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Emerging Role of Cooperative Health Insurance in Achieving Health System Goals under Saudi Vision - 2030

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Abstract
Saudi Arabia's vision -2030 aims to bring fundamental changes in the health care financing and delivery system with a view to improve access to quality health care to its population. As a part of the national transformation program (NTP)-2020, the Ministry of Health (MOH) has proposed to increase private share of health spending through alternative financing and delivery mechanism, particularly through health insurance and partnering with the private sector. The cooperative health insurance (CHI) provides comprehensive health coverage to significant segment of workers in the private sector. This paper attempts to assess the prospective role of CHI in achieving the health system goals and examines the major challenges to be faced by the CHI while working with the private sector and suggests certain policy recommendations.
Keywords: Cooperative health insurance, Saudi Vision, National Transformation Program, health service delivery, financing

INTRODUCTION

Since the beginning of development plans in 1970, the Kingdom of Saudi Arabia has witnessed a steady progress in overall socio-economic and health indicators as reflected by its human development index (HDR). Saudi Arabia ranks 38 out of 188 countries with the HDR of 0.847 [1]. There has been significant decline in the infant mortality rate from 118 cases per 1000 live births in 1970 to 4.82 cases in 2016; the increase in life expectancy at birth increased from 53 years in 1970 to 74.8 years in 2016 [2]. The population of the country is estimated at 31.74 million in 2016, out of which 63.2 percent are Saudi nationals [3].

Saudi Arabia is one of the few countries in the world providing free health services to its citizens. The private sector is the major source of health care for non-Saudi citizens either paid by the employer or by the individual. [4] During the last decade, a huge investment in public health infrastructures including hospitals and primary health centers were built up and as a result the overall public spending on health care increased manifolds. [5] A series of reforms were also introduced by the government to improve health system delivery in the country. The establishments of the Council of Cooperative Health Insurance (CCHI) in 1999, Saudi Central Board for Health Accreditation Institutions (CBAHI) in 2005 and Saudi Health Council (SHC) in 2009 are the milestone that have brought out far-reaching changes in health financing and delivery.[6,7] However, with the decreasing oil prices in post 2014, there has been a considerable cost pressure on the government to deliver free health services to its citizens, particularly in view of growing population, high cost of medical technology and increasing demand for health services by the population.

In April 2016, Saudi Arabia unveiled "Vision 2030" an ambitious program of development with the primary goal of transforming its economy by 2030 [8]. In order to achieve this goal, the country announced an interim development plan called 'the National Transformation Program 2020' (NTP) that sets out strategic objectives for all key sectors of the economy including health [9]. Among other things, the vision 2030 envisaged a reduction in public spending through efficient use of resources and greater participation of private players in different spheres. It also emphasizes improving the performance of public establishments with the participation of private sector and visualizes increasing the private sector spending to 35 % by the year 2020 from the current level of 25% in 2016 [9]. The Ministry of Health (MOH) has identified a number of strategic objectives for the health sector. One of the objectives is to increase private share of health spending through alternative financing and delivery mechanism, particularly through health insurance and contracting to the private sector.

The objective of this paper is to provide an overview of cooperative health insurance in Saudi Arabia and assess its prospective role in achieving health system goals under Saudi Vision 2030. The inferences based on this paper will be a valuable step towards understanding of effectiveness of the CHI program as an alternate strategy of providing health care and relieving government resources on health care in Saudi Arabia.

COOPERATIVE HEALTH INSURANCE – AN OVERVIEW

The CHI Act of 1999 made the health insurance compulsory, to all non- Saudi workers in the private sector. Under the Act, the CCHI was set up to supervise and regulate the implementation of the CHI program. The council is chaired by the Minister of Health with representatives from other ministries including the private sector as its members [10]. The CCHI plays a crucial role in accreditation and empaneling of health care providers. The regulation and control of insurance companies is vest with Saudi Arabian Monetary Agency (SAMA).

The implementation of CHI was planned over three stages. [6] During the first stage the CHI was applied for

both non-Saudi and Saudi workers engaged in the private sector, and employers were mandated to contribute towards health insurance of their workers. In the second stage, it is proposed that program will cover both Saudi and non-Saudi workers in the public sector and government will pay the insurance premium for all employees. In the third stage, the CHI will be applied to pilgrims from all over the world. Currently, the target population in the program includes both Saudi and non-Saudi workers engaged in the private sector, including their dependents. In accordance with the policy, it is mandatory for employers to obtain a health insurance to their workers and dependents. Except for emergency cases and hospitalization, insured workers are required to pay the agreed upon deductible amount, as applicable.

The CHI provides a comprehensive benefit package to its clients. The policy covers all costs related to hospitalization including surgeries, medical consultation, diagnosis, treatment and medicines, day care surgeries, obstetrics and delivery, treatment of dental and gum diseases. It also covers preventive measures such as vaccinations including seasonal vaccinations and maternity and child care, acute psychological disorders and cases of contagious diseases requiring isolation in hospitals as specified by the MOH. The policy excludes certain conditions like self-inflicted injury, sicknesses from abuse of medicines, stimulants, or alcohol and narcotics use, cosmetic treatment, general checkups, medically recognized venereal or sexually transmitted diseases including HIV/AIDS, tooth implant, dentures, orthodontic treatment, vision or hearing correction or aids, hair loss, baldness or artificial hair, psychological, mental or nervous disorders, treatment of acne or any treatment relating to obesity or overweight, organ transplant, or implant of artificial organs, ancillary limps etc. Health insurance companies offer variety of health insurance packages that range from a basic plan to the elite plan, each with a corresponding cap on expenditure. [10] The insurance premium is mutually agreed upon by the insurance company and the employer in accordance with average rates approved by SAMA. The maximum cap on the policy is fixed at SAR 500, 000[10]. The employer are solely responsible for the payment of premiums at the beginning of every year.

The health services providers are considered as the backbone of any health insurance and no good design can succeed without cooperation from providers. The CHI program provides healthcare for the insured population through the network of health services providers accredited by the government. Accreditation requires that the facilities meet minimum quality requirements and committed in providing all health care services in accordance with generally accepted ethical and professional standards, licensing by the MOH, and the registration with the Saudi Commission for Health Specialties (SCHS).

With regard to quality of care, all health service providers are required to meet the procedures concerning the maintenance of good quality according to the decisions and instructions issued by the Central Council for Accreditation (CCA) of health facilities time to time. Health providers are required to submit a report every three years to the Council demonstrating their commitment to deliver quality health care, and in the event of nonfulfillment of these conditions, their accreditation status will be cancelled. Accreditation of insurance companies by SAMA is limited to a period of three years, but renewable for the same period. Renewal of accreditation can be denied in cases of reporting incompetent management, lack of necessary professionals and inability to protect the insured interest.

Ministry of Labor plays a proactive role in implementing the program. Labor offices under the ministry are entrusted with the task of supervision and control of offenders and reporting to the Ministry in case any company has not applied for health insurance for their workers.[11] Labor officer also follow up and monitor companies that are violating the rules. The defaulters are liable to pay all over dues, in addition to fines. The insured workers can report to the nearest labor office in case of grievances or complaints related to CHI services.

POTENTIAL OF CHI PROGRAM IN ACHIEVING SAUDI VISION 2030

It is widely recognized that health insurance as a promising means for achieving universal healthcare coverage in countries.[12] It can include both mandatory and voluntary schemes. Mandatory health insurance is also called as social health insurance (SHI) which is primarily based on contribution from the employer ad employees. Countries like India, Thailand, Philippines and Vietnam have established such program. On the other hand, voluntary health insurance program is a form of private health insurance that has been implemented in many countries. In few developing countries, state sponsored health insurance program have been implemented for the poor population or those working in the unorganized sector with a subsidy from the government. These programs are completely different from the tax-based system where the government delivers health care through its network of health facilities.

CHI is a form of social health insurance with contribution from the employers. With the implementation of CHI, coverage of health insurance in Saudi Arabia has witnessed a significant improvement over the last few years. There is steep raise in number of insured members from 4.80 million in 2008 to 12.07 million in 2016, of which non-Saudis accounts for about 9.39 million. Health insurance coverage among Saudi nationals has increased from 0.45 million in 2008 to 2.68 million in 2016.[13].There are 27 registered health insurance companies and 9 Third Party Administrators (TPA) in the program.[13,14] There has been tremendous growth in number of hospitals equipped with the latest techniques and services to match up with the growing needs of the insured population.

Recently, the government has also introduced a medical policy for the visitors and their dependents with maximum cap of Saudi Riyal100,000.[14] The insurance covers the cost of emergency cases, investigations, medicines, inpatient treatment, pregnancy/childbirth, dental/gum diseases, endodontics, nerve treatment, removal of abscess, premature childbirth cases, emergency dialysis, medical evacuation within and outside the Kingdom, injuries from traffic accidents, and expenses of deportation of the insured deceased visitor's body to his or her country.

The effectiveness of CHI program can be assessed in terms of reduction in out-of-pocket payments by the families. Data from the World Health Organization (WHO) reveals that out-of-pocket expenditures of the families have declined sharply and health insurance expenditure as a percentage of private expenditure on health has increased. WHO data shows that out-of-pocket expenditure as percentage of private expenditure on health reduced to 57.3% in 2010 from 66.7% in 2000.[15] Private prepaid plan as percentage of private expenditure on health care increased from 10.4% in 2000 to 23.6 in 2012 [15].

INCREASING ROLE OF THE PRIVATE SECTOR IN ACHIEVING UNIVERSAL HEALTH CARE

The role of governments in the delivery of public goods and services has been debated long back. The major debate was related to the efficiency, quality and economy and the ways in which these goods and services provided to the population.[16] During 1945-1980, the United Kingdom was considered as the welfare state where government was expected to meet all the needs of citizens by providing at least the minimum standards of living to all. However due to disappointment with the model, many changes were brought from 1970s.[17] In China, the government managed and financed health services during 1940s-1980s and over a period of time there were problems of overutilization, abuse of free medical care, and increased cost of care which triggered substantial pressure on the government finance. In 1978, China introduced health reforms through introduction of market competition [18].

During the last two decades health financing and delivery systems in many countries led to significant changes. Most countries initiated health sector reforms that resulted in major institutional changes leading to decentralization of health services, autonomy for public health institutions, partnership with the profit-for-profit and non-profit private sectors, and diversifying of health financing options. These reforms resulted in larger separation of health services delivery and financing functions.[19]The government's role is limited to regulation, oversee quality standards, and stewardship and oversight functions.[20]In few countries increasing pressure of governments to improve health services quality led to a trend towards contracting the private sector to deliver services in public health facilities. Contracting was perceived as an opportunity to combine the benefits of economy with the efficiency of the private sector.[21]Critics argue that partnership with the private sector is mainly concerned with reducing cost and economy rather than effective delivery of services.[16] Contrary to this, there are concern about accountability role of the private sector's in protecting the interest of patients and health system. The 2016 Lancet series have brought out the issues of private sector provision which largely involved inadequate access to health care for the poor, inadequate regulation, risk of maximizing profit and reliance on trained health work force from the government facilities. This one of the major challenges of partnering with the private sector is how to achieve equity and quality in the health systems.

PRIVATE HEALTH SECTOR AND HEALTH INSURANCE – EXPERIENCES OF COUNTRIES

The role of private sector in health insurance ranges from health services provision to management and financing. However, in majority of countries, the role is restricted to delivery of health services. In Vietnam, health insurance program was reformed in 2005 to improve private sector participation to achieve universal coverage by 2020.[22] Gradually, the program resulted in increased utilization of both outpatient and inpatient services and succeeded in reducing out-of-pocket expenditure among the insured population.[23] Based on the success of the program, in 2014 Vietnam made the program compulsory for all individuals by categorizing their membership into different groups with government subsidy.[23]

National Health Insurance Scheme (NHIS) established in Ghana in 2003 provides health services to the poor at all levels of the health system through both public and private sectors. Studies have established increased utilization of health services and improved access to services by the insured population.[24]The government envisaged to increase the share of private health care provision in total provision from 35% to 65% by 2017. [25] In Netherlands all primary and curative care are financed from private health insurance, whereas long term care for the old age is covered by social insurance. The Netherland health system has strong private involvement and stringent regulations. However, in this system market forces play an increasingly important role, and policy makers are facing new challenges regarding quality, costs and access. [26] Insurance companies mainly compete on the price of health insurance policies and the cost of health care services and not on the quality of care. One of the fundamental problems is that quality of care lacks transparency but easy access to health services is an important achievement. [26]

In Colombia, the private health sector plays a wide role including management as well as service delivery. The governments at local level contracts not-for-profit insurance companies.[27] Insurers can avail medical services

from both public and private providers based on their ability to offer the government-defined health package at the lowest costs. There are also voluntary health insurance schemes which offer additional coverage to the basic benefits plan. These plans are completely funded from private spending. [27]

In Philippines, the National Health Insurance Programme (NHIP) and PhilHealth, the corporation that managed the Social Health Insurance programme was established in 1995. Due to resource crunch, the government encouraged competition in provision of health services and insurance was encouraged through social or private insurance for clinical services. As a move towards universal healthcare coverage, the Act of 2013, made the health insurance mandatory for all Filipinos including those engaged in the unorganized sector. [28,29] In South Africa, the private health providers are efficiently and effectively used to treat public sector patients to target key populations, address specific health concerns, and serve as a stop-gap measure to meet urgent health needs of the population.[30,31]

EMERGING CHALLENGES FOR COOPERATIVE HEALTH INSURANCE

Health insurance as an alternate strategy in providing health care and relieving public resources on health care may face a number of challenges. One of the challenges is the rising cost of medical care as spending on medical care is likely to rise manifold times due to strong incentive to demand and consume health care, in excess of what is medically considered an optimum. Manifestation of asymmetric information between principal and agent provides opportunity for the patients, the providers and the insurers to maximize individual gain in the health care market. While the patients have the incentive to demand excess medical care, the physicians, on the other hand, have more advantage over the patients due to the nature of health care market.[32] Asymmetric information plays a detrimental effect in health care, particularly when there is risk pooling through insurance mechanism. Under the scenario of health insurance, patients, insurers and providers have a unique position of their own to influence outcomes. Physicians have a unique role in overstating claims and therefore disproportionately benefit from such outcomes, as they enjoy the ability to influence medical treatment.[33]

Global experiences of countries which have implemented health insurance reflect the fact that there are large number of violations and fraudulent claims predominant in the systems. It is not so easy to detect fraud and manage it as monitoring insurance claims of hospitals on continuous basis is an expensive affair that in turn adds to the overall cost of insurance premiums. Most health insurance schemes whether offered by the government or private insurers suffer from high claim ratios and over utilization.[33] The hospitals tend to benefit the most from fraud claims and supplier induced demand. Like other health insurance program, CHI in Saudi Arabia may also tend to face these problems. Despite the presence effective regulations in the country, there are possibilities of unfair practices and manipulations of transactions and procedures. Reports of CCHI indicate several mal-practices in the implementation of the program. It was reported that six health insurance companies were suspended from issuing health insurance policy for violating the rules. There has been increasing number of complaints against the health service providers, insurance companies and the employers.[14] Furthermore, with an increase in number of insured workers, and their awareness on CHI, the complaints against insurance companies, service providers and employers are expected to rise in future.

During the first phase of the program, companies with 500 or more workers were covered, while the second phase applied to companies with more than 100 workers. During the process, there could be a challenge to cover non-Saudi workers engaged in the unorganized sector and in small or own-account enterprises.[34] Another challenge is to extend the provision of health insurance to all Saudi employees in the private sector. The number of Saudis and their families who work in the private sector is about 5.5 million, while the number insured till 2016 is about 2.67 million and in this way, it is long way to cover the entire population in the country. [13] It is expected that number of Saudi nationals in the private sector will increase manifolds by 2030.

IMPROVING EQUITY IN ACCESS AND QUALITY OF HEALTH CARE

Equity in health care has become a major challenge for most health care systems in the world. The economists talk about horizontal equity which deals with an equal treatment for equal need.[35,36] This means that those who are in equal need of health care should be given the same treatment, irrespective of their economic status. The experiences from countries have shown that a well-designed social health insurance system may provide an equitable redistribution of health care between the rich and the poor.[37] Equity has different dimensions, such as equity in access, financing, and health outcomes.

Equity in access refers to the ease in which patients are able to effectively receive health care services. Accessibility of health care can vary from location to location in Saudi Arabia due to the existence of vast rural areas.[38] Equal access to health care to all population including those living in far flung rural areas is a challenge. There is existence of uneven distribution health professionals across geographical areas, malpractices of health care services and, the shortage of services for disadvantaged groups such as the elderly, adolescents and people with special needs such as disability, especially those living near border of the country. Therefore more number

of both public and private health facilities are required in remote areas to avoid imbalance in access to health services. This will guarantee equitable access to healthcare for all citizens and eligible workers. However, there is a need for caution while considering health insurance as major means of achieving equity in access to health care of the poor population. For instance, a study in Georgia by Carrin et al (2005) showed that many policies that were aimed to improve equity would lead to reduction in quality of health services. [39]

Perceptions of quality have been increasingly emphasized as measures of health care quality and these are associated with health outcomes.[40,41] Quality has two main dimensions. One is the quality of services as measured by patient's satisfaction. The other dimension is the technical quality involving provider's competence and application of standard treatment protocols. [42] A considerable body of literature has documented the factors contributing quality perceptions by the insured patients. These studies have shown that patient's perception on quality of care is a multi-dimensional and insurance status may or may not influence their perception on quality.[43-45] On the contrary, as the payers of health care, insurance companies are uniquely placed to influence quality of care they purchase from various providers. It is also likely that improvement in access may not frequently result in improvement in quality. A number of approaches are suggested to improve quality of health care according to a country's context and requirements. However, most important of them include accreditation of health facilities by the internal review or external bodies, mandatory application of standard treatment guidelines to practice evidence based medicine, and consolidation of information on standard treatment guidelines by health care providers. In few countries, community participation plays a key role in making health providers more responsive to the expectations of the people. In Saudi Arabia, there are constraints like variation in health access and health outcomes in different regions.[46] Over-prescription by doctors in health facilities, and poor quality of care provided for certain conditions like hypertension, excessive use of antibiotics etc., are recorded. Though private sector provides a significant share of health care, limited information is available on quality of care in this sector.

Nevertheless, the government's commitments to quality of health care are fully reflected in various policy documents and its concerted efforts to improve health care quality through training of health professionals, mandatory accreditation of health facilities, and development of referral systems and application of evidence based medicine. The CCHI plays a key role in spreading awareness among the insured population through electronic and print media. As a part of social responsibility, the hospitals in the network can play greater role in spreading health awareness in the community. The hospitals are informed to organize awareness campaigns that are designed to provide the members of community with information on health risks, preventions, health promotion and healthy living.[11] The CCHI also proposed to introduce Saudi Health Insurance Bus (SHIB) project using State-of-the-art methods and technology to increase the quality of service for all stakeholders. [14]This will not only benefit in quicker approval of medical claims, but also in improving services provided by the health providers and insurance companies.

FUTURE DIRECTIONS

Like other developing countries, the proposed shift in the health care financing and delivery mechanism in Saudi Arabia may face certain challenges, particularly with increasing role of private health sector. Experiences from the both developed and developing countries show that health insurance can be a solution to deliver efficient and effective health care to the population through private sector participation. However, the country needs to chalk out its health sector plan carefully directed towards achieving intended objectives.

Firstly, with regard to CHI program, on the one hand there is a compulsion on improving equity in access and quality of care; on the other hand, health insurance companies often resort to immoral tactics like denying coverage of individuals with preexisting conditions, increasing copayments, and deductibles, and mandatory preauthorization of costly investigations and procedures. The country can learn from the experiences of many countries which have successfully implemented health insurance with the participation of private players. It also calls for robust regulatory mechanisms and strong implementation of regulatory authority by the CCHI.

Secondly, there is inadequate health care workforce to tackle the growing needs of health services in the country. At present only one in three health care work force is Saudi national and enough number of professionally qualified persons are not in place to replace the retired professionals or those leaving the job. As far as health insurance specialty is concerned, there has been inadequate number of qualified Saudi personnel in health insurance specialization.[11,34] Currently, Saudi employees represent only a small share of the total workforce in insurance business.[34] There is need for specialized manpower to work in this sector. Moreover, the medical professionals need expertise in several areas, such as in cryptography, medical and public underwriting, claims reviewing, marketing of insurance documents, documentation and the detection of frauds.[34] Therefore while restructuring the health financing and delivery system, it is also important to examine the context of demand and supply of health work force in the country. The NTP-2020 has prioritized planning, production and development of health work force as one of the goals of the health sector. In order to meet the future requirements of health work force, the country needs a huge investment in medical, nursing, paramedical and other public health education.

Thirdly, a majority of Saudi nationals are working in the government sector; in contrast non-Saudi national

constitutes a major share of employees in the private sector. Increasing role to private sector may create a competitive situation in which public sector has to compete with the private sector. It is likely that many of the new employment to be created in the private sector may not be attractive to Saudi citizen due to lower salary in comparison to government sector.

Fourthly, in the long run aging population will become a major concern to health financing in Saudi Arabia. The proportion of population in the country aged 60 years and above is expected to reach 25 percent of the total population of 40 million by the end of 2050. The number of people aged 80 years and above is also expected to reach 1.6 million, or 4 percent of the total population.[47] As a result, health care spending tend to increase manifold times in future. This will also have an adverse effect on health insurance market in the country.

Fifthly, the strategic healthcare plan of the MOH needs to be directed towards achieving the objectives of the vision 2030. It should clearly spell out how the private sector can be engaged to ensure equitable access to good quality health care to all population both Saudi and non-Saudi nationals engaged in public and private sectors through insurance, including those living in far off and rural areas. It requires a vertical and horizontal coordination between the government and the private sectors with respect to infrastructure development, health services delivery, and effective implementation of regulations.

Sixthly, there are many possible ways to improve equity in access and quality of health care under health insurance where private sector is the dominant provider. In order to improve quality and particularly health outcomes by the private sector, strategies like selective contracting, pay for performance and result based financing can be introduced. By institutionalizing health expenditures tracking and regular health surveys, MOH can assess the contribution of cooperative health insurance in achieving its intended goals.

Finally, health insurance has become mandatory for all workers engaged in the private sector. With the strengthening of private sector and it is likely that a huge share of Saudi nationals working in the public sector will also be covered under health insurance in the future. The insurance companies may develop new products keeping in view future requirements of the population. All these developments in turn encourage the growth of the insurance sector and creation of job opportunities. Growth of insurance sector in the country will also foster competition between public and private sectors in delivering quality health services to the population. It may also reduce dependence on other countries for medical treatment and depletion of MOH budget.

CONCLUSION

Health insurance in Saudi Arabia has witnessed an unprecedented growth during the last decade. Saudi Vision-2030 acknowledges the significance of health insurance in economic growth as well as in reducing public spending on health care. The NTP-2020 aims to increase private share of health spending through alternative financing and delivery mechanism, particularly through health insurance and public private partnership. The major challenge for the government is to guarantee access to efficient and quality healthcare to all residents whilst financing healthcare through privatization and PPP. At the same time, it is imperative to meet the expectations of Saudi Vision 2030, for which CCHI and SAMA should play a proactive role in controlling and regulating the insurance companies. Nevertheless, it is expected that the CHI would contribute to the development of health service delivery and reducing the burden of government in meeting health services requirements of significant share of population in the long run.

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