

Prospects and challenges for free-of-charge health care system: A way forward to health insurance in Saudi Arabia

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ABSTRACT


This article discusses the evolution and development of the effective health care system and the government strategy in reducing its financial burden that are associated with the health care through privatising the public health services and demonstrating the importance of the social health insurance (SHI) cooperative scheme in Saudi Arabia. In recent past, Saudi Arabia's health care services have been regarded well internationally, as reflected in by high average life expectancy and low rate of infant mortality. The literature suggests that the Saudi health care system has become competitive in the international health care systems such as those available in Canada, Australia, New Zealand as well as United Arab Emirates, Qatar, and Kuwait in the Middle East. Three levels of health care services-primary, secondary and tertiary-greatly contributed for the advancement of Saudi Arabia's health sector. However this paper argues that the Saudi Government will confront major challenges in the funding and delivery of health care as the current pattern of the health funding system has stretched by an ageing population, growing number of labour immigrants, the growing burden of chronic illness, and the ineffective health services. It contends that the inequalities in health services that exist between urban and remote regions' citizens persist; therefore, it points to the need for reforming Saudi health care system. This paper also discusses that the private sector is playing effective role in assisting the government to reduce its medical expenditure. Despite these improvements, extending equity health services is a serious challenge for the government. This paper further suggests that this challenge can be mitigated through an effective and efficient operation of SHI services in all geographical regions encompassing rural friendly healthcare services and easy and affordable access to health services delivered by the public and the private sector.

KEY WORDS: Health Care; Saudi Arabia; Privatisation; Social Health Insurance; Cooperative Health Insurance; Economic Burden; Equity

INTRODUCTION: OVERVIEW OF HEALTHCARE SYSTEM IN SAUDI ARABIA

Saudi Arabia shows dramatic growth in their health systems to outreach large geographical areas and all

segments of the people in a short period of time.^[1,2] Establishment of a health department began the new era of healthcare services in Saudi Arabia in 1953.^[3] This department was mandated for financing and supervising free-of-charge health care services through a number of hospitals and dispensaries for the population and pilgrims. The oil economy proved to be the blessing to the country to advance modern and organised healthcare services to its citizen. Provision of quality health care services, proclaimed under the supervision, regulation and guidance of the Health Department, which later became the general directorate of health and aid, attached to the Bureau of the Attorney General, aimed to raise the standards of the

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healthcare services and control diseases in the country through providing curative health services.^[3]

However, the national income was not adequate to achieve a major advancement in the health care system. Albejaidi claimed that though the establishment of the health department in Saudi Arabia was considered as the milestone in providing curative health services, the modernisation effort was confronted with the deeply rooted traditional health practices and medicines that continued to lure people who had faith in the indigenous and traditional systems.^[4] As a result, a majority of people continued to depend on traditional medicine and the incidence of epidemic diseases remained high among the population and pilgrims.^[5]

Founding of the Ministry of Health in 1954 was supposed to take off the transformation of Saudi Arabia's healthcare sector,^[6] but it took two decades to make a change in the health policy. The First Five Years National Development Plan 1970-1975 to the Ninth Five Year Plan were able to improve all government sectors including health care services focusing on the improvement of the infrastructure for the effective implementation of healthcare services. This was augmented through importing expatriates from all over the world, as well as investing a huge amount of budget to train local health professionals.

In the pursuit of welfare state economy, the Saudi government implemented universal health care services to its people with the "health-for-all" policy remaining a top priority in the Kingdom.^[7] Furthermore, with the establishment of the Ministry of Health, a decentralised healthcare system began to offer preventative, curative and rehabilitative healthcare services to everyone.^[8] Other autonomous government bodies and hospitals active for providing health care services are: King Faisal Specialist Hospital and Research Centre; Security Forces Medical Services; Army Forces Medical Services; National Guard Health Affairs; Ministry of Higher Education Hospitals (168 teaching hospitals); ARAMCO (formerly Arabian-American Oil Company) Hospitals; Royal Commission for Jubail and Yanbu Health Services; School Health Units of the Ministry of Education and the Red Crescent Society. Most of the service holders of Red Crescent Society and the teaching hospitals are usually limited to their employees and their dependants.^[9]

The General Organization for Social Insurance and the General Presidency of Youth Welfare also operate medical services to special sections of the population. While contributions of these institutions are indispensable for the country's health system, today Saudi Arabia's health system operates under a typical mix model of state-funded welfare economy model with a gradual increment in the involvement of the private sector.

NEW INSTITUTIONALISM THEORY AND SAUDI ARABIA'S HEALTH SECTOR

Social institutions, whether public or private, are central to the way a government delivers services to the people. Positioning institutions, their networks and function is a key to analysing performance of a system, the new institutionalism theory provides an explanation of how institutions within a system interact and, in return, how they affect society and people at large.^[10] Nature, function and behaviours of institutions and the way they produce outputs and outcomes are, therefore, a key to understanding the behaviour and characteristics of a system.^[11,12]

One of the features of Saudi's development planning experience relied on the principles of the market economy, along with encouraging the private sector to play an effective role in the process of socio-economic development.^[5] The gradual shift from state-centric welfare economy to the open market-led economy demonstrates an unfolding feature of New Institutionalism in Saudi Arabia. According to Scot,^[12] New Institutionalism also creates a friction between peer institutions, as many institutions competing for their identity and legitimacy. This proposition provides an important vantage point to analyse what kind of institutional arrangements exists, what limitation have occurred and what outcomes are experienced in Saudi's health system environment.

Using this lens, the next section discusses an emergent actor - the private sector in Saudi's health system. This will be followed by an analysis of gaps in the health network system. Then the paper discusses social health insurance (SHI) system, which is a situational need deemed necessary to reduce health-related burden on the part of the government. Finally, it analyses accessing health care services and diversification of investment. The analysis will then be revisited to draw a reflection in the health system, which may serve as recommendations of this paper.

INVOLVEMENT OF PRIVATE HEALTHCARE SECTOR

Along the public sector, the private sector-run hospitals, clinics, dispensaries, physiotherapy centres, and health care facilities are only prominent in urban areas in spite of the government's open door policy for international and national investments. However, transitioning from a state welfare economy to market-led economic model particularly in the health sector has gained a momentum only recently. Recently, there are 56 market-centred private hospitals, which occupy only 21.1% of the total beds (53,888 beds) (MoH, 2013). Additionally, they produce drugs and medical supplies as well as the supply of medical equipment, and operate a number of government health facilities.^[13]

The rapid rate of demographic changes in the country has opened up a huge space for the private sector to join hands with the government to work in rural areas as well as with disadvantaged people. It is predicted that Saudi Arabia will have 36 million people by 2020, which will require a massive scale of sophisticated health care system. This predicted scenario implies that the government alone will be hardly able to manage the public health system and service delivery; therefore, the private sector's contribution to health care industry will be inevitable.^[13,14]

However, it is important to note here that the private sector in Saudi Arabia is itself in the initial stage with the private sector expenditures in healthcare accounting for 25% of the total expenditures of the healthcare sector.^[5] Barrage, Perillieux and Shediach state that the common opportunities in the sector are: Medical device manufacturing, generic pharmaceuticals and education.^[15] What is, however, not discussed sufficiently in the literature is the private sector's potential role in health insurance.

GAPS IN THE HEALTH SERVICES NETWORKS

Health insurance distributes the financial risk associated with the variation of individuals' health care expenditures by pooling costs over time through pre-payment and over people by risk pooling.^[16] The objectives of SHI is to either prevent or drastically minimise a large out-of-pocket expenditure; offering universal healthcare coverage; increasing appropriate utilisation of health services; and improving health status.^[17] SHI can improve welfare through better health status and maintenance of non-health consumption goods by smoothing health expenditure over time and by preventing a decline in the household labour supply.^[18] SHI programmes is a means of moving towards universal health care coverage in some countries. If universal healthcare coverage is to be financed through insurance, the risk pool needs the following characteristics: (i) Compulsory contributions to the risk pool (otherwise the rich and healthy will opt out); (ii) the risk pool has to have large numbers of people, as pools with a small number cannot spread risk sufficiently and are too small to handle large health costs; and (iii) where there is large number of poor, pooled funds will generally be subsidised from government revenue.^[19]

The research conducted by Ellis et al.,^[20] in five developed countries shows that Japan and USA adopted employer-sponsored insurance schemes; Canada adopted a single payer system; Germany adopted the universal multi-payer system, and Singapore subsidised a self-insurance scheme. This means that the government is the primary sponsor in Canada, Germany, and individual self-sponsor in Singapore. The four countries covered by the study made insurance mandatory against the USA, there is a choice. Insurance systems in these five countries witnessed much of the diversity exhibited

by health insurance systems. These countries include both the most expensive system (US) and the least expensive (Singapore), single payer along with multiple insurers, government sponsored and employer-sponsored insurance.^[21]

The World Health Organization (WHO) considers health insurance a promising means for achieving universal health-care coverage, which can come in various forms. National or SHI is based on individuals' mandatory enrolment. Several countries, including Thailand, the Philippines and Viet Nam are establishing SHI.^[22] Voluntary insurance mechanisms include private health insurance, which is implemented in countries like Brazil, Chile, Namibia and South Africa, and community-based health insurance, now available in the Democratic Republic of the Congo, Ghana, Rwanda and Senegal.^[19,23]

These low and mid-level income countries have experienced some forms of extension of state-sponsored insurance programmes to its citizen focusing mainly in the informal sector in order to enhance access to healthcare and provide financial protection against to the burden of illness. SHI is mandated for those who are employed in many developed countries where employment and wage rates are high while this service is extended to those unemployed through a state subsidy.^[22] The SHI differs from a tax-based system where the Ministry of Health finances its own network of facilities and are paid through a mixture of budgets and salaries.^[24] This kind of tax-based insurance system currently does not apply in Saudi Arabia.

Let us now turn to the context in Saudi Arabia. Funding health care services is a central challenge faced by the Saudi Ministry of Health. The free medical service system lead to a huge cost pressure on the government, the rapid growth of new diseases, technologies.^[24] As a consequence, to ensure the high quality of equity health services, the Council of Cooperative Health Insurance was established in 1999 with the mandate of introducing health insurance, regulating and monitoring. The scheme was designed to launch in three stages: (i) For the private sector's non-Saudis and Saudis employees and their dependents where insurers have to pay for health cover costs; (ii) for government sector that applies for Saudis and non-Saudis for its employees and their families for which the government pays the insurance premium and (iii) the third stage pilgrims.^[25]

Later on, the employer-sponsored health insurance was initiated in Saudi Arabia after the introduction of Cooperative Council Act 2005, which is in the process of the diversifying economic burden for the government.^[26] The government is expected to apply the second phase insurance scheme for employees in the government sector and the third phase of the scheme for pilgrims before privatising the state-owned health care facilities and services. Around 8.1 million non-Saudi employees and expatriates are associated with this scheme.

However, accurate recording of the working population is a challenge in itself for the cooperative. Social Services includes 145,4000 employees of the private sector and 9.1 million workers of the public sector^[27] the increment in the size of employees is 395 times higher today than in 1973.^[28]

The cooperative health insurance movement originated with one company in 2004 has now increased to 35 companies. However, this scheme is criticised for not addressing the equity aspects of the services because of their locations mostly in the market centres; lack of a comprehensive, fair, equitable and affordable services to suit all segments of the population, and failing to capture the spirit of Islamic concept of Takaful (Islamic Cooperative Insurance) in health insurance services.^[25] Takaful applies the principles of mutuality and cooperation.^[29] Furthermore, the emerging concept of consumer-driven health plans offering a high-deductible insurance plan and a tax-rated health spending account were completely ignored in the cooperative health insurance system.

Overall, it is true that the health insurance system is critically important to lessen the government’s burden on health expenditure. This system is also essential to ease the transition from state-led health welfare system to a market-is driven health system that Saudi Arabia has already considered to adopt. This will however, require a strong and competent private sector, a comprehensive policy, plans and strategy to engage public and private actors in health insurance. This will eventually increase access to health services by all as well as diversification of investment in the health sector as discussed hereunder.

ACCESS TO HEALTHCARE SERVICES

Health inequity is not only detrimental to the most vulnerable but can be seen across the social gradient. This is a multidimensional issue that is related to the income, geographical locations, education and gender.^[30] It means that health equity is examined not only between economically rich and poor but also between rural and urban residents and highly education and less education and women and men. Similarly, Intelligence Unit of the Economist asserts policymakers in Saudi Arabia recognise that better access to healthcare is critical to ensure the wellbeing of the kingdom’s people and to safeguard its economic stability.^[7] The report further states that the government’s free-for-health services have not reached to the needy people and the current size of private sector hospitals and their market-cantered approach are inadequate to outreach their services to the rural and disadvantaged society. WHO statistics reveal that there is a malpractices of health care services and uneven distribution health professionals across geographical areas, long waiting list for many health care services and facilities and the shortage of services for disadvantaged groups such as the elderly, adolescents and people with special needs such as disability, especially those 17% of the people living in border

and remote areas.^[31] Optimising the accessibility of health care services requires adequate, quality and timely distribution of health care facilities and professionals throughout the nation in remote regions, border areas.

DIVERSIFICATION OF INVESTMENT ON HEALTH SECTOR

Health insurance is not subject to government income taxation in Saudi Arabia compared to developed countries like Canada, Germany and Singapore. The major source of insurance comes from individual income tax on the model of SHI. Experiences from developing countries and developed countries manifest that the health insurance can be worked out effectively and efficiently in the open market through privatisation of health insurance schemes which can act the theories of address adverse risk and risk pooling in their offerings.^[32] Following the world health insurance market, the government of Saudi Arabia introduced Cooperative Health Insurance Council to regulate SHI schemes so that the government can reduce its financial responsibilities. It could be early to debate about the lessening financial burden to the government due to the introduction of cooperative health insurance in 2004. However, there are some clear indications to argue that the government is moving in a right direction. For example, over the period of a decade, between 2002 and 2012, the percentage of total expenditure of gross domestic product reduced to 3.8 from 4.2; the percentage of government expenditure on health of total government expenditure to 7.7 from 8.6 and per capita government expenditure on health reduced by per cent 534, as shown in Table 1.

Employer-sponsored health insurance proved to be the better way to shifting economic burden of the government in the United State of America and other countries. If this case happens to Saudi Arabia workforce that consists of 40% non-Saudis, immigrants from more than 24 countries either working in the private sector or the government, the economic pressure to the government, will dramatically reduce.

HEALTH POLICIES AND STRATEGIES: A CRITICAL ANALYSIS

In addressing the challenges of the current health services, a new strategy was introduced to improve the quality of health

Table 1: Health expenditure^[31]

Indicators	Total expenditure on health as percentage of gross domestic product	General government expenditure on health as percentage of total government expenditure	Per capita government expenditure on health (\$)
2000	4.2	8.6	1432
2012	3.8	7.7	898

care services; the MoH has set a national strategy for health care services with the approval of the Council of Ministers in 2009. A 20-year timeframe health strategy identified strategies to address the several issues, which can be classified into three areas: (i) Diversifying funding sources, (ii) developing information systems, and (iii) encouraging private sector involvement also to improve equal access and quality of preventive, curative and rehabilitative care to all regions, remote regions and border area. The strategy focuses on developing the human workforce so to sustain its health sector goals and reduce its dependency on non-Saudis.^[31]

The government's universal health and free access to health services policy have contributed significantly to improving the quality of life by reducing the incidence of disease and enabling people to live longer and healthier lives.^[1] However, there are several issues as stated in its new strategy plan that is affected by an effective implementation of commitments at all levels. For example, many hospitals require collaborative research with specialised hospitals while the utilisation of modern infrastructure and technologies are other challenges. The result of rapid population growth; growing lack of health awareness; emerging new health issues and rapid changes in the lifestyles, the increase in the number of dependent population and work-relate health problems associated with industrialisation and modern agriculture have further consolidated the challenges to the Saudi health system.^[33] While the execution of the concept of decentralised spending policy can be seen critically, in Saudi Arabia the decentralised fund is foreseen to improve preventive care, regionally balanced development in health care with allocation and distribution of resources on actual requirement but they remained only in the document.

A REFLECTION ON IMPROVING THE HEALTH SYSTEM

The critical discussion on the existing health care system, its historical background, healthcare networks and the health insurance along with the strengths and weakness of the current health policies, development plans and long-term health strategies draws the attention of policy makers and the actors engaged in the health industry in various issues. This discusses, in turn, offers few important considerations that might be useful as recommendations for a national health policy in Saudi Arabia.

That increasing demand on healthcare is retaining a financial pressure on Saudi Arabia. Annual population growth of 2.7% and the incidence of chronic diseases for example diabetes, heart disease and kidney transplant, the need for quality and timely healthcare is escalating. This is the reason why the government is facing a challenge on the improvement of the existing healthcare infrastructure and this has a direct impact on finances.

Therefore, it can be argued that the strategic healthcare plan needs a pragmatic reform. The country's health related strategic plan should ensure equitable access for health services to the people of remote regions and border areas based on the first-hand research in a sustainable fashion. Continuous investment in research, innovation and development is to be given an utmost priority. This is where the role of the private sector can be foreseen. At the same time, as is discussed above, a potential challenge in this regard is vertical and horizontal coordination between and within government agencies as well as between the public and private sectors. Hence the coherence between the health care service providers and health insurance providers needs strengthening, ensuring an effective implementation of the regulations, health services delivery system, financial subsidy, infrastructure and research.

Growing demand for quality health services at rural areas and gradual entry of the private sector in the health sector further points to the need for constant monitoring and evaluation of financial expenditure.^[34] This would further require to track and diversify health care budget in order to increase access to quality health care equitably. This will, however, necessitate to better understanding of what kind of health insurance model would be appropriate to Saudi Arabia. The proposition put forward by this paper is that health insurance system is indispensable to meet growing health demand in the country. However, what kind of health insurance model is appropriate can only be established with further research. Investing in health research could, therefore, be an additional step towards mitigating the challenges of health care system in Saudi Arabia today. One possible way, as proposed by this paper, is that given the important role of private sector in the health care system, the viability of employer-sponsored health insurance policy could be further investigated and adopted in a best possible way as per the needs of Saudi Arabia.

What is, however, equally important is that these observations with regard to improving the health policy need to be coupled with a simultaneous change in good health governance system. It is acknowledged here that this paper was far from engaging in a comprehensive discussion of health governance in the health system. Perhaps this topic will merit a separate discussion. However, the point that should not be missed out here is that improving health service delivery and practices in Saudi Arabia cannot be envisioned at the cost of a lack of transparency, reliability and accuracy of health information at all levels of administration and management.

CONCLUSIONS

The continued attention of the government to support Saudi health services has advanced over recent years at all three levels of health services: Primary, secondary and tertiary. As a consequence, the health of the Saudi population has

improved markedly. The MoH has introduced many reforms to health services, with substantial emphasis on universal health care at primary level. Despite these achievements, health services, and in particular the public sector health services are confronted with a variety of challenges. In order to address these challenges and continue to improve the status of the Saudi health care system, the MoH and other related actors should coordinate their efforts to implement and ensure the success of the new health care strategy focusing more on health insurance to ensure equity and efficacy in the health industry.

This paper has particularly highlighted the potential roles that the private sector can play in improving access to health care and also diversifying the investment. An area where investment can be diversified and government's burden on quality health service can be reduced is financing health insurance system. A brief review of further continuous research, development and innovation yield the better results in the health insurance, which is ultimately leading to quality and cost-effective healthcare services. This strategy further releases the substantial financial pressure of the government into health sector in the long run.

REFERENCES

1. United Nations Development Programme. Human Development Report 2013. New York: UNDP; 2013. Available from: <http://www.hdr.undp.org/het/en/reports/global/hdr2013/download>. [Last cited on 2016 June 09].
2. Gallagher EB. Modernization and health reform in Saudi Arabia. In: Twaddle AC, editor. Health Care Reform Around the World. London: Auburn House; 2002. p. 181-97.
3. Mufti MH. Health Care Development Strategy in Kingdom of Saudi Arabia. New York: Springer; 2000.
4. Albejaidi FM. Healthcare system in Saudi Arabia: An analysis of structure, total quality management and future challenges. *J Altern Perspect Soc Sci*. 2010;2(2):794-818.
5. Nadia Y. Private and public healthcare in Saudi Arabia: Future challenges. *Int J Bus Econ Dev*. 2014;2(1):114-8.
6. Al-Mazrou Y, Khoja T, Rao M. Health Services in Saudi Arabia: Health Care World Wide. Proceedings of Annual Conference of the Royal College Physicians. Vol. 25. Edinburg; 1995. p. 263-6.
7. The Economist. Health care in Saudi Arabia increasing capacity, improving quality? The Economist. Dubai: Economist Intelligence Unit Ltd.; 2014.
8. Sebai ZA, Milaat WA, Al-Zulaibani AA. Health care services in Saudi Arabia: Past, present and future. *J Family Community Med*. 2001;8(3):19-23.
9. Al-Yousuf M, Akerele TM, Al-Mazrou YY. Organization of the Saudi health system. *East Mediterr Health J*. 2002;8(4-5):645-53.
10. Jepperson RL. Institutions, institutional effects, and institutionalism. In: DiMaggio PW, editor. *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press; 1991. p. 143-63.
11. DiMaggio PJ, Powell WW. The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *Am Sociol Rev*. 1983;48(2):147-60.
12. Scott RW. *Institutions and Organizations*. 2nd ed. Thousand Oaks: Sage Publications; 2001.
13. Ministry of Health. Saudi Arabia Ministry of Health Statistical Yearbook. Riyadh: Ministry of Health; 2013.
14. Sherman & Sterling LLP. Healthcare in the Kingdom of Saudi Arabia-An Overview; 2016. Available from: <http://www.shearman.com/~/media/Files/NewsInsights/Publications/2016/09/Saudi-Arabia-Publications/Healthcare-in-the-Kingdom-of-Saudi-Arabia--An-Overview.pdf>. [Last accessed on 2016 Apr 23].
15. Barrage G, Perillieux R, Shediak R. Investing in the Saudi Arabian Healthcare Sector; 2007. Available from: http://www.booz.com/media/file/Investing_in_the_Saudi_Arabian_Healthcare_Sector_FINA_L.pdf. [Last accessed on 2016 Apr 23].
16. Underhill K. Paying for prevention: Challenges to health insurance coverage for biomedical HIV prevention in the United States. *Am J Law Med*. 2012;38(4):607-66.
17. Jacobs R, Goddard M. Social health insurance systems in European countries. *The Role of the Insurer in the Health Care System: A Comparative Study of Four European Countries*. York, UK: Centre for Health Economics; 2000.
18. Saltman RB, Busse R, Figueras J, editors. *Social Health Insurance Systems in Western Europe*. Berkshire, England: Open University Press; 2004.
19. World Health Organisation. *Community Based Health Insurance in Developing Countries: Facts, Problems and Perspectives*, Discussion Paper Number 1-2003. Geneva: World Health Organisation; 2003.
20. Ellis RP, Chen T, Luscombe CE. Comparisons of health insurance systems in developed countries. *Encyclopaedia of Health Economics*. Philadelphia, PA: Elsevier Press Inc.; 2014.
21. Acharya A, Vellakkal S, Taylor F, Masset E, Satija A, Burke M, et al. Impact of national health insurance for the poor and the informal sector in low and middle-income countries: A systematic review. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London; 2012.
22. Talampas RG. Review of Experience of Social Health Insurance in Three Asian Countries: China, Thailand and Viet Nam: Discussion Paper Series No. 2014-46. Philippines Institutes for Development Studies; 2014. Available from: <http://www.dirp3.pids.gov.ph/webportal/CDN/PUBLICATIONS/pidsdps1446.pdf>. [Last accessed on 2016 Apr 23].
23. Gobah FK, Zhang L. The national health insurance scheme in Ghana: Prospects and challenges: A cross-sectional evidence. *Glob J Health Sci*. 2011;3(2):90-101.
24. Ruth R, Sarah G, Joni J. *The Social Care and Health Systems of Nine Countries*. London: The King's Fund, London; 2014. Available from: <http://www.kingsfund.org.uk>. [Last accessed on 2016 Apr 23].
25. Kahtani AA. Experience of mandatory health insurance in Kingdom of Saudi Arabia. Presentation of Compulsory Medical Insurance Workshop. Bahrain: Bahrain Insurance Association; 2008.
26. Morrissey MA. *Health Insurance*. Washington DC: AUPH Press; 2008.
27. Al-Kelya M, Al-Saggabi A. Health Care Data in Saudi Arabia: Challenges in Collecting, Sharing and Applying, n.d. Available

- from: <http://www.docplayer.net/6558315-Health-care-data-in-saudi-arabia-challenges-in-collecting-sharing-and-applying.html>. [Last accessed on 2016 Apr 23].
28. Ministry of Economic and Planning. Achievements of the Development Plans, Thirty First Issue. Riyadh, Saudi Arabia: Ministry of Economy and Planning; 2014.
 29. Dawood YT. Takaful in the new millennium where are we now? Where do we go from here? Number 1. Saudi Arabia: ICMIF; 2005.
 30. World Health Organisation (WHO). World Health Statistics, 2015. Geneva: WHO; 2015.
 31. World Health Organisation (WHO). Saudi Arabia Country Cooperative Strategy at a Glance. Geneva: WHO; 2014.
 32. Armstrong BK, Gillespie JA, Leeder SR, Rubin GL, Russell LM. Challenges in health and health care for Australia. *Med J Aust.* 2007;187(9):485-9.
 33. Almalki M, Fitzgerald G, Clark M. Health care system in Saudi Arabia: An overview. *East Mediterr Health J.* 2011;17(10):784-93.
 34. Drechsler D, Jütting J. Different countries, different needs: The role of private health insurance in developing countries. *J Health Polit Policy Law.* 2007;32(3):497-534.

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