

A Comparative Study of Public and Private Health Insurance Models in Pakistan and Saudi Arabia

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ABSTRACT

This study examines and contrasts the health insurance system of Pakistan and Saudi Arabia with respect to (w.r.t) the structure, regulation, coverage, affordability, digital administration and experience reported by the stakeholders of the health insurance system(s). It follows a qualitative, comparative policy analysis design using only secondary sources such as government documents, regulatory documents, international health reports, and academic papers that were located in the source dissertation. The dissertation describes the system as being disjointed with public protection programmes being in parallel with a comparatively limited private insurance market, and with significant out-of-pocket expenditure. Saudi Arabia is characterized as having a more centralized regulatory structure, mandatory insurance for expatriates, employer-sponsored insurance for many in the private sector and digital claims administration via the National Platform for Health Insurance Electronic Services (NPHIES). In Pakistan, the population coverage was estimated to be 18% and out-of-pocket expenditure was 58%, while in Saudi Arabia it was 90% and 20% respectively. It is important to recognize these estimates are for cautions purposes due to fluctuating data and a lack of well-documented data sources for each indicator in the dissertation. The comparison indicates that policy issues of relevance to Pakistan include benefit design transparency, interoperable digital systems, policy coordination and targeted financial support. There are limitations to the analysis due to the use of secondary data and the lack of a documented systematic review protocol and primary stakeholder data.

Keywords: Health Insurance, Pakistan, Saudi Arabia, Comparative Policy Analysis, Health Coverage, Out-of-Pocket Expenditure, Health Insurance Regulation, Digital Health Administration, Healthcare Affordability, Health Financing.

INTRODUCTION

Health financing has four key goals, one of which is financial protection: people should be able to access health services without suffering financial hardship. However, health insurance can play a role in contributing toward this goal by providing risk pooling and pre-payment of services, depending on the size of the population covered, the range of services covered by benefit packages, provider availability, and the costs of the premiums/co-payments.

Both countries offer different policy background on the issues at hand: Pakistan and Saudi Arabia. The dissertation characterizes Pakistan as a hybrid public-private health protection regime, where public health-protection programs are concurrent with private insurance products, and where many households still use out-of-pocket payments. It describes Saudi Arabia as a system that is more

centrally-managed, where healthcare coverage for citizens is publicly provided, while private insurance for expatriates and employer-sponsored insurance for many in the private sector are mandatory.

This article aims to integrate the findings of the dissertation and draw out policy implications which can be applied in Pakistan for comparison to the two systems. The analysis centres on governance, coverage, digital administration, cost, access and satisfaction reported by stakeholders. The numbers indicated below are not independently validated in this manuscript, but are reproduced as reported in the dissertation.

METHODS

The source dissertation is a qualitative comparative cross-national policy analysis that uses only secondary data. Sources cited included government and regulatory documents, academic journal articles and international health databases. Pakistan-related articles were from the Ministry of National Health Services and Securities and Exchange Commission of Pakistan (SECP). Materials from Saudi Arabia, which were attributed to the Council of Cooperative Health Insurance (CCHI), the Ministry of Health, and NPHIES, were included among the sources. The dissertation also refers to World Health Organization and World Bank publications.

The data were reportedly identified by searching websites like health insurance Pakistan, Sehat Sahulat program, health insurance Saudi Arabia and CCHI regulations, official government websites, PubMed, Google scholar etc. According to the dissertation, the system structure, regulation, coverage, digital integration, access, affordability and stakeholder satisfaction were compared using thematic content analysis and numerical indicators were summarized descriptively.

Important methodological detail is missing from the source document: it offers no reproducible search strategy, exact search dates, full list of the documents included, a formal quality appraisal method, or a clear rule for reconciling conflicting statistics. No primary interviews nor surveys were made. Therefore, the quoted values are not measured values but estimates that have been taken from the dissertation.

FINDINGS

System Structure and Governance

The system in the account of the dissertation includes public initiatives such as Sehat Sahulat Program (SSP) and private insurance that is concentrated in the formal and urban sectors. The responsibility is spread between public authorities and the private-insurance regulator, and the dissertation suggests that this can lead to coordination problems. It highlights provider inequity, administrative delays, lack of interoperability, and public lack of understanding as obstacles to broad and effective coverage.

Saudi Arabia is shown to have a more centralized regulatory system in cooperative health insurance with CCHI, and government-funded health insurance for citizens. The dissertation explains mandatory insurance for expatriates and employer-provided insurance for most of the private sector employees including Saudi nationals. It also points to the digital platform NPHIES that is assisting with eligibility verification and claims administration. The arrangements outlined are offered as possible sources of more uniform administration, but the effect of centralization and digitization on the standardisation of administration has not been measured independently in the dissertation.

Dissertation

According to the dissertation, the insurance coverage of the population in Pakistan was estimated at 18 per cent and in Saudi Arabia at 90 per cent. It estimates the proportion out of pocket spending to be

58% of total health expenditure in Pakistan and 20% in Saudi Arabia. The source also provides estimates of public and private coverage separately, but does not consistently define the two categories and can overlap coverage with employer-based care or with access to publicly-funded care.

Indicator (as reported in dissertation)	Pakistan	Saudi Arabia
Estimated population coverage	18%	90%
Out-of-pocket expenditure as share of total health expenditure	58%	20%
Urban coverage estimate	30%	95%
Rural coverage estimate	8%	85%

Table1; Selected comparative indicators reproduced from the source dissertation. These values require verification against the original, dated datasets before journal submission. In particular, the dissertation reports, other estimates elsewhere, such as roughly 54% for Pakistan's out-of-pocket spending and varying definitions of the SSP reach, do not match this figure.

Accessibility, affordability and service experience

Geographic and financial barriers in Pakistan are identified in the dissertation. It identifies less coverage in rural areas than in urban areas, and says some hospitals in rural areas are not participating, that private premiums are higher than household resources, there is limited awareness, and that there may be costs associated with services not covered in a benefit package. It also mentions that public programmes can concentrate on inpatient treatment, neglecting the outpatient needs.

The dissertation also argues that mandatory insurance may not guarantee full coverage for all insurance policy holders in the case of Saudi Arabia. It is used to highlight any potential restrictions that may apply, such as co-payments, network restrictions, access to specialist services, and access differences in non-metropolitan areas. It also mentions climbing healthcare expenses as a problem for the sustainability of public and private financing.

Digital administration and satisfaction of the stakeholders

The source highlights the value of NPHIES to the Saudi system, in terms of helping to enable electronic eligibility verification and claims management. Digital integration is less advanced and less interoperable in Pakistan, between public and private arrangements. The dissertation proposes that a national platform based on common data standards could facilitate transparency of claims, provide administrative efficiency and oversight, but does not provide a formal impact assessment of such a platform.

Satisfaction indicator (as reported)	Pakistan	Saudi Arabia
Accessibility	52%	88%
Affordability	40%	81%
Service quality	55%	90%
Claims-processing efficiency	38%	85%
Awareness of insurance benefits	35%	78%

Table 2; Satisfaction estimates reported in the dissertation for 2023–2024. The original document cites different organizations for these indicators but does not provide survey titles, sample sizes, sampling methods, questionnaire wording, or direct links. These percentages therefore should not be presented as directly comparable survey results until the underlying sources and methods have been verified.

DISCUSSION

The comparison in the dissertation suggests three potentially important differences: the organization of regulatory oversight, the use of digital administrative infrastructure, and the level of coverage, which is either based on public funding or formal employment. The dualistic structure of Pakistan's arrangement might offer some protection to certain groups, but it can be challenging to set standards and provide protection to informal workers and to underserved rural populations. Saudi Arabia's more centralized insurance regulation and digital infrastructure provide examples of mechanisms that can help enhance consistency and administration.

The differences should not be seen as evidence of the superiority of one regulatory regime or single digital platform. Coverage and income protection also rely on benefit design, public spending, provider capacity, purchasing arrangements, enforcement, and income and employment distribution. Additionally, having insurance coverage and access to government-sponsored healthcare is not synonymous. Setting the parameters for a comparison requires defining the population to be covered, the benefits that count, the time period, and the comparison to an insurance policy.

The numerical evidence for the dissertation should be given special attention. Percentages may not add up to 100 percent due to changes in coverage estimates by section, and percentages may be public and private, with no overlap. Several of the references are incomplete or repeated and a few of the references with percentages provided are not sufficient to be reproduced from the same source for the survey. These do not negate the topic, they don't rule out the qualitative comparison, but they do render the current statistics a non-absolute proof until they have been sourced.

POLICY IMPLICATIONS AND RECOMMENDATIONS

Enhance coordination and regulatory clarity

Create clear responsibilities and formal arrangements for coordination for public programmes, provincial authorities and private insurers. The concept of the single authority must be kept in mind in the light of constitutional and administrative frameworks of Pakistan and not merely copied.

1. Implement financial protection in phases

Assess the gaps in informal employment, low income and rural groups of the population coverage. Implement pilot enrollment and subsidy models, monitor utilization and financial protection and scale only when funding and provider capacity are sustainable.

2. Construct interoperable digital management

Establish common data and claims standards, privacy protection, audit trails and interoperable systems. This national platform should be rolled out in a staged manner, put under a governance plan, and analyzed for costs, reliability, and impact on claim turnaround.

3. Make benefit packages and costs transparent

Communicate covered services, exclusions, co-pay, provider network, and routes for complaints in easily understood language. Track if coverage of a service translates to timely access to needed care.

4. Improve access for providers in rural communities

Relate insurance expansion to provider network and adequacy, referral system, transport access and availability of services. The problem of shortages of facilities or health professionals can't be solved by insurance enrolment.

5. Use similar indicators to monitor outcomes

Provide and regularly update methodologically documented data on claims processing, complaints, out-of-pocket spending, access to services, coverage, and equity. Apply uniform terminology to the different types of arrangements, as well as across provinces.

LIMITATIONS

This is because this analysis is based on secondary sources, and its source dissertation does not fully document the search process and materials used. No primary stakeholder data were collected. Numerous numerical estimates have inconsistencies throughout the text and the sources are not always detailed enough to find or verify the source evidence. The comparison is descriptive only and does not infer that changes in coverage or satisfaction were a result of any particular regulatory or digital interventions.

CONCLUSION

The dissertation has painted a picture of a health insurance system that is poorly developed and less accessible in Pakistan, heavily subsidized by out-of-pocket payments, whereas in Saudi Arabia is described as having public health care, which is available to citizens, and regulated private insurance for expatriates and most private-sector employees. Key lessons for Pakistan are better coordination, building interoperable digital government, clarity of benefits and consumer protections, and coverage gaps for low-income and rural populations. The statistics and references used in the underlying material should be checked prior to publication, discrepancies in statistics should be corrected and methods documented to a level of detail that will enable another researcher to repeat the process of analysis.

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The entries below are carried over or adapted from the dissertation's reference list. They have not been independently verified for existence, bibliographic accuracy, or support for the claims attributed to them. Verify each item against the original publication and replace incomplete or incorrect entries before submission.

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