: "[p]overty alleviation through setting up micro-enterprise projects[,] [g]irls’ education[,] [p]rovision of safe drinking water[,] [s]anitation and environmental health[,] [and] [i]mprovement of health facility infrastructure.”

3. Accountability

Decentralized decision-making authority in the health sector could promote accountability among citizens and policymakers.

142. MINISTRY OF PUB. HEALTH, supra note 60, at 14.
143. See Carrin et al., supra note 21, at 807.
144. Carrin et al., supra note 21, at 803.
145. Carrin et al., supra note 60, at 14.
146. Sameh El-Saharty et al., supra note 114, at 21; see also MINISTRY OF PUB. HEALTH, supra note 60, at 35-36 (noting that the SFD cooperates with other organizations on development projects).
147. Id. at 35.
Accountability is "the obligation of individuals or agencies to provide information about, [or] justification for, their actions to other actors, along with the imposition of sanctions for failure to comply [or] to engage in appropriate action." The NHIA, in its stewardship capacity, would oversee such a system of responsibility and sanctions. Given the prevalence of both unofficial and official user fees, effectively implementing accountability in health financing has the potential to curb abuses of power and would help regain the public's confidence.

Accountability serves three purposes in health systems: (1) financial accountability promotes control over the abuse of public resources and authority; (2) performance accountability ensures that proper legal procedures are followed; and (3) political accountability improves public management by making it more responsive to constituent needs.

Within the Welfare Regime Framework, top-down oversight in Yemen would consist of financial and performance oversight of CHI schemes by the NHIA, and bottom-up accountability would result from the government being held responsible for its oversight of the NHIA by voters in democratic elections.

To identify institutional capacity gaps, all the stakeholders involved at the international, national, and local levels will need to trace all of the accountability relationships both within and without the public health bureaucracy in Yemen. This process can be operationalized by mapping out a matrix of all of the health system actors. By plotting out the intersection of the various actors, the nature of information requirements and ability to impose sanctions can be determined for each relationship. Each relationship would indicate the strength of the actors' capacity to supply information or respond to sanctions, or, conversely, to demand information or impose sanctions. A matrix that shows too few accountability linkages likely will suffer from corrupt practices, whereas a matrix with too many will have limited effectiveness. Ultimately, striking the right balance of accountability linkages will aid in effectively implementing health insurance reform in the informal sector.

149. Id. at 372.
150. See generally id. (defining accountability as the requirement to provide information and answer questions, and sanctions as the ability to impose punishment).
151. See id. at 373.
152. See id. at 373–74 (specifying that financial accountability refers to the ability to track expenses for the purposes of auditing, budgeting, and accounting; performance accountability ensures the quality of service; and political accountability refers to measures used to ensure the government maintains commitments made to the health system and that it does not become a political tool).
153. See, e.g., id. at 376–77.
154. See id. at 377.
4. Quality Assurance

The role of the NHIA in contracting with health providers to offer defined benefits packages means it can also require them to meet quality standards.155 “Quality” in health systems is defined by the criteria selected to evaluate it.156 Three of the principal objectives of quality assurance are: (1) complying with the societal commitment of the government to efficiently protect public health, (2) monitoring the quality of services provided, and (3) using quality assessment for research purposes to define the role of the patient in the health system.157 In addition to the unregulated nature of the private sector and lack of developed management information systems, Yemen also lacks the capacity to effectively monitor and evaluate health outcomes.158 Accordingly, much technical assistance would be needed at the international level to develop standards and create hospital accreditation programs.

Given the gaps in management capacity, efforts should focus on the structure of the health insurance system, which consists of physical inputs, personnel, financial resources, and organizational arrangements.159 Even without developed information systems, Yemen can still put in place management strategies that seek to improve quality. Moreover, an evaluation of a quality management system for a hospital in Yemen identified several determinant factors of patient satisfaction (such as nearby services, good staff attitude, and cleanliness) and dissatisfaction (such as lack of drugs, poor staff attitude, and poor lab services).160

Bearing in mind the relationship of patient satisfaction and quality, the NHIA could adopt a system-wide management approach based on continuous quality improvement (CQI). CQI involves four processes: (1) “transforming the organizational culture to one focused totally on [patient] satisfaction”; (2) “empowering employees at all levels to improve organizational processes”; (3) “integrating support systems and methods to motivate and reward employees on the basis of quality and productivity”; and (4) “committing . . . management to . . . decentralized decision-making, . . . and a systems approach to managing
organizational change.”161 Under this management approach, the NHIA would continually seek to improve its stewardship tasks because “health sector reform is a continuous, dynamic and evolving process, and . . . strategies may need to be reconsidered during implementation.”162

C. Role of International Donors

International donors play an important role in social policy reform, especially where “governments demonstrate political will to foster development, but lack capacity.”163 International assistance in health-related projects typically consists of the provision of technical assistance,164 such as developing the administrative and management capacity necessary for CHI programs to be successful.165 These skills include “setting of contributions, collection of contributions and compliance, determination of the benefit package, marketing and communication, contracting with providers, management information systems, and accounting.”166 In Yemen, such external assistance in health spending has played a key role.167 For example, in 1998, it accounted for 25 percent of the total health expenditure in the public sector, which amounted to USD 33 million. Most of this support (roughly two-thirds) was for technical assistance, while 26 percent was for investment and 9 percent for budget support.168 International assistance should follow a sector-wide approach, and financial assistance should be coordinated through multi-donor trust funds.

162. El-Saharty et al., supra note 114, at 23; see also Abdulwahed Al Serouri et al., Strengthening Health Systems in Yemen: Review of Evidence and Implications for Effective Actions for the Poor, in HEALTH MANAGEMENT: DIFFERENT APPROACHES AND SOLUTIONS 285, 292 (Krzysztof Smigorski ed., 2011) (“There is evidence that implementation effectiveness is increased by providing continuous feedback to the strategy team and leaders about health service needs, constraints, implementation progress, and health service impact.”).
165. See Carrin et al., supra note 21, at 806 (noting that many small CHI programs lack the resources to hire professional management, leading to management-related and administrative issues).
166. Id.
167. See El-Saharty et al., supra note 114, at 22.
168. Id.
1. Sector-Wide Approach

In a transitioning country like Yemen, international donors should avoid activities that would undermine national reform efforts, "such as developing parallel systems without thought to transition mechanisms and long-term capacity development." To avoid such pitfalls, international donors should follow a sector-wide approach (SWAp). SWAp changes how international donors cooperate with institutions at the national level in two ways: (1) "donor procedures are harmonized, so that they follow one system"; and (2) "donors use national systems for monitoring performance . . . with strong coordination in financial management." In order for this arrangement to work, it must be implemented so that the resulting management systems are trusted both by donors and the government.

SWAp represents a shift away from the traditional project-based approach of international involvement. The old approach saw international donors take on projects in certain geographic areas, develop their own management system, and then hand over their model to the government after withdrawing from the project. But under the old approach, the systems typically collapsed once the donors pulled out. The old systems failed partly because they developed parallel to dysfunctional national systems, thereby keeping them immune from the problems of the national system, at least while the donor remained involved. Once the donors left, the problems of the national system were allowed to take over. With SWAp, donor involvement would have to work at both the national and community level to guarantee effectiveness. In other words, international donors are an important part of the welfare mix within the welfare regime's top-down and bottom-up design.

2. Multidonor Trust Funds

Under SWAp, international donors must also coordinate their financial contributions to prevent the creation of parallel systems that SWAp seeks to avoid. One method that has already shown success in

169. Baird, supra note 163, at 24 (quoting OECD, supra note 163, at 3).
170. MINISTRY OF PUB. HEALTH, supra note 60, at 37.
171. See id.
172. See id.
173. Id. at 38.
174. See id.
175. Id.
176. Id. at 39.
Afghanistan is the use of Multidonor Trust Funds (MDTFs). MDTFs are appropriate for Yemen because they can be used "to coordinate budget support in countries where fiduciary risks are high, while also building the capacity of the state to manage and control its own budget." This funding approach requires donors to act more as investors in a venture capital fund, which requires them to be willing to take on "fiduciary, developmental and reputational risks." Accordingly, measures taken to further accountability and quality assurance will be crucial in fostering trust with international donors.

CONCLUSION

Global processes in Yemen's health system have thus far left behind the informal sector while allowing the private health sector to thrive. In order to protect Yemen's largely poor and rural citizens in the informal sector from excessive out-of-pocket health expenditures, globalization now necessitates a more comprehensive approach to health reform that involves cooperation among local, national, and global stakeholders. This cooperation requires both decentralizing decision-making to the community level and effecting accountability and quality assurance measures to rebuild trust in Yemen's national health system. The Welfare Regime Framework is both general enough to accommodate these global requirements and flexible enough to tailor adequate legal reforms for overcoming the various hurdles of Yemen's health system. Although Yemen faces many challenges in expanding access to its health system, passing legal reforms to implement CHI programs would represent an important step in fulfilling its constitutional promise of providing its citizens with access to health and can pave the way for future social policy reforms.

177. See Baird, supra note 163, at 27–28.
178. Id. at 28.
179. Id.