King Saud University

College of Business Administration

Department of Health Administration

Executive Master in Health Administration

EHHA 506 – Health Insurance Administration

Second Semester 1441/ 1442

Mohammed S. Alnaif, Ph.D.

E-mail: alnaif@ksu.edu.sa

Introduction, History of Health Insurance

Health Insurance

- In the absence of **national health insurance**, or when there are many obstacles that prevent access to the needed health services at the time of needs, most people cannot afford to pay the high cost of health care on their own.
- That's where **health insurance** comes in. A person pay a **premium** each month, and the insurer pays for a portion of the covered medical costs.
- The **insurer** may be able to negotiate better rates from the doctors and hospitals.

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- So instead of paying hundreds of riyals in **out-of-pocket costs** for a doctor visit, or thousands for a surgery, the insured pay a lesser amount depending on his/her plan.
- **These purposes** include promoting health, obtaining health care for individuals and families, and protecting people financially from exceptional health care costs.

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- **Health insurance pools the risks and resources of a large group of people so that each is protected from financially disruptive medical expenses resulting from an illness, accident, or disability.**
- **In addition to serving the typical functions of risk insurance, health insurance has developed as a mechanism for financing or pre-paying a variety of health care benefits, including routine preventive services, whose use is neither rare nor unexpected.**

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- **Despite the fact that a large proportion of persons with health insurance make claims against their coverage every year, health care spending, and thus health insurance payouts, remain concentrated among a relatively small number of claimants, who incur high costs for serious conditions.**
- **Ten percent of the population accounts for 70 percent of health care expenditures, a correlation that has remained constant over the past decades.**
- **Thus, health insurance continues to serve the function of spreading risk even as it increasingly finances routine care.**

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- **For individuals and families, health insurance both enhances access to health services and offers financial protection against high expenses that are relatively unlikely to be incurred as well as those that are more modest but are still not affordable to some.**
- **Health insurance is a powerful factor affecting receipt of care because both patients and physicians respond to the out-of-pocket price of services. Health insurance, however, is neither necessary nor sufficient to gain access to medical services.**
- **Nonetheless, the independent and direct effect of health insurance coverage on access to health services is well established.**

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- **A social health insurance system, that is publicly financed, is supposed to achieve equality by providing free access to health care services based on the believe that health care is an individual right and a social good that should have a joint consumption.**
- **However, even with increasing the proportions of governments outlays allocated to the healthcare systems; rising health care costs, long waiting lists, and timely access to health care services have become major obstacles that threaten the very existence of the national healthcare systems.**

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- **In addition, some nations that cover medically necessary and appropriate services are debating the limits of publicly defined coverage.**
- **Challenges such as changes in demography and patterns of disease, adoption of advanced technologies, increased drugs consumption, duplication of services, inefficiency and lack of cost awareness will eventually inhibit these public systems from achieving their primary goal of equal access to health care services.**

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- **Reform policies around the world vary considerably from nation to nation, some are moving towards a more competitive system others are continuing to rely more on government organization and financing of health care services.**
- **The Kingdom of Saudi Arabia have recently introduced cooperative health insurance to cope with the fundamental problems of shrinking access to health care and the rising costs of medical services.**

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- The cooperative health insurance scheme is not a new concept. Paul Starr in his book "The Social Transformation of American Medicine" dates the modern cooperative movement to nineteenth century England.
- Advocates of medical cooperatives see it as an alternative to "state medicine" that combines the fundamental concerns of both socialism and capitalism, equality, collective action, and the ability to compete in the health care market.

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- **Medical cooperatives that were established in 1930s in the United States emphasized four principles: group practice; prepayment, preventive medicine, and consumer participation.**
- **However, the main principle of the proposed health insurance scheme in Saudi Arabia is to increase the participation of the private sector in the health care market and to reduce the financial burden on government provided healthcare services.**

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- **While market competition has been exported to European nations and many developing countries as the solution that will slow down or lower health care costs, many countries have concluded that competitive schemes in health insurance are likely to produce higher costs and inequities.**
- **The inherent causes of market failure concerns two weaknesses in the health insurance market, namely adverse selection and moral hazard.**

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- **In health insurance, adverse selection refers to the scenario in which higher-risk or sick individuals, who have greater coverage needs, purchase health insurance, while healthy people delay or decide to abstain.**
- **Adverse selection refers to the difficulties associated with providing health insurance to individuals who know more about their true medical condition than the insurer does. (organizations have difficulties distinguishing high risk from low risk consumers)**

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- **Moral hazard arises when the insured that pays only part of or none of the marginal cost of covered services overutilize these services and knowingly engage in behaviors that allow controllable aspects of their health to deteriorate.**
- **Moral hazard became an important question in the modelling and build-up of the German health insurance system created in the 19th century. The main point of moral hazard in health insurance could be described as follows: when people are insured, they use more medical care services than if they didn't have health insurance.**

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Community rating vs. risk-rated premiums

- **Premiums based on a community rating allocate risks evenly across a defined community. This means that everyone pays the same, regardless of age, gender or health status.**
- **Under community rating, higher cost groups (e.g., groups made up of older or sicker people) are averaged out with lower cost groups (e.g., groups made up of younger or healthier people).**
- **The expenses of all participants are pooled together and then spread out equally across all participants.**

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Community rating vs. risk-rated premiums

- **With risk-rated premiums are adjusted based on the age, gender and health history of those covered, the actual cost of providing health care coverage to the group during a given period of time; the group's claim history.**
- **Thus, the insurer calculates the group's insurance premium based on its own, not the overall community's, experience.**

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- **Accordingly, the problems of "risk-rated premiums" and the increase in demand for medical services will require more government regulation of insurers and greater control over the insured.**
- **On the other hand, social insurance systems that rely on government organization and financing with the objective of providing universal access and social solidarity are now under pressure to control health care costs and national spending on health care services.**

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Paying for medical care

- **Consumers pay for most medical care indirectly, through taxes and insurance premium. Healthcare managers must understand the structure of private and social insurance programs because much of their organizations' revenues be shaped by these programs.**
- **Exhibit 3.1 depicts a healthcare market in general terms. The direct payment paid by consumers are often called out-of-pocket payments.**

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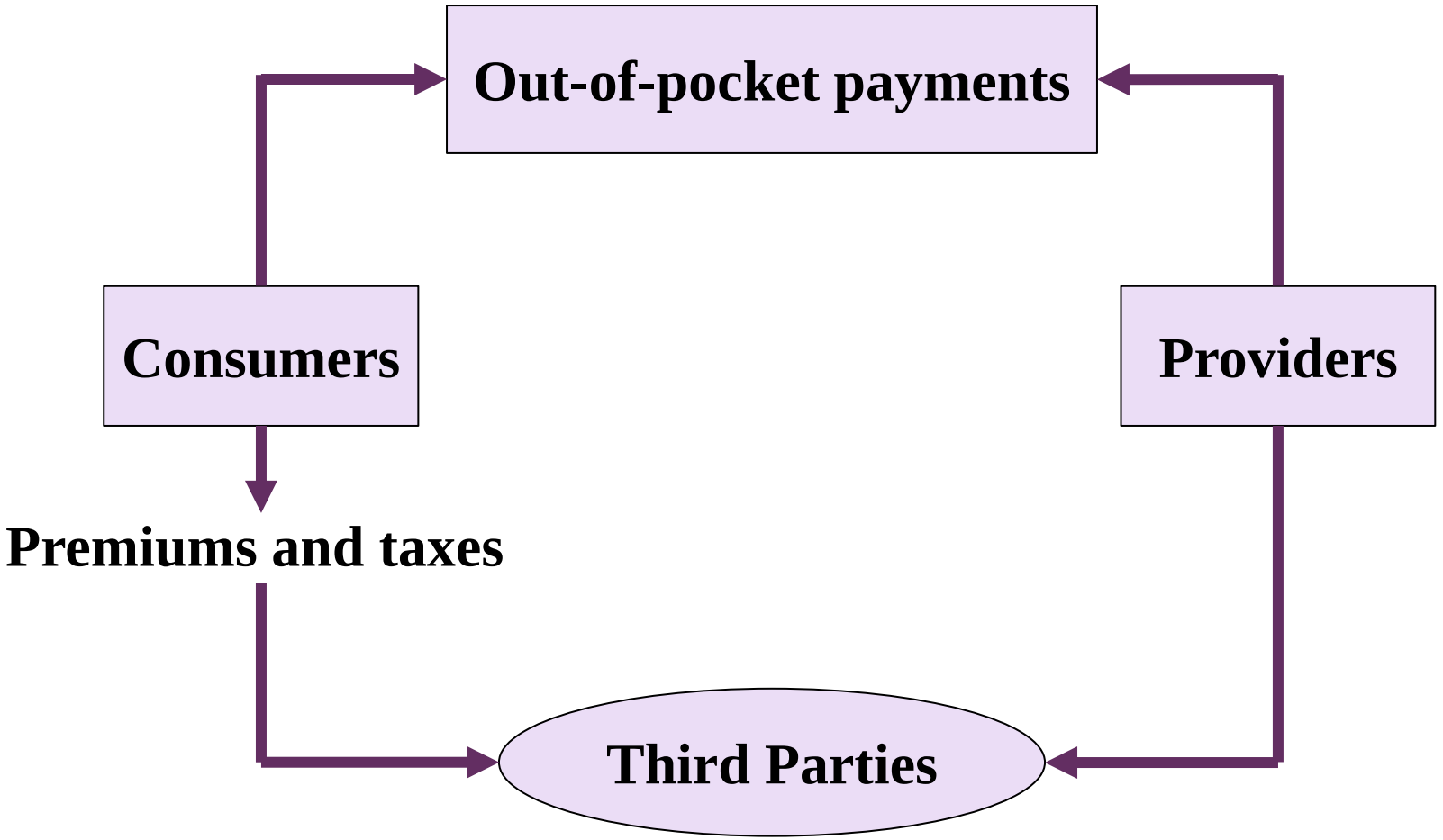

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Health Insurance

- **Centralized healthcare system adopted by some Western nations (e.g., Germany, Great Britain) and funded by taxes. The government pays for each resident's health care, which is considered a basic social service.**
- **Socialized medicine A type of single-payer system in which the government owns and operates healthcare facilities and providers (e.g., physicians) receive salaries.**
  Universal health insurance the goal of providing every individual with access to health coverage, regardless of the system implemented to achieve that goal.

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- **Germany has the world's oldest national social health insurance system, with origins dating back to Otto von Bismarck's Sickness Insurance Law of 1883 Initially the health insurance law of 1883 covered blue-collar workers in selected industries, craftspeople and other selected professionals.**
- **It is estimated that this law brought health insurance coverage up from 5 to 10 per cent of the total population.**

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- **In Britain, the National Insurance Act 1911 created a national system of insurance to protect working people against loss of income relating to sickness or unemployment. the National Insurance Act 1911 included national social health insurance for primary care (not specialist or hospital care), initially for about one third of the population — employed working class wage earners, but not their dependents.**

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- **This National system of health insurance continued in force until the creation of the National Health Service in 1948 which created a universal service, funded out of general taxation rather than on an insurance basis, and providing health services to all legal residents.**

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- **The final legislation for the NHS, implemented in July 1948, contained a number of compromises:**
  1. **Universal coverage was financed primarily by general revenues, with social insurance contributions limited to a small percentage of the total;**
  2. **GPs were paid via capitation;**
  3. **Nearly all public and voluntary hospitals were put under the control of the national government;**
  4. **Public hospitals were permitted to maintain up to 5% of beds for private patients of consultants, that is, senior hospital physician specialists; and**
  5. **Health centers were limited to a few experimental facilities.**

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The United States Healthcare System

- **Organized health care in the United States began with the almshouses and pest houses of the 1700s.**
- **Local governments established these facilities to feed and shelter the orphaned, homeless, elderly, disabled, and chronically or mentally ill, and they provided health care as a secondary function.**
- **During the industrial revolution in the United States, advances in science and medical technology all aided in the demand for, and the subsequent development of, nongovernmental for-profit and not-for-profit hospitals.**

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The United States Healthcare System

- **Along with medical advancements came the need to standardize medical education and training.**
- **In 1910, Abraham Flexner led a study of medical education. The Flexner Report sparked systematic efforts to standardize medical education.**
- **At this same time, concerns about workers' access to health insurance led progressive politicians such as Teddy Roosevelt to support compulsory, employer-based, social health insurance in the 1912 presidential election.**
- **Roosevelt's loss to Wilson, coupled with the United States' entry into World War I, signaled the death of this reform effort.**

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- In America, reformers outside the government, rather than political leaders, took the initiative in advocating health insurance.
- The idea did not enter political debate under antisocialist sponsorship, as it often did in Europe. Indeed, the socialists in 1904 were the first American political party to endorse health insurance.
- But throughout the debate over health insurance in the United States, the conflict was intensely ideological, much more so than in Europe.

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- **The defeat of national health insurance meant that health insurance in America would be predominantly private, but it left open what form of private system would take.**
- **Private health plans began to grow significantly during the thirties (1930s). once these plans became involved, they needed to control their financial liability—which was an infuriating problem because physician's authority and the uncertainties of medical care make it hard for third parties to exercise effective control.**

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- **The difficulty in controlling costs in health insurance arises because sickness is not always a well-defined condition and many of the costs of treatment are within the control of the insured.**
- **The costs are partly within the control of the physician and hospital, which may profit from additional services and raise prices as the patient's ability to pay increases.**
- **So particularly in a society where the government does not directly finance and operate the hospitals, health insurance involves a severs problem of moral hazard.**

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- **However, a new element of health insurance had developed quietly during the 1920s: the rising costs of hospital care and its affect of such costs for middle-class families.**
- **This development had opened up a new market for health insurance. 1929 the first Blue Cross policy was established, Justin Ford Kimball, an official at Baylor University in Dallas, introduced a plan to guarantee school teachers 21 days of hospital care for $6 a year.**
- **Other groups of employees in Dallas joined, and the idea attracted nationwide attention. This is generally considered the first Blue Cross plan.**

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- These early arrangements were all direct-service plans, set up by hospitals in competition with each other.
- As these plans emerged, the Depression of 1929 began to expose the financial insecurity of the nation's voluntary hospitals, they could not continue to rely on patients to pay all their bills when they were hospitalized, and encourage them to turn to insurance for a solution.

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- **The drive and enthusiasm for the Blue Cross idea, originated with the early pioneers, not the hospitals. But it was the hospitals that provided the underwriting.**
- **Unlike insurance companies, these plans were organized with hardly and starting capital. This was possible because of "hospital underwriting."**
- **Medical underwriting is the process of evaluating an application for health insurance coverage by examining the applicant's medical history. The price of coverage is determined by the risk factors of the applicant.**

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- **In 1994 commercial insurance companies began offering indemnity coverage against hospital expenses on a group basis. Since it enjoyed tax exemptions and privileged relations with hospitals, Blue Cross held an early advantage over commercial competitors.**
- **The American Medical Association (AMA) insisted that all health insurance plans accept the private physicians' monopoly control of the medical market and complete authority over all aspects of medical institutions.**

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- **The difference between these plans is partly expressed by two terms traditionally used to describe what the plans provide: "insurance" and "prepayment."**
- **Indemnity insurance have a variation in third party involvement, typically allow subscribers free choice of any licensed practitioner or facility, prepaid plans have their own physicians and sometimes their own hospitals.**

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- **The cooperative health plan established in 1929 at Elk City, Oklahoma was the creation of a local physician, Michael Shadid, who had in practice twenty-two years.**
- **Shadid was a prosperous, middle aged doctor, who as a young man had emigrated to America from what later became Lebanon.**
- **Shadid first approached his colleagues with a plan for medical cooperative embracing all local physicians.**
- **He thought that if they enrolled six thousand families from the area at $50 per year, they could provide medical and surgical care, protect their patients against sudden medical expenses.**

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- When his colleagues proved unsympathetic, he turned to “some of the more progressive farmers,” enlisting their help and obtaining membership subscription from them.
- However, once the project took form and work began on a hospital, the other physicians published a manifesto declaring the plan, as one might expect, “unethical.”
- The local medical profession then entered into a long campaign of sabotage. It tried repeatedly to deprive Shadid of his license.

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- During the 1950s insurance companies in the US began offering major medical insurance, which provided coverage for catastrophic or prolonged illnesses and injuries.
- Most of these programs incorporate large deductibles and lifetime maximum amounts.
- A deductible is the amount for which the patient is financially responsible before an insurance policy provides payment.
- A lifetime maximum amount is the maximum benefits payable to a health plan participant.

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- In 1966 Social Security Amendments of 1965 were implemented Medicare provides healthcare services to Americans over the age of 65. (It was originally administered by the Social Security Administration.)
- Medicaid is a cost-sharing program between the federal and state governments to provide healthcare services to low-income Americans. (It was originally administered by the Social and Rehabilitation Service [SRS].)
- On June 14, 2001, the Centers for Medicare and Medicaid Services (CMS) became the new name for the Health Care Financing Administration (HCFA).

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Tax-Funded Models for Direct Provision of Health Services

- **While both Sweden and the United Kingdom make use of national health services that provide universal access to health care to all of their citizens, they differ in the degree to which those services are decentralized and locally controlled.**
- **Nonetheless, each country recently has engaged in reforms to control expenses, reduce waiting times for specialized services, ensure the quality of care, and develop national health information networks.**

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Tax-Funded Model for Indirect Provision of Health Services

- **While Canada shares with Sweden and the United Kingdom a single-payer model of funding health services, it differs in that health providers are not employed by the state, and the federal or provincial governments typically do not own healthcare facilities.**
- **Ten provinces and three territories administer the Canadian system of Medicare, with the federal government recently instituting reforms to ensure equitable funding for, and access to, health services.**

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Tax-Funded Model for Indirect Provision of Health Services

- **Canada indirectly provides health services through a tax-funded public system, which is accessible by all Canadians.**
- **Citizens receive coverage for ambulatory services, inpatient services, prescription medications, physician services, community health services, disease prevention programs, and health protection programs.**
- **Home care is covered at varying levels.**

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Compulsory Insurance Model for Indirect Provision of Health Services

- **Both Germany and the Netherlands rely on compulsory health insurance that is used to purchase health services from various health providers.**
- **Recent legislation in both countries has reformed how and by whom health insurance is purchased.**
- **The Dutch have implemented an individual mandate for health insurance.**
- **The Germans have made access to health insurance both a right and a requirement within an employment-based insurance system.**

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Compulsory Insurance Model for Indirect Provision of Health Services

- **Both the German and Dutch models of compulsory health insurance provide universal access to basic health services and achieve very good to excellent quality as measured by a variety of health outcomes.**
- **However, both systems have struggled to contain costs, and both have either adopted or independently developed certain managed care techniques, ranging from primary care gatekeeping and capitation to DRGs and disease management.**
- **Both health systems also have introduced various forms of managed competition between insurers and providers to increase efficiency.**

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- **Capitation is a method of payment for health services in which healthcare providers are paid a fixed rate per person served, per month (usually prospectively) to cover all care within a specified scope of services plus administrative costs, regardless of the number of services they provide.**
- **Gatekeeper describes the person in charge of a patient's treatment. A gatekeeper's duty primarily is to manage a patient's treatment. This means the gatekeeper is in charge of authorizing the patient's referrals, hospitalizations and lab studies.**

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- **A diagnosis-related group (DRG) is a patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives.**
- **In general, a DRG payment covers all charges associated with an inpatient stay from the time of admission to discharge. DRG payment is based on the care given to and resources used by a "typical" patient within the group.**
- **The hospital gets paid a fixed amount for that DRG, regardless of how much money it actually spends treating the patient.**

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- **Managed competition in health care is an idea that has evolved over two decades of research and refinement. It is defined as a purchasing strategy to obtain maximum value for consumers and employers, using rules for competition derived from microeconomic principles.**
- **Managed competition is based on comprehensive care organizations that integrate financing and delivery.**
- **Prospects for its success are based on the success and potential of a number of high-quality, cost-effective, organized systems of care already in existence, especially prepaid group practices.**

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Mixed Models for Provision of Health Services

- **With the exception of Greece and Turkey, all of the national health systems that follow mixed models for the funding and provision of health services have not yet achieved universal access to health insurance.**
- **Those nations include Argentina, Brazil, Indonesia, Mexico, and the United States. Many of these countries have declared health care as a right, but rely on both public and private systems of care.**
- **Regardless of the funding mix, all of these countries are attempting to reform health care to expand insurance coverage and access to care.**

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Mixed Models for Provision of Health Services

- **All of the countries using mixed models for funding and providing health care have problems ensuring that quality care is equitably accessible and is cost-effective.**
- **As a result, all of these countries have been reforming their health systems. On one hand, during the past decade, Turkey enacted a transformational health reform to achieve universal financial access to care; on the other hand, Greece enacted incremental health reforms primarily to contain costs.**
- **However, most of these countries—Argentina, Brazil, Indonesia, Mexico, and the United States—have or are attempting to incrementally improve access to care.**

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- **The French health care system has achieved sudden notoriety since it was ranked No. 1 by the World Health Organization in 2000.**
- **The French health care system combines universal coverage with a public–private mix of hospital and ambulatory care.**
- **The health system in France is dominated by solo-based, fee-for-service private practice for ambulatory care and public hospitals for acute institutional care, among which patients are free to navigate and be reimbursed under NHI.**

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- **All residents are automatically enrolled with an insurance fund based on their occupational status.**
- **In addition, 90% of the population subscribes to supplementary health insurance to cover other benefits not covered under NHI.**
- **Another distinguishing feature of the French health system is its proprietary hospital sector, the largest in Europe, which is accessible to all insured patients.**
- **Finally, there are no gatekeepers regulating access to specialists and hospitals.**

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- **The constitution of Saudi Arabia elucidates health care as a fundamental right. The public health system and the Ministry of Health (MOH) were established in 1925 and 1949, respectively, to provide free health services to its citizens.**
- **The Kingdom has followed welfare policy and provided universal access to health care for many decades since its establishment.**

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- **The government successfully implemented various development projects in the last few decades.**
- **However, the government has recently faced challenges to sustain free health services to its population.**
- **This is due to escalating costs of health care, diminished revenues from oil, changes in demographics, improved life expectancies, a larger shift to sedentary lifestyles in the country, changing disease patterns, high expectations from consumers, as well as inadequate management practices in the delivery of health services.**

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- There have also been issues with providing free services to the country's large expatriate population.
- In this context, the government has been keen to reform the health sector to provide the best possible health services to maintain and fulfill social demands of quality improvement and reduce expenses.
- Saudi Arabia's ambitious program of social and economic renewal, Vision 2030, program initiatives include the privatization of healthcare services.

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- **Privatization in health care is a process where non-governmental actors become increasingly engaged in the health sector in the provision financing and management of services.**
- **The government partially or fully withdraws itself from its historical role in the provision and management of the health sector.**

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Health Insurance

- **Saudi Arabia's Health Ministry will establish a holding company and five regional companies under plans to privatize the healthcare sector.**
- **Plans will allow full foreign ownership in the health sector so the ministry will become a regulator and not a service provider.**

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- **The plans will see** 15 hospitals and 100 primary healthcare centers managed under the holding's companies by the end of 2018.
- **These companies will** then compete with each other to provide better quality care.
- **Every company will manage** a cluster of hospitals and health centers.
- **The kingdom eventually** plans to privatize 290 hospitals and 2300 primary health centers by 2030.

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- **The government views healthcare** as the sector with the best potential for privatization and is reported to be studying whether to sell off all public hospitals and pharmacies.
- **The Kingdom faces rising medical expenses** related to areas such as accidents, smoking and obesity (which may manifest through diabetes).

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- **Many of these initiatives will ultimately be procured through a Public-Private Partnerships (PPP) mechanism.**
- **What Is a PPP? A long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance.**

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Health Insurance

- **Both the World Health Organization and the World Bank have been advocating for PPPs as a way of improving health care service delivery to the population.**
- **The government has drawn up a PPP law which is expected to boost the private sector.**
- **It is expected that PPP models of health care unlock value in the health system and allow for an increase in private sector contribution against total health care spending.**

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- It is suggested that the government needs to quicken the pace of the shift from its current government-led economic model to a more market-based approach, which will be filled by the private sector.
- It is expected that both the Saudi economy, international entrepreneurs and health care providers will be benefited from a market-driven health care system.

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Money, Insurance & Prices										المالية والتأمين والاسعار
Gross Written Premiums by Line of Business (Thousand Riyals)										إجمالي أقساط التأمين المكتتب بها حسب نوع النشاط (ألف ريال)
Table 9 - 20										جدول 9 - 20

General Insurance											التأمين العام	الفترة
الإجمالي	الصحي	الحماية والادخار	المجموع	أخرى	المركبات	الحوادث والمسئوليات	الممتلكات	البحري	الهندسي	الطاقة	الطيران	
Total	Health	Protection and Saving	Total	Other	Motor	Accident and Liability	Property/ Fire	Marine	Engineering	Energy	Aviation	Period
30,482,219	15,720,484	904,361	13,857,374	199,071	8,026,207	880,285	1,923,248	811,400	1,434,109	442,698	140,356	2014
36,496,269	18,966,790	1,035,691	16,493,789	224,107	10,799,248	868,964	1,961,948	726,221	1,204,016	562,637	146,647	2015
36,855,343	18,630,284	1,051,377	17,173,682	229,019	12,158,399	820,528	1,825,784	634,102	908,415	457,778	139,656	2016
36,503,240	19,035,518	1,140,273	16,327,449	271,809	11,136,449	782,408	1,708,536	621,844	932,440	739,019	134,944	2017
35,014,465	19,883,370	1,102,724	14,028,371	288,277	9,423,328	713,039	1,697,937	544,574	701,745	511,478	147,993	2018

Source: SAMA — المصدر: مؤسسة النقد العربي السعودي

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Money, Insurance & Prices											المالية والتأمين والاسعار
Net Written Premiums by Line of Business (Thousand Riyals) [1]											صافي أقساط التأمين المكتتب بها حسب نوع النشاط (ألف ريال) [1]
Table 9 - 21											جدول 9 - 21
الإجمالي	الصحي	الحماية والادخار	التأمين العام General Insurance								الفترة Period
			المجموع	أخرى	المركبات	الحوادث والمسئوليات	الممتلكات	البحري	الهندسي	الطاقة	الطيران
Total	Health	Protection and Saving	Total	Other	Motor	Accident and Liability	Property/ Fire	Marine	Engineering	Energy	Aviation
24,334,249	14,654,512	729,571	8,950,166	64,071	7,601,729	500,003	315,758	251,525	204,921	8,665	3,494	2014
30,274,525	18,189,146	835,925	11,249,454	108,312	9,912,374	419,034	330,267	248,899	216,523	11,120	2,926	2015
30,847,464	18,095,018	820,603	11,931,843	128,112	10,720,429	397,310	272,707	192,335	213,547	-1,653	9,057	2016
30,838,740	18,411,602	846,210	11,580,928	148,673	10,388,217	357,653	322,417	172,432	168,645	17,176	5,714	2017
30,043,428	19,319,417	794,806	9,929,205	155,500	8,860,429	314,939	313,960	155,421	120,170	3,492	5,294	2018

Source: SAMA — المصدر: مؤسسة النقد العربي السعودي

1- The premiums retained with the insurance company after the subtraction of the premiums ceded to local or international reinsurers. — 1- الأقساط المحتفظ بها لدى شركة التأمين بعد حسم الأقساط المسندة إلى شركات إعادة التأمين المحلية والدولية.

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Money, Insurance & Prices									المالية والتأمين والاسعار
Total Number of Policies by Line of Business									**إجمالي عدد وثائق التأمين حسب نوع النشاط**
Table No. 9 - 24									جدول رقم 9- 24

الإجمالي	الصحي	الحماية والادخار	General Insurance التأمين العام									الفترة Period
			المجموع	أخرى	المركبات	الحوادث والمسئوليات	الممتلكات	البحري	الهندسي	الطاقة	الطيران	
Grand Total	Health	Protection and Saving	Total	Other	Motor	Accident and Liability	Property/ Fire	Marine	Engineering	Energy	Aviation	
6,338,936	2,158,236	245,087	3,935,613	11,981	3,606,849	155,958	25,649	118,568	16,325	72	212	2014
8,123,504	3,412,786	103,539	4,607,179	17,550	4,258,900	146,238	17,237	121,535	45,381	76	262	2015
7,308,067	2,916,663	97,976	4,293,428	22,492	3,903,486	163,757	17,525	101,024	84,644	260	240	2016
5,666,234	1,282,574	90,286	4,293,374	30,962	3,953,987	153,023	11,474	93,757	49,790	98	283	2017
6,012,326	1,371,959	56,654	4,583,713	59,875	4,297,381	133,934	11,135	75,281	5,778	83	246	2018

Source: SAMA	المصدر: مؤسسة النقد العربي السعودي

Introduction, History of Health Insurance

Health Insurance

- **Health insurance is a contract between a policyholder and a third-party payer or government program for the purpose of providing reimbursement of all or a portion of medical and health care costs.**
- **The history of healthcare reimbursement can be traced back to 1860, when the Franklin Health Assurance Company of Massachusetts wrote the first health insurance policy.**

Introduction, History of Health Insurance

Health Insurance

- **Subsequent years, through the present, have seen significant changes and advances in healthcare insurance and reimbursement, from the development of the first Blue Cross and Blue Shield plans to legislation that resulted in government healthcare programs (e.g., to cover individuals age 65 and older), payment systems to control healthcare costs (e.g., diagnosis-related groups), and regulations to govern privacy, security, and electronic transaction standards for healthcare information.**

Introduction, History of Health Insurance

Health Insurance

- **A *patient record* (or *medical record*) documents healthcare services provided to a patient, and healthcare providers are responsible for documenting and authenticating legible, complete, and timely entries according to federal regulations and accreditation standards.**
- **The records include patient demographic (or identification) data, documentation to support diagnoses and justify treatment provided, and the results of treatment provided.**

Introduction, History of Health Insurance

Health Insurance

- **The primary purpose of the record is to provide for continuity of care, which involves documenting patient care services so that others who treat the patient have a source of information to assist with additional care and treatment.**
- **The *electronic health record (EHR)* is a global concept (as compared with the EMR) that includes the collection of patient information documented by a number of providers at different facilities regarding one patient.**

Introduction, History of Health Insurance

Health Insurance

- **The EHR uses multidisciplinary (many specialties) and multi-enterprise (many facilities) recordkeeping approaches to facilitate *record linkage*, which allows patient information to be created at different locations according to a unique patient identifier or identification number.**
- **The electronic medical record (EMR) has a narrower focus (as compared with the EHR) because it is the patient record created for a single medical practice and uses total practice management software (TPMS) to generate the EMR and automate medical practice functions.**

THANK YOU