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FINANCE SYSTEM OF HEALTHCARE AND IT'S EFFECTS AND CHALLENGES IN SAUDI ARABIA HOSPITALS

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Introduction

Background

Healthcare expenditure is recognized as one of the important factors influencing health consequences in nations. Achieving health organization objectives requires appropriate financing strategies that ensure complete health upkeep for the populace. To grow appropriate strategies, health policy makers need to assess health organization performance and order resource distribution through different actions to attain optimal health consequences. National Health Accounts (NHAs) are one of powerful implements that help choice makers not only keep track of economic resources, however also provide the indication they need to develop operational health policy.

The NHA tracks and informs the flow of funds into and out of the country's healthcare system. Kind of payer and facilities acquired. NHA can be used for comparison of medical fields between nations. Regular use of the NHA will help the NHA provide important data, provide a further nuanced accepting of the features affecting health sector presentation, introduce policy instruments that can be used by planners, and inform reforms in the health sector. Evaluable and sustained resources have proven benefits. (Mohammad 2018).

Out-of-pocket (OOP) Paying for medical services and medicines as you use them can have serious consequences for financial hardship. Making the OOP payments for medical services beyond their ability to pay, whether formal or informal, puts people in financial hardship. As a result, it can lead

to poverty for individuals and families. Nations about the world last to implement improvements to reinforce health organizations and deliver economic defense to their citizens. In comparison, Arab nations, counting the Kingdom of Saudi Arabia (KSA), have been criticized for failing to implement the health fairness campaign seen around the world. Saudi Arabia is some of lushest and wildest rising states in Middle East. The world's main oil creator and the exporter, generating most of country's income. However, in recent periods, Saudi Arabia has expanded its budget and now yields a wide diversity of industrial products and exports them around the world. A healthy economy and established industrial base are impacting Saudi society through increased income. (Wagstaff 2018).
Saudi Arabia is high-income nations in Arab area, by a predictable populace of thirty five million in 2020. Detection of the oil deposits in 1930s brought rapid economic growth to the Saudi Arabia. Similar to other developed countries. Saudi Arabia is deeply dependent on petroleum capitals, with the petroleum subdivision contributing closely 65% of the country Gross Domestic Product (GDP) in the 1991. Since its first financial growth strategy in 1970, the KSA has assumed importance to the fitness area. According to the Saudi establishment, the government is responsible for funding, providing and management health facilities. Ministry of Health (MOH) is the main basis of medical facilities over an extensive system of the 287 the provincial clinics and 2,257 major health centers. (Hasanov 2021).

Healthcare system

The alteration of Saudi Arabia's healthcare system over the past 60 years has been remarkable, resulting in significant improvements in the health of the Saudi people. We use proportional techniques to draw consideration to the similarities and changes in healthcare systems between the Kingdom of the Saudi Arabia and United States and their impact on selected health outcomes. Use her six components of the WHO health system as a framework for this comparison. Health outcomes selected for comparison included life expectation at birth and age 65 years, infant and motherly mortality. Overall, Saudi Arabia has achieved impressive health outcomes over the past decades. Compared to the United States, Saudi Arabia spends her one-third of U.S. healthcare costs on health care, and her fledgling HIS has significantly fewer healthcare workers. However, Saudi Arabia's life expectancy and infant mortality are now at US levels, and maternal mortality is declining. These significant improvements in health consequences can be credited to Saudi Arabia's worldwide health coverage and free admittance to medicines/diagnostic technology. (Yuchi 2021).
The Saudi Ministry of Health is privileged to deliver all essential health prevention and curative facilities to travelers during the Hajj period, regardless of population. Hajj participants have special necessities for vaccination against certain illnesses. These facilities are provided through the Ministry of Health through 24 clinics, containing 8 seasonal clinics, with an entire of 5,535 beds, containing 550 emergency beds. In addition, there are 177 health hubs for pilgrims. Enough workers are also being employed to work in these medical amenities. GCC countries, including Saudi Arabia, lack empirical evidence of financial distress in financial inclusion and public health. It is unclear how financial inclusion will improve access to medical loans and emergency funds. Financial inclusion through universal health coverage Access to essential healthcare without financial adversity is one of the key constituents of UHC, as it can lead to better health outcomes for people. Financial inclusion can help reduce economic hardship. Therefore, the many study purposes to fill a literature break by concentrating on one of KSA's major monetary difficulties. (Mohammad 2018).
Saudi Arabia's healthcare scheme was graded 26th (on view of 191 nations) through the World Health Organization (WHO), forward of greatest of its adjacent Gulf States, including United Arab Emirates. It also ranks advanced than numerous other healthcare systems in industrialized countries despite these achievements, there remains a significant challenge in providing the improved health facilities to the Kingdom's the rapidly growing populace. The health upkeep financing arrangement is subject to socioeconomic demographic trials. In most nations, personal out-of-pocket payments are the main basis of funding for health upkeep, but in some nations government incomes are used to fund and provide health care, and in some nation's Insurance helps are used as such funding causes. Similar to other Gulf Cooperation Council (GCC) associate nations, the Saudi Arabia's health financing system

is also partial by demographic features, with a great proportion of foreigners in the population and a disparity with other countries in the world. (Mohammed Khaled Al-Hanawi 2019).
Saudi Arabia has made great strides in its economy and development in recent periods. Though, the occurrence of non-communicable illnesses and their associated risk factors, such as fatness, hypertension, hypercholesterolemia, diabetes, as well as road accidents, is on the rise, putting pressure on the Saudi public health system. In Saudi Arabia, over the past 30 years he has increased per capita spending on health care, but this spending is relatively low when likened to other high-income nations in world. Financial defense is not a repetitive part of the surveillance procedure in high-income nations, however it has established considerable attention in European countries in the wake of the recent global financial crisis. Little is known about the aspects related to financial presence and monetary distress in Gulf area and the Kingdom of Saudi Arabia. (Neaime 2018).

Challenge

K.S.A face many medical trials such as increased prices, increased action requirements, and increased call for quality medical facilities. Due to the mutual factors of high population development and a rise in lifestyle connected diseases, healthcare prices are likely to rise in the pending years. Saudi Arabia's well-being care is sponsored from the management's yearly budget, the main source of which is oil revenues. The Kingdom has two main healthcare providers, the administration subdivision and the private area. Government departments provide free medical care to all Saudi people and strangers working in the community segment. The Ministry of Health (MOH) delivers 60% of all well-being facilities over 13 fitness registries in the Saudi Arabia and is administration's primary supplier. Further government health service suppliers deliver the complete health facilities to a target group, typically workers and their charges, and make up 20% of health facilities. Finances are owed straight from the Ministry of Economics through the respective offices. (Alkhamis, 2013)
The MOH is state's primary health manager and has broad controlling authority. Additionally, overall budgets are allocated to clinics through medical handbooks. Though, it has no expert over other government health departments. The fitness care system is said to be fragmented and this has led to the fragmentation of health care funding between these different institutions. These activities obtain more funding per divan than the Ministry of Health and have additional capacity even though the Ministry of Health has an excess demand for services. Also, doctors in these institutions are usually paid better than doctors in the Ministry of Health. These issues can offer the impression that other government activities provide better medical facilities than the Ministry of Health. (Alkhamis, 2013)
The private area delivers 20% of facilities in Saudi Arabia. Before the introduction of required company based health insurance (CEBHI), Saudi individuals and private companies were the main sources of private sector funding. Saudi persons will wage out of their own concise and large private businesses will offer unpaid health cover to expatriates. In Saudi Arabia, funding nationwide health care scheme is one of the biggest tests for the administration. Despite augmented budget allocations for these free facilities, real average per capita spending is predictable to decline. This is the consequence of rapid populace growth and declining administration incomes. Free healthcare leads to overuse and misuse of facilities. Patients can request facilities and transfers even when they are not needed. Public sector health workers are paid on a pay basis and have no inducement to control the costs. (Al-Hanawi Mohammed 2018).
Numerous hospitals in the Kingdom are well armed and use sophisticated events to deal with minor difficulties. The absence of consequences for the incompetent use of capitals and the propensity of doctors to deliver practical care of the highest quality might donate to the problem of overuse with indeterminate benefits. Another problem is the lack of organization among the various health departments of government and the lack of financial incentives to share costs. This reduces the likelihood of sharing devices among different amenities and medical disciplines. As a result, the kingdom is underutilized of its expensive capital goods. Increased use of Saudi Arabia's private health area may reflect displeasure with free public health care. (Al-Hanawi Mohammed 2018).
Another trial for Saudi health segment is its great reliance on foreign fitness workers, with 61% of its workforce being foreign. This leads to problems of the continuousness and high income, as the

average tenancy of foreign medical specialists is only two and three years. The Saudi Arabia survives to capitalize in instructive institutions and teaching medics overseas to decrease its reliance on foreign physicians and other medical specialists. Notwithstanding these struggles, Saudi Arabia is improbable to achieve the self-sufficiency in health workers anytime soon. There is an imbalance in health care in different parts of Saudi Arabia. Most health centers and certain clinics are located in borrowed structures that are ancient, unsuitable and do not encounter the project supplies of the model medical ability. On further hand, there are also many clinics and amenities with state-of-the-art tackle and extremely fit expert work, such as military clinics, college clinics and some private clinics. In addition, particular clinics are focused in large urban parts. People living in distant villages and small towns have difficulty retrieving these clinics. Public participation is considered essential to the success of health care reform, and public participation needs to be considered when designing health care financing systems. However, little is known about public preferences and support for fitness care reform in the Saudi Arabia.(Al-Hanawi Mohammed 2018).

The public sector delivered free medical facilities to Saudi citizens without requiring additional financial support from oil revenues. Over the past decades, the administration has positively implemented numerous development schemes. However, the government has recently faced the challenge of maintaining free medical services for its citizens. This is due to rising health care costs, declining oil business revenues, demographic changes, improving life expectancy, major shifts towards inactive lifestyles in the nation, altering disease patterns, great consumer prospects, and domestic due to poor management practices in healthcare delivery. There have been problems in given that free facilities to the nation's large number of foreign residents. In the connection, the administration has endeavored to improvement the healthcare segment in order to deliver the best likely healthcare facilities and to uphold and meet society's burdens for quality development and cost reduction. (Rahman 2019).

Literature Review

Al-Sharqawi and Abdullah believe that Saudi Arabia is characterized by its rich economic situation, but at the similar time has health difficulties unique to emerging countries. So, they indorse that KSA progress its own bespoke health assurance system rather than repetition current systems. (Al Rashidi, 2013).

It also recommends that policy makers in Saudi Arabia acquire from other nations' experiences by social health assurance and be conscious of its undesirable impact, including its negative impact on the work market. Rule makers have decided to oppose the profitable insurance model employed by the US hybrid health system because of its many negative consequences. The reason is its many negative effects, especially the combination of quality and price.(Al Rashidi, 2013).

The survey also found only two insurers with know-how in that kind of coverage. It is predictable that numerous community clinics will be transferred and will be capable to deliver health care to insured persons. The administration is considering setting up a government endowment to account the scheme. The objective of this rule alteration is to increase private subdivision contribution in healthcare market and reduce price of given that healthcare facilities to the state. It is also predictable to have an optimistic impact on admittance to healthcare, competence, competence, price, and excellence of upkeep, adoption of new skills and use of healthcare facilities.(Arabiya, 2013).

Health insurance

Waltson et al. From a business point of view, Ministry of Health hospitals argue that they are not ready for this insurance model. These hospitals lack the management skills to succeed in a competitive environment. In these facilities, doctors are dependent on management. Most of these doctors are untrained administrators, and without proper training, their role requires planned and market examination and board organization in an progressively complex and modest system.(Al-Borie, 2013).

Additionally, Ministry of Health clinics lack the administrative constructions needed to contest, such as proper planning and classy billing schemes. Despite the large population, private hospitals are

concentrated in metropolitan areas, neglecting rural areas. These parts are served through a limited amount of public clinics, which are not as particular as in urban parts. Failure to extend health facilities to these parts could pose a risk to health assurance as access to health care is unlikely to improve. (Al-Borie, 2013).

Al Naif plotted two major clinics in Riyadh to assess doctors' attitudes towards Saudi health insurance. The survey presented that doctors believed admittance to healthcare was the main problem and that fitness protection would resolve the problem. It also supposed that fitness cover would rise the part of the secluded area and increase rivalry among health care suppliers, foremost to stronger rule and improved access to health facilities. As markets tend to emphasis on spending on novelty rather than on achieving desired social consequences, the authors believe that an obliging health cover arrangement is one of the finest responses to the challenges opposite the Saudi fitness sector. (Arabiya, 2013).

Alosiami et al. led the study to inspect equity in admittance to health facilities (usually delivered within basic health assurance) across different classes using a cross-sectional study project. Therefore, we used a multistep proportional systematic random sample to randomly select 600 insured persons from four insurance classes. The survey presented that the insight of poor service excellence is a major barrier to accessing health services. This obstacle was reported more frequently than economic or logistical obstacles such as transport or obtaining work permits. (Ahmed, 2013).

The King Abdulaziz Center for National Discourse conducted a survey reflecting public opinion on compulsory health insurance. It found that 52.2% of Saudis support compulsory health insurance, in which citizens pay monthly premiums. Additionally, 62% decided that health assurance would reduce the burden on public clinics. The survey also found that about partial of Saudis without health cover seek action in the reserved region, though the other partial rely on the community health segment. It may indicate that Saudi Arabia prefers to pay for private health services compared to Saudi Arabia, citing quality and accessibility. (Al Rashidi, 2013).

It is with this higher level of funding that the Southern Saudi health system is clearly successful. Despite the administration ability to assign significant capitals to the health care system today, the biggest challenge facing the publicly funded health care system is putting it under increasing pressure and resources becoming scarce. It remains limited, prominent to a fast increase in spending and request. These challenges include rapid demographic change, aging populations, and increasing sedentary existences, increasing costs, rising user prospects, and altering disease arrangements. The current state appears unsustainable in the average to extended term, especially given the uncertainty surrounding oil values. Therefore, the future feasibility and sustainability of the present health sponsoring system is being questioned through both scientists and worldwide health administrations. To ease the financial liability, the administration introduced required employment-based health assurance (CEBHI). CEBHI shields all private segment workers and is paid through companies. Certain researchers suggest extending this to all countries, on the other hand, have recommended presenting user dues.(Elachola 2016).

Reform

The Saudi administration has introduced reforms to recover the finance and distribution of the nation health care system. The reform highlights numerous challenges in assembly the medical requirements and rising costs of the healthcare. Rising healthcare costs are due to a growing and aging population, an upsurge in the non-communicable chronic illnesses, and the price of given that current healthcare (increasing cost of diagnostic and treatment options). Uncertainties in oil prices and long-term demand in international markets are raising concerns about fiscal sustainability, and increasing the share of public spending on health upkeep. Private health coverage is understood as a means of decreasing government spending on health upkeep (Mahalik, 2017). Given that the Saudi administration reserves 67% of healthcare, apprehensions arise about monetary sustainability of present finance model. The Oil export revenues that account for above 90% of administration revenues are the chief source of backing for the public area. (Mahalik, 2017).

In the 2016, the Saudi Arabia unveiled its "Vision 2030" plan, and determined development strategy through the main goal of improving the republic's budget through 2030. Some of goals in the well-being sector is to reform the fitness financing arrangement to address present system encounters and further facilitate the transition to private fitness assurance. One of the declared goals is to ensure that all insured persons have admission to essential medical facilities without additional financial burden. The Ministry of Health is now considering implementing new improvements with a specific focus on refining the financial system and institutionalizing the health classification to guarantee the capacity and achievement of service delivery in line by Saudi Vision 2030. method health care systems are subsidized has an important influence on how health care is transported and whether care organization and delivery are reliable with what is recognized about operative care for patients and other patient groups. Persons known to have a non-communicable disease. It is recognized that health assurance, a key constituent of Saudi Arabia's healthcare financing, may impact NCD treatment in primary care. (Lee, 2020)

Approaches to the system

There are several ways to classify the healthcare system. Simply put, healthcare organizations may be publicly or privately subsidized, and may be openly or privately run. Field labelled a taxonomy of four kinds of health systems: multidimensional systems, insurance systems, health systems, and socialization systems. Pluralistic systems focus on private care and provide a great degree of independence for healthcare workers. Insurance-based systems also come with a high degree of autonomy, however the emphasis is on backing from third-party insurers. The health care system also comprises a high amount of professional independence, though it also includes state-funded facilities and care amenities. Finally, in a socialized organization, the state owns all amenities and controls the arrangement. (McPake 2013).

No republic has a fully private or public healthcare scheme. There is continuously some level of input from government. The degree to which the private sector plays a role varies from country to country, but most nations have a mixed method to health care. This is to ensure that the government maintains some control over the system and can take responsibility for public fitness. One of the chief benefits of accepting a mixed public-private organization is that it avoids the limits associated with by an all-public or all-private healthcare scheme. Additionally, a mixed method helps guarantee that ethical values of medicine are adhered to. From an financial and ethical perspective, a mixed approach recognizes that it is in national attention to take certain precautionary measures, such as providing vaccinations against diseases that could affect great segments of the populace. Furthermore, from a moral point of view, exposing the most susceptible people in society to pure market services is considered morally wrong, and could be so without state involvement. (Mastrobuono 2012).

Most republics with government-funded methods have expressed anxieties about lasting sustainability and have proposed improvements. The UK, for example, reports massive infrastructure backlogs due to inadequate funding to speech the problem. It highlights the superior problem of years of persistent funding shortfalls. However, the amount of required funding is expected to continue to increase, raising the question of how these shortfalls can be spoke under present funding preparations. The UK's NHS is one of the most distinguished examples of administration funding models. This model supporters universal, complete, and free health care facilities at the point of admission. The NHS is primarily funded by general taxes, but some of the NHS' backing comes from National Insurance (NI) assistances and public collections such as medicine, dentist and optician fees. In many social health cover systems, counting France and Germany, medical facilities are provided by a combination of public and private medical institutions. One of the limits of this kind of insurance-based scheme is that it can reduce an employee's net salary if it becomes more expensive for employers to pay premiums. In addition, the unemployed may be disadvantaged. To overwhelm this, some republics have accepted a universal coverage method that extends the social insurance method to provide health insurance to the uninsured. In real, most republics that rely heavily on private healthcare provision have had to make concessions and offer some form of social insurance rule. One

instance is the United States. Medicare was presented there to help the ageing, and then Medicaid was introduced for low-income relations.(Mastrobuono 2012).
If private assurance is an operative means of retrieving better health care, the goal of health care equity may be jeopardized in countries opting predominantly for public approaches. One of the main problems is that many people belonging to sub-socioeconomic groups are at risk of being uninsured. Even if people have insurance, the risk of widening health inequalities still exists, Phelan and others believe. This is due to a market mechanism whereby healthcare service providers try to distinguish themselves by offering higher quality facilities than their competitors. Though, these are likely to be more expensive, so only those with high incomes or better insurance can afford to buy them. An alike situation is observed in schemes where both private and social assurance are accessible. High-income earners have access to private assurance, which means they have access to higher excellence private care, while others are limited to the public arrangement. Cuff and others maintain that even private schemes have limited financial resources, and policyholders are likely to pay advanced rates than the administration in order to safe financial possessions for their premium-paying customers. Though, whether this corresponds to realism has been discussed in diverse studies examining different aspects of upkeep, making comparisons challenged. Findings from the United States show that people with private health insurance receive better quality care than those with communal insurance. Insurance businesses offer insurance at carefully calculated premiums. (Cuff K, 2012).
Hospital records structures adoption and implementation in Saudi Arabia aren't clearly approximately obtaining and putting in new technology, new hardware or new software. This technique everywhere in the international is extra approximately equipping healthcare businesses and hospitals with equipment and strategies to acquire their crucial commercial enterprise targets thru offering customers and healthcare experts with technical abilities that make new matters viable and through enticing customers into converting their behaviors to correctly use the new abilities to generate the target results. This is why coordinating the implementation of hospital huge records structures and digital scientific statistics have many huge demanding situations each from a managerial or an administrative attitude as nicely as from a scientific attitude. Planning for the paintings involved with using and controlling a paradigm shift of this importance is regularly underestimated if not certainly overlooked. Actually the organization must commit to the change with robust sponsorship, committed resources, and adoption of a bendy implementation technique that can be tailor-made to the man or woman practices at the same time as maintaining the integrity of the standardized answer and workflow mode.(McCarthy 2013).
Hasanain et al studied the development of EMR application and recognized factors and obstacles driving execution. The particular level of EMR application at the national level in the Saudi Arabia could not be strong-minded from the literature. Revisions on MOH clinics appear to have been conducted in specific capitals or regions, subsequent in slow and low adoption rates in those hospitals. Though, use of EMR in NGHA, armed and civilian hospitals seemed more progressive. Possible reasons for this difference include custom, independence in decision-making, and lesser size of the organization likened to MOH doctors. Planning a nationwide combined EMR system is one of the main urgencies of the Saudi Ministry of Health (Hasanain et 2014). In addition, Alshammari conducted a cross-sectional education with a total of 781 members from city and countryside Saudi Arabia using online review questionnaires distributed on various social media platforms. On the other hand, a significant portion (70%) of participants subjectively perceived the potential benefits of telemedicine and expressed concerns about by this tool for medical purposes. Though, 52% of them have not ever used the Ministry of Health's e-health use. Public confidence in telemedicine in the Saudi Arabia is high. It is necessary, and aligning telemedicine service delivery with native Saudi cultural and social standards will help build that trust (Alshammari, 2019).
In addition, Shaker et al. conducted a study to control doctors' perceptions of EMRS in terms of its output in order to recover its function and benefits. He was selected for a cross-sectional survey of doctors working in six different hospitals in the Makkah region. The EMRS overall rating was rated positive with 52.8%. They concluded that the mainstream rated EMRS highly, but had sure doubts about its ease of use and disruption of work processes (Shaker et al., 2015). One revision examined

patient gratification with EMR. Wari et al. directed a cross-sectional review in 2018 with an entire of 377 patients attending five main health care centers in the western district. After completing a proprietary structured questionnaire, results revealed that the introduction of EMR improved patient gratification during scientific counseling and overall gratification with various PHC facilities (Wali et al., 2020).

Three studies explored telemedicine preferences and experiences of people in different parts of Saudi Arabia. Main, Albarrak et al. accompanied cross-sectional views in four clinics. King Abdul Aziz Medical City, the King Faisal Specialized Hospital and Investigation Center. A whole of 391 doctors contributed. As a result, despite the mainstream of doctors owning two or additional of smart devices and interacting through patients through email and social media, the mainstream of physicians are now unaware of telemedicine technology. Additionally, most participants expressed a willingness to integrate telemedicine into their clinical practice. Concerns about secrecy, lack of groundwork, cost, and info and communication technology matters were identified as major obstacles to the implementation of telemedicine (Albarrak et al., 2019). Furthermore, Abolfotouh et al. showed a review from October 2016 to November 2016 at the King Abdulaziz Medical City (KAMC) in the Riyadh to determine perceptions of smartphone use and practicality in clinical settings. A cross-sectional survey was conducted with 351 Health Care Workers. Smartphone usage was 42.3%, and merely 6.1% of healthcare suppliers reported by the app constantly in their rehearsal. This percentage was measured low and was credited to poor usability.(Abolfotouh et al., 2019)

Research Methodology

This paper will critical review founded on secondary data gathered from numerous sources such as reports, articles, books, reports, papers, and previous studies on the Saudi health care system. This paper efforts to discuss, analyze and assess these efforts, with a focus on assessing the rearrangement of the health segment to facilitate the financial system.

Critical review

The community segment remains the key basis of finance for healthcare in K.S.A., accounting for nearly 70%. Private sector contributions are increasing slowly but steadily. Recent regulatory reforms have encouraged private sector involvement. As a result, the community segment's share of healthcare expenditure has fallen from 73% in the 2000 to the 70.9% in the 2009. The country face many medical trials such as increased costs, increased action requirements, and increased request for quality medical facilities. Due to the mutual issues of high populace development and a rise in lifestyle connected diseases, healthcare prices are possible to rise in the approaching years. Healthcare spending in the region is estimated to reach US$60 billion by 2025. The need for treatment, particularly for cardiovascular and diabetes connected diseases, is expected to increase in the approaching years. Improved demand for clinic beds and rising patient outlooks. (Ahmed, 2013).

A lack of medical specialists is also a major problem in the country. Medical training opportunities are very incomplete in the area and although medical institutions vary by country, he relies on expatriates who make up 40-80% of the total staff. Now, there are about 20 capable physicians in practice per 10,000 population, associated to about 27 physicians in the US and UK arrangements, leaving a lack of about 180,000 experts. Although K.S.A., numerous residents continue dissatisfied by the quality and availability of medical care available in government clinics and health center, despite significant investment in the health care arrangement. Policy makers aim to strengthen the part of the private area in health upkeep, both as the funder and as a supplier of health care. KSA healthcare system will face trials in transitioning to health insurance. In general, the Saudi government lacks the knowledge and services to shape and work a multifaceted health assurance company. The main trial, therefore, will be finding skilled professionals to set up and achieve multifaceted health assurance companies in the area. In addition, the Gulf Region lacks standardized quality standards for healthcare. (Al Zughaibi 2013)

The Saudi government is aware of the challenges it faces and is committed to improving its healthcare system to encounter future demands. Saudi Arabia has proclaimed plans to enlarge its medical

substructure. A number of worldwide companies have arrived the KSA healthcare market with advanced amenities and technology, acting independently, in partnership with the administration or as facilities directors in a variety of roles. These nations are also capitalizing in medical skill. EHealth services are predictable to type the provision of healthcare facilities more moneymaking. Medical travel is another part the Kingdom is directing through the construction of medical cities. In addition, the Ministry of the Health has introduced policies to facilitate the authorization of current health amenities through internationally documented bodies like the Joint Commission International (JCI). The move could recover quality values and encourage medical travel as well. Aggregate private segment involvement through health assurance is a significant governmental method to reducing reliance on community funding. Also, K.S.A. is expanding its educational substructure to allow more locals to arrive medical occupation, thereby reducing dependence on foreign medical professionals. (Khaliq, 2012).

In the Saudi Arabia, funding the nationwide health upkeep scheme is one of the biggest trials for the government. Despite increased inexpensive allocations for these free facilities, actual typical per capita spending is predictable to decline. It is the consequence of rapid population growth and decreasing government incomes. Free healthcare leads to overuse and misuse of facilities. Patients can request facilities and transfers even when they are not needed. Public sector health workers are paid on a salary base and have no inducement to control costs. Numerous hospitals in Kingdom of Saudi Arabia are well armed and offer advanced treatment for slight difficulties. The absence of consequences for incompetent use of capitals and the propensity of doctors to deliver care of the highest practical quality might donate to the problem of overuse through indeterminate returns. Another problem is the lack of organization among the various health departments of government and the lack of financial incentives to share costs. This reduces the option of sharing devices between different facilities and medical disciplines. As a result, expensive capital goods are underutilized in the Saudi Arabia. Increased use of the Saudi Arabia's private health segment may reflect displeasure with free public health upkeep. .(Al Rashidi, 2013).

Another trial for the Saudi well-being subdivision is its great reliance on foreign health workers, with 61% of its workforce being foreign. This leads to problems of steadiness and high income, as the average tenancy of foreign medical specialists is merely 2.3 years. The Saudi Arabia lasts to capitalize in instructive institutions and teaching physicians abroad to decrease its reliance on foreign physicians and other medical specialists. Despite these labors, Saudi Arabia is improbable to achieve self-sufficiency in health workers anytime soon. Government may need to rethink 'Saudization' rules as dependence on foreign health workforces grows. There is an inequity in healthcare in various parts of Saudi Arabia. Most health middles and some clinics are located in borrowed structures that are old, unsuitable and do not encounter the project necessities of the model medical capability.(Al Rashidi, 2013).

On the other side, there are also many clinics and services with state-of-the-art tackle and highly capable expert staff, such as armed clinics, university clinics and some private clinics. In addition, particular hospitals are focused in large urban parts. People living in distant villages and minor towns have difficulty accessing these clinics. Al Borie and Damanhouri apply SERVQUAL tool to assess inpatient gratification with facility excellence in public (MOH) and reserved clinics in five areas of Kingdom. It was a big difference in the quality of services depending on the type of hospital, such as whether it was public or private. Isolated hospitals rated higher excellence of service than community hospitals, and the changes were statistically important. Public clinics ranked worst in terms of professional health facilities, patient-hospital engagement, and staff-patient cooperation. The study did not distinguish among Saudi and non-Saudi responses. (Al-Borie, 2013).

The main upkeep model adopted by MOH has been effective in growing admittance to health care, particularly obstetric care, vaccination and endemic controller. But this model has also resulted in longer hospital waiting lists, overuse of alternative subdivisions, and improved use of private fitness facilities. Wait times for non-urgent surgeries in community clinics can range from a few months to the year. It is additional motive why the community is more aware of the private segment and other government health departments than the Ministry of Health.(Al Rashidi, 2013).

Saudi Arabia's healthcare scheme aspects several trials, and administration is captivating aggressive stages to discourse these matters. Any of major creativities that could play the key part in altering the healthcare organization is introduction of the artificial intelligence (AI) answers that will transform healthcare through increasing competence, decreasing prices and improving the feature of upkeep. In the Saudi Arabia, the AI answers could be used in numerous parts of healthcare containing analysis, cure and patient upkeep. One range where AI resolutions could have a big influence is medicinal diagnostics. AI procedures examine large totals of medical statistics to aid healthcare suppliers identify diseases precisely and rapidly. This reduces the problem on healthcare suppliers, improves diagnostic accuracy, and leads to improved patient consequences. (Alahmari , 2022)

AI resolutions can be used for create modified cure tactics for patients. Through examining patient statistics, containing hereditary statistics, AI procedures can classify the most operative action choices for separate patients. It improves patient consequences and reduces the potential for adverse proceedings. In adding to analysis and action, AI answers can also recover patient upkeep. For instance, AI-powered chatbots could aid patient's book actions, admittance medical data, and obtain personalized health information. This reduces the burden on healthcare workers and improves patient gratification. Though, the introduction of AI resolutions in the healthcare sector originates with certain trials. One of biggest trials is requirement for great value files. (Jiang 2017).

Effective training of AI algorithms requires large amounts of data, and data quality is critical to algorithm accuracy. Another trial is the essential to improve rules and policies for the usage of AI answers in the healthcare. Governments must guarantee that AI answers are used morally and clearly, and that patient confidentiality is secure. In summary, AI answers have possible to alter Saudi Arabia's healthcare system and recover the quality of patient upkeep. Though, deploying AI explanations needs careful preparation, asset in technology and substructure, and development of rules and policies. (Jiang, 2017).

In recent years, Saudi Arabia has faced a global trend of rising health care costs, along with high population development and prevalence of chronic illnesses. The government therefore recognized that the existing petroleum-based medical financing scheme was unsustainable. It can therefore be argued that the optimal use of existing health resources, a prerequisite for achieving universal health coverage as recommended by WHO, is also relevant for KSA. Applying these insights is useful for high-income countries, especially Gulf countries, with the same health financing schemes and comparable demand for health services. This recent analysis of public clinics in the Kingdom of Saudi Arabia shows great potential for more efficient use of medical resources. Policy makers should reflect on the appropriate use of resources within hospitals and reallocate resources among hospitals based on the findings. This is to ensure maximum cost effectiveness through efficient use of medical resources, and is expected to contribute greatly to the achievement of universal health insurance in Saudi Arabia. (Al-Salem 2018).

The Saudi administration has presented improvements to recover the funding and distribution of the state's health care system. The reform highlights several trials in conference the medical needs and increasing healthcare costs. Rising healthcare costs are driven by a growing and elderly population, an rise in long-lasting non-communicable diseases (NCDs), the price of given that contemporary healthcare (increasing cost of diagnostic and treatment options. In the 2016, Saudi Arabia unveiled its "Vision 2030" plan, and determined growth plan by main goal of reforming the nation's economy by 2030. The goals in the fitness sector is to reform the fitness financing system to address current system trials and further facilitate the transition to private fitness insurance. The declared goal is to guarantee that all insured persons have admittance to necessary medical facilities without additional financial burden. The MOH is now seeing implementing new improvements with a specific focus on refining the financial arrangement and institutionalizing the health system to guarantee the capacity and achievement of service delivery in link with Saudi Vision 2030. How health care systems are funded depends on what is known about how health care is brought and how the organization and distribution of care is effective for patient groups, such as those with non-communicable diseases. have a significant impact on whether or not they are consistent with It is recognized that health

insurance, an important component of Saudi Arabia's fitness care financing, may impact non-communicable chronic diseases NCD treatment in primary care. (Bittoni, 2015).
Pursuant to the Compliant Insurance Corporations Management Act, the Saudi Arabian Monetary Authority (SAMA) has controlled insurance business in Saudi Arabia as 2003. The main task of SAMA is to safeguard that insurers obey with the new rule standards and necessities. The Saudi assurance industry is characterized through intense struggle from smaller insurers for marketplace share. The major products of the Saudi insurance area include health assurance and motor insurance. Saudi Arabia's health protection segment explanations for 32% of the total assurance market. Additionally, fitness protection market contributed 55% of gross premiums written (GWP) of the assurance industry in the Saudi Arabia in the 2012. (Alkhamis, 2014).
Saudi Arabia's Cooperative Health Insurance Arrangement is being extended. Without careful planning, this method could have a devastating effect on the country's healthcare arrangement. Due to the absence of an operative insurance controlling arrangement and the very partial obliging insurance trade, the implementation of CHIS has proven to be very difficult. Ethical hazard, also recognized as access risk, is the singularity of people with National Health Insurance (NHI) abusing health facilities for they are free or merely pay the fraction of cost. A major challenge for the NHI is unsatisfactory distribution of well-being professionals among the commercial and community areas and among city and country areas. Increasing the amount of health specialists providing facilities, training and health research is one of the administration's most urgent goals in preparing for national health insurance. Lack of Saudi health workers, diversified responsibilities of the Office of Health, limited financial means, altering disease patterns, high request due to free facilities, nonappearance of national emergency administration rules, poor access to certain health amenities, national The absence of health care data systems in the country and the underutilization of e-health plans are all matters that posture trials to the health care arrangement. (M. Sohn 2016).
One of biggest difficulties to supportive protection is the absence of medical substructure, lack of public and private health facilities, and absence of health insurance companies. Additional problem is the lack of information about public health protection. In addition, there is a shortage of skilled workers in the medical field. Another issue is the overlap in insurance regulatory oversight. The National Health Insurance System (NHIS) lacks institutional infrastructure such as a regulatory framework, operational documentation and public health awareness. Explore obstacles to the application of South Africa's planned national health insurance arrangement under World Health Six buildings of the organization's healthcare system framework component. (R.V. Passchier 2017).
National Health Insurance offers a wide variety of services. These include inpatient care, outpatient upkeep, laboratory exams, analytic imaging, treatment and definite over-the-counter (OTC) medications, dental maintenance (excluding orthodontics and prosthetics), customary Chinese medication, day-trip mental well-being upkeep, partial home upkeep, and definite preventive medicine (childhood vaccinations, adult physical examinations, containing pap smears, prenatal upkeep and screening of children).Also, expensive HIV/AIDS treatment and the organ relocates are enclosed. The advantage package is much more complete than US Medicare package. "Why do people buy health insurance?" is a query numerous economists ask. This helps the purchaser avoid potential financial losses. Therefore, health protection is also desirable because it delivers the opportunity to receive medical care that would otherwise be unaffordable. (R. Alshamsan, 2017).
A reassessment of Wright's research showed that solitary confinement is a fundamental factor in the provision of protection in health care settings because it removes inequalities and encourages social parity. As the effects of national health insurance continue, fragmenting resources on the basis of high equity will achieve equality for groups in society, secure health care costs, distribute health care costs evenly, and reduce morbidity across generations. It would be advantageous to curb volatility, stabilize fiscal revenues, and improve health care costs. Diversification. Consequently, it is beneficial to have an improved influence on social standards. (Wright 2018).
NHI's implementation in Saudi Arabia is not only limited by limited management capacity and identified barriers, but many other factors will also affect NHI's future performance and achievement of high sustainability in Saudi Arabia. Moreover, these factors are of great importance when planning

the implementation of the NHI, as they have both negative and positive impacts on the implementation of the NHI and its consequences for the KSA culture and health segment. As a medical sector, the administration of National Health Insurance has a significant impact on each variable. Respondents noted that the lack of insurance businesses, administrative prices, increased managerial work and obtainability of reception beds, lack of awareness of national health insurance, lack of facilities for chronic diseases, bariatric surgery, and the creation of cosmetic surgery, among others, were among the factors affecting medical care among patients proved destructive to the equitable distribution of facilities. In addition, difficulties in accessing tertiary hospitals and the direct appointment of specialists without registration had a negative impact on national health insurance. By examining the factors highlighted, Al-Harbi, Atkins and Stanieh's study concluded that the Saudi Arabia's poor healthcare infrastructure stems from customary rehearses and a lack of management and novelty in the healthcare sector, that hinders the sector's presentation. Therefore, it affected the performance of the National Health Insurance medical institutions. (Alharbi, 2015)

In addition, lack of understanding of technical aspects, fraud within the system, lack of space for patients, absence of training, long coming up times, weak substructure of the healthcare arrangement, and unsatisfied employees of healthcare facilities. Other factors, such as low insurance coverage, contribute to the unacceptable insurance situation in Saudi Arabia. Given these considerations, Kingdom of the Saudi Arabia cannot implement National Health Coverage accurately and benefit neither society nor the administration. Governments and health authorities should therefore take precautionary measures to mitigate these problems and manage the tough substructure and management teams of Saudi Arabia's health facilities. (Alharbi, 2015).

Habbash's observations on health insurance demonstrated the importance of the NHI in developing customer service professionals and CSR to significantly reduce future health care costs. Respondents also believe that reducing the cost of medical services will benefit the Royal Government of Saudi Arabia. (Habbash 2016). In addition, Al-Harbi reiterated that the NHI could add high overhead costs in the long run, which would allow the administration to cut yearly costs. Other research by Deng, found that insurance rules are essential to part the government's monetary burden by easing the financial burden. (Alharbi 2019).

Advanced NHI facilities, managerial misconduct, unethical government practices to finance premiums, and a limited emphasis on the geographic delivery of health facilities are increasing societal pressures on insurers and reducing the benefits of implementing the NHI in Saudi Arabia. A study by Baraka and Al Saleh found fraud to be a major factor disrupting the entire healthcare process in Kingdom of Saudi Arabia. Therefore, governments and institutions need to promote ethical guidelines to effectively implement national health insurance policies in society to strengthen a culture of trust in the community, prevent problems at stake, and provide health benefits. (D.M. Barakah 2011).

Fraud and dishonesty are common in the application of national health insurance. Respondents contended that the lawful aspects of the insurance segment and the level of consciousness in Saudi civilization limited insurance welfares due to deception on the part of protected persons, insurers and health care suppliers. A study by Al-Bashrawi and Lowell found that fraud in the health sector undermines the interests of society and has a negative influence on the country's monetary situation. Thus, the government needs to fight illegal fraudulently. In the future, interviewees noted that other factors that contribute to such barriers could increase inequality and misconduct in NHI implementation, including lack of management, lack of control, lack of workplace localization, administrative mismanagement, legal matters, unequal staffing of health workers, rising tackle costs, absence of workplace localization, regional misconduct, and the NHI system. (Albashrawi 2016).

AL-Ahmadi investigated the quality of main care in Saudi Arabia by a systematic search plan. They decided that Saudi Arabia's primary health care program has significantly improved access and efficiency of customary primary health facilities such as immunization, motherly health and endemic disease control. On the other hand, there were considerable differences in the treatment of chronic diseases. For instance, only a small fraction of listed hypertensive patients seek action at primary care centers. Reasons include a lack of expert skills reflected in the misdiagnosis and poor management

of long-lasting conditions such as hypertension, asthma and psychiatric illnesses. Another issue is the lack of local teachers, with only 8% of main care hubs having adequate health schooling staff. Quality of upkeep is also compromised by lack of devotion to evidence-based rules, poor recommending practices, and unsuitable referral arrangements (mainly under-referral). This is related to poor distribution of evidence-based rules and poor career development plans, as many physicians report never taking instructive leave and others do not have admittance to the internet or papers. The excellence of interpersonal care varied widely. This was powerfully connected to language obstacles and national differences between surgeons and patients. The 80% of general practitioners are foreigners, numerous of whom do not speak Arabic, which is spoken by the mainstream of patients. In addition, physicians found it problematic to engage with certain patients due to low levels of community education, absence of compliance, and patient persistence on receiving medicine and hospital referrals. This was worsened by short consultation times, that research found averaged five minutes, well below international values. The study found a lack of operational leadership in primary upkeep. Of the technical managers responsible for overseeing health center actions, 65% had no management teaching and 85% did not have a postgraduate degree. Also, their roles were limited and their expectations were not clear. The general practitioner reported a demanding work environment and patient excess (50-60 patients in 8 hours for him). Foreign doctors report additional bases of stress including income, agreement terms and cultural changes. Saudi Arabia's health coverage experience has proven fruitful in providing expatriates with access to medical facilities. This is reflected in the increase in the number of insured persons. The health insurance market is growing rapidly every year. Prior to the implementation of this policy, it was difficult for expats to access medical services. Expats had to pay their own medical bills in the private subdivision. (Almalk 2011).

Numerous of them have low incomes and have to pay filled costs, so they refrain from medical care except in extreme crises. Though, the system is still under development face many challenges. Admittance has improved, but the quality of services provided remains poor, especially for foreigners with basic health insurance. There are financial concerns about co-payments that expatriates have to pay and this area needs further evaluation. One of the obstacles to the expansion of the health insurance system to Saudi Arabia is the lack of awareness of health insurance.

Co-operative insurance is the only type of insurance permitted in Islam. As a religious country, many citizens are unaware of the nature of health insurance in Saudi Arabia and may be reluctant to purchase it, believing it to be contrary to Islamic teachings. Efforts should therefore be made to educate the public about the cooperative health insurance system and its observance of Islamic teachings. CCHI has developed media relationships to communicate its mission, values and role. Another problem is that the Kingdom's health insurance infrastructure is fragile. CCHI is developing efforts to address these concerns. CCHI is currently working to improve electronic communication and information exchange between various parties. The recent Saudi Health Insurance Bus (SHIB) initiative, a national project to standardize parties and enable health insurance transactions to be exchanged electronically in a safe and reliable manner, will have a positive impact on the health insurance business. Expanding medical infrastructure through the construction of new hospitals and clinics will increase employment opportunities for Saudi health workers.

It has been suggested that the private sector would prefer to hire foreign health workers who have lower wages. Meanwhile, the government mandates a certain quota of Saudis for each agency. Ultimately, Saudi health workers may compete with foreign migrants for jobs. As the health insurance system expands, the need for trained health care workers and administrators will grow even more. Many Saudi universities have integrated health administration faculties into economics faculties. It is important to have a Saudi health caretaker to reduce the dependence on foreign caretakers. But it will take time to train enough Saudi health managers to meet demand. As many health care workers are currently Saudi doctors, emphasis should be placed on providing them with appropriate management training to keep up with changes in the new system. (Almalk 2011).

With the increasing prevalence of lifestyle diseases, new programs should focus on disease prevention and health promotion to improve public health. New technologies and advanced treatments are certainly needed, but a continued focus on prevention is needed to prevent disease. Endless demand

and consequent rising costs for specialized care. There seems to be a consensus that strict government regulation and oversight of the new health insurance system is necessary to ensure that it not only achieves its goals of cost reduction, but also ensures access and quality assurance of healthcare for all Saudis and expatriates.

Both CCHI and SAMA work to ensure the proper operation of cooperative health insurance schemes. Health insurance still evolving in Saudi Arabia, lessons can be learned and regulations designed accordingly. The public health relevance of this issue is based on the premise that health care reform is aimed at achieving better health outcomes for the population. As Saudi Arabia embraces this change, it will be useful to see if it has the desired impact. Health care for expatriates is also a challenge in many countries, and if Saudi Arabia can provide quality health care to its citizens, other countries in the Middle East could follow the Saudi model.(Almalk 2011).

A trial calculation of the cost reductions resulting from the introduction of the National Health Insurance in the medical field showed that most Respondents emphasized that high transparency and low corruption reduced annual health care costs and the government's financial burden. As a result, many respondents pointed out that forced labor related health insurance (CEBHI) is the most appropriate insurance policy that gives equal consideration to all members of society and has a positive impact on annual cost savings. In response to the conflicting response, some emphasized that government expenditures incurred through insurance for free medical care and other free medical care include misuse and wasteful use of medical facilities, equipment and medicines, putting increasing pressure on government budgets. (Mohammed Khaled Al-Hanawi 2022)

Citizens of Saudi Arabia are unaware of the laws and benefits of insurance policies in healthcare. Therefore, governments should appoint trainers and influencers to publicize such services to society, bring significant benefits to people in treatment facilities, and create strong awareness by encouraging them to apply for such services. In addition, educators need to inform and educate about the impact of legislative action and national health insurance on improving health quality and economic development.

It will also clarify the awareness of those who have strong religious values and are working for the benefit of society as a whole, and potentially enable them to be actively involved in the application of the National Health Assurance. Considering the limited medical facilities in the implementation of national health insurance, the relevant authorities should focus on building a strong medical infrastructure in which people follow strict regulations, have strong leadership, have staff trained, and enhance employee job satisfaction. In addition, it is necessary to ensure long-term contracts, a genuine registry of specialists, increase the profitability of the system, and clearly allocate resources within people and medical institutions. (Mohammed Khaled Al-Hanawi 2022)

Socio-political, economic and administrative factors shape a country's healthcare system. In Saudi Arabia, the government uses a variety of instruments to shift the burden onto market forces, emphasizing the effectiveness, efficiency and rationality of choice. Moreover, with continued fiscal deficits, oil price volatility and turmoil, the coronavirus pandemic and looming economic uncertainty, governments have focused on shifting some of the burden onto consumers. This contributed to inequality, limited access and inequality in the overall distribution of health services.

As the market plays a dominant role, advanced technology and facilities will be established, consumers will bear the rising costs of health care, and public health care will be left to the state to provide the service. Public Health is currently only interested in policy planning and regulation, and has declared itself responsible only for the public health aspects of health services. This means that the country wants to bear most of the load in the market. This healthcare change has not brought any positive welfares to customers. Increased use of private health facilities is associated with customer dissatisfaction, various restrictions and poor public sector management practices. Taif's study found that 77% of patients treated in private health amenities were satisfied with his level of treatment, compared to 59% in public institutions. Saudi Arabia's private sector is involved in a variety of activities connected to direct provision of health facilities, management and administration of health amenities, industrial of medical products, and funding of the health system. (Mohammed Khaled Al-Hanawi 2022)

These are approved out by numerous non-state actors. These include national and multinational corporations, non-governmental governments, non-profit organizations, and individuals working as over-all practitioners and consultants in the delivery of health facilities. There appears to be a growing reliance on private actors to deliver finance and health goods and facilities. The private sector is concerned with public sector management inefficiencies, consumer displeasure with public sector facilities, private sector organizational behavior, improved access performance, improved drug supply and receptiveness, and patient satisfaction and capacity. It is growing due to reasons such as improvements in friendliness. Though, there are many complaints about the numerous shortcomings of the private subdivision. (Mohammed Khaled Al-Hanawi 2022)

These include inadequate infrastructure without registering, poor quality gear, absence of qualified workers, poor service circumstances, high costs of action, misdiagnosis of illness, fee-based facilities, excessive maintenance, excessive medicine of medications and tests, excessive use of technology, fee sharing, income motives, negligent inpatient upkeep, poor quality and values, lack of business ethics, absence of accountability, and a general lack of expected service quality. Leadership and governance are concentrated in southern Saudi Arabia. Under the direction of the King and Crown Prince, community health establishments are responsible for strategic planning, policy making and oversight of service delivery. Saudi Arabia has a much simpler legislative process and chain of command than the United States. For instance, laws and rules are drafted through the Saudi Health Council and submitted to the Cabinet by the Ministry of Health for final endorsement by the King and Crown Prince. (Yuchi Young 2021).

In difference, U.S. leadership and supremacy is more decentralized, making the procedure of enacting and enforcing laws and rules complex. Lobbyists and advocacy groups can effect legal decision-making, which could slow progress on health care reform. Saudi Arabia's system will help transform health policy quickly. For instance, in the 1960s the Saudi government decided to cut child humanity, and the Ministry of Health directly implemented her two measures. (1) public awareness campaigns on vaccination; (2) admittance to free vaccinations for the general public through clinics and schools; These swift actions have dramatically reduced infant mortality to U.S. levels. As for the future of the health systems in both republics, the United States will continue to consider ways to expand coverage while curbing spending, while Saudi Arabia will last to increase recruitment of HIS, expanding medical personnel and facilities, particularly in rural parts. The advantage of the Saudi health scheme is its well-established policies of universal attention and efficient governance. When it comes to specific health outcomes, Saudi Arabia is on par with established industrialized nations. (Yuchi Young 2021).

This examination shows the impact of dramatic vicissitudes in healthcare funding and delivery on key population fitness indicators such as life expectation, infant mortality and maternal humanity. Future investigation needs to explore the extent to which US health insurance reform was based on narrowing access inequalities to healthcare, which may lead to lower health statistics in the US compared to Saudi Arabia. The Saudi government embraces e-health as an enabler and transformative for the country's health. One of the Saudi government's efforts is to fund medical amenities that cannot have enough money e-health technology. The administration also delivers educational programs to teach medical specialists about e-health and its possible impact on the healthcare manufacturing. As such, the Saudi administration is working to introduce and use e-health in various health facilities across the country. (Yuchi Young 2021).

While the government is pushing to introduce e-health, it's not being implemented as quickly as expected by medical institutions. In some cases, implementations fail because healthcare specialists lack the skills and information necessary to advance skill (Zaman et al., 2018). Additionally, certain healthcare institutions lack the capitals to deploy e-health technology. These tests must be overcome for the fruitful introduction of e-health in this republic Vision for 2030. Because the use of e-health in the public health sector can advance healthcare in Saudi Arabia. EHealth increases patient literacy by enabling them to share information with medical professionals, while giving them control over the health issues that affect them. EHealth improves the convenience and distribution of healthcare

facilities to patients through skills such as telemedicine. In addition, it will allow for a more efficient design of Saudi Arabia's public health system.

In this setting, this review article attempts to current the current state of e-health in Saudi Arabia. Saudi Arabia recognizes the welfares of e-health and fitness informatics in the delivery of health services. She does everything to ensure that technology is well implemented in various fields. In the Saudi Arabia, electronic health/medical informatics methods such as Computerized Supplier Order Entry (CPOE), Scientific Decision Support Schemes (CDSS), Electronic Medical Registers (EMR), and Electric Medical Records (EHR) have improved the health care workforce. Improved interaction between patients and healthcare professionals. Patients and access to patient health information and records. (Zaman et al., 2018)

This is important as it reduces costs associated with healthcare. Eliminate duplication of healthcare facilities provided and improve the quality of healthcare facilities delivered to patients. Similarly, Saudi Arabia has introduced mobile health and telemedicine approaches to improve the accessibility of medical services. Since Saudi Arabia began to introduce this technology, the availability of health services has improved. In particular, mobile medicine and telemedicine stand out in the ways in which health services are delivered to vulnerable populations such as the elderly in the country. (Zaman et al., 2018)

Saudi Arabia has also introduced electronic health/health informatics into its public health system to enhance surveillance and surveillance of public health threats in the country. The good news is that the integration of e-health/health informatics improves cooperation between different health departments and health professionals. Data generated from these areas will help create evidence-based rehearses that are already reproduced in the rules and programs adopted by countries. This means that the eHealth/Medical informatics strategy, when applied to the Saudi context, will actively contribute to the growth of data-driven and operational health rules and agendas. Buntin et al. (2011) found that health data technology improved the performance of various health care subsectors in the nation. Because e-health and medical informatics are data-driven, their use in the healthcare systems can make large amounts of statistics. (Buntin et al. 2011)

This statistics can be used to create critical health data that serves as a valuable resource in policies and health programs in developing countries. So, e-health and fitness informatics have been important to this republic in many habits. These are factors driving the medical development of this country.

E-Health and Medical Informatics Help Governments Meet Health Goals and Improve Quality of Healthcare Services. Based on World Health Organization (WHO) references, many nations have attempted to introduce e-health into their healthcare schemes to recover healthcare delivery (Al-Rayes et al., 2019). impact of eHealth has been noted in various countries where eHealth has been introduced, with mixed results. A similar mixed trend is seen in Saudi Arabia. Various studies are being conducted in Saudi Arabia to assess the e-health situation in the country. Saudi Arabia has great concerns about the proper use of eHealth facilities. The application of e-health and electronic information systems has previously started in many hospitals and governments. However, eHealth services have lagged behind in MOH organizations. Hospital managers and investigators are beginning to use electronic databases to analyze the availability, quality and impact of healthcare. Numerous studies have investigated the correctness of electric databases created for over-all administrative drives.(Al-Rayes et al., 2019).

For example, Youssef and Alharthi slow the correctness of an electric database in a large education hospital in the Eastern Area of Saudi Arabia, capturing the 17 comorbidities that make up the Charlson Directory, and documenting them in the paper medical records by health care suppliers. Researchers arbitrarily selected statistics from 1,019 hospitalized patients and scored for matches with related paper diagrams. The study concludes that electronic annals have a bright upcoming in health care (Youssef and Alharthi 2013).

Almaiman et al. showed research The Realm of Saudi Arabia spoke about the implementation of Health Data Technology (HIT) in Primary Fitness Centers (PHCCs). Data collection includes interviews with key stakeholders and scientific searches using a set of keywords. Data show an increase in the use of health data technology in Saudi PHCCs. With the numerous steps being taken

to inform and function the eHealth information scheme in the KSA, there is also a rising need to deliberate viable replacements to the provision of eHealth facilities. In particular, it concerns removing barriers to the usage of EHIS in PHCC (Almaiman et al., 2014a).

Two studies evaluated the use of electronic medical (e-health) services from different professional perspectives and identified barriers to e-health system adoption in Saudi Arabia. Arslame et al. discussed the role of eHealth in Saudi Arabia from a health informatics perspective. By a case study method and thematic investigation of participant statistics, data collection incorporated interviews with nine major health data suppliers in Saudi Arabia. This result suggests that there are differences in his eHealth adoption among Saudi medical institutions. Two main suggestions from participants were the establishment of an independent national eHealth body and the development of a coherent strategy for implementing Saudi eHealth initiatives (Alsulame et al., 2015).

Zaman et al. showed a randomized study in three major clinics in the Makkah region. The total amount of examples collected for this revision was 51. They belong to the managerial and medical workforce of the hospital and are the personnel accountable for the day-to-day operations of providing medical amenities to patients. Results showed that all three clinics used e-health in different ways. They also identified major barriers to the use of these systems, such as the cost and capabilities of such advanced data management methods, and the lack of technical and expert expertise of clinic staff (Zaman et al., 2018).

Several revisions have explored the relationship between proper application of e-health and influencing Saudi citizens to self-manage their diabetes, as well as assisting stakeholders in providing the best possible support for people with diabetes. The possibility of building a successful framework for developing a knowledge management system that supports Citizens of Saudi Arabia and potential obstacles they may encounter.

Almuayqir et al. explored and categorized barriers to the e-health in Saudi Arabia from the perspective of three investors. Statistics were collected using a survey. An examination of the survey found that the public and medical experts believe poor connectivity in Saudi Arabia's Hospital Information System (HIS) is the main reason for e-health failures, while IT experts say the lack of drug safety is the main reason. It turned out to be the cause. The biggest obstacles lead to such failures (Almuayqil et al., 2016).

Arsulame et al. investigated e-health situation in Saudi Arabia. The results provided evidence that e-health is on the rise in Saudi Arabia, with many businesses and singular agendas adopting e-health submissions. Though, available investigation on eHealth in Saudi Arabia is still incomplete. Data are incomplete to a small number of administrations and do not reproduce the possibility and depth of current and future use of eHealth (Arsulame et al., 2016). In the same setting, Alshahrani et al. conclude that the e-health subdivision in Saudi Arabia shows marks of steady growth, both in terms of books and perceptions of its importance. However, the lack of eHealth research from the viewpoint of health care bosses and the limited research to a insufficient geographic areas were recognized as knowledge breaches (Alshahrani et al., 2019).

Noor therefore underscores this deduction in his study, which includes statistics on 508 hospital bed numbers, authorization status by the Central Board for Authorization of Healthcare Organizations (CBAHI), and utilization of 45 e-health services registered by region. We collected data on hospitals in Social groups and administrative associations. Of the 508 clinics, Riyadh and Makkah had more hospitals than any other city or region. This change is credited to the detail that these towns are the most densely populated and important business districts in the Kingdom. While the adoption and utilization of his e-health services has increased in Saudi Arabia, it has become clear that the adoption rate in various Saudi cities is still notable. So, references for future e-health implementations crossways Saudi Arabia may be extended to distant and sparsely populated parts of Saudi Arabia (Noor, 2019).

Altuwaijri (2011) shown a qualitative education describing the experiences of the Office of National Health and Security (MNGHA) in applying EHRs. MNGHA first formulated a dream to deploy her EHR in the three areas of Saudi Arabia. MNGHA management then recognized a plan committee

and project group to integrate the outline. The planning and implementation process took around ten years and was awarded the Middle East Fineness Award in 2010 (Altuwaijri, 2011).
Bar et al. investigated the use of electric medical registers in government-affiliated clinics in Saudi Arabia. Statistics were collected through an online survey. Only 3 out of 19 public clinics (15.8%) used an EHR. Some IT administrator faces the challenge of implementing his EHR in the hospital. Some doctors and nurses are uncooperative with her use of the EHR.
Similarly, Aldosari (2014) studied the implementation of EHR arrangement in Riyadh, Saudi Arabia. Defendants from 22 hospitals were asked about stages of application, upkeep and development of their EHR organization implementation. 37 points were scored on a 3-point readiness/done scale. Determinants measured comprised hospital size, level of upkeep, possession, and composition of the EHR arrangement development side. Eleven of the hospitals had EHR systems fully operational, eight had arrangements in development, and 3 had not yet implemented systems. Sixteen diverse systems were used in all 19 clinics that took over. Large hospital-to-hospital differences in adoption affect policymaking and intervention funding (Aldosari, 2014).
Two revisions investigated the acceptance of his EHR system between both Saudi health care suppliers and customers and the factors that affect adoption and receipt of such arrangements. For healthcare suppliers, Al-Rayes et al. performed a quantitative cross-sectional analysis. The study is founded on a paper survey conducted on a group of 213 doctors. Overall, 133 (62%) of them used an EHR and the 80 (38%) did not use an EHR. We found that users and non-users of EHR systems differed significantly due to many factors, including: In terms of perceived usefulness, perceived usability, social influence, and confrontation to change. Furthermore, age, work history, and medicinal specialization are powerfully associated with a physician's usage of the EHR arrangement (Al-Rayes et al., 2019).
Alsahafi et al. conducted a study evaluating the capabilities of eHealth for healthcare consumers. Data were collected by questionnaire survey, which yielded 794 authoritative responses. The results indicate a low level of understanding among the Saudi public for the country-wide rollout of a combined ePHR method, highlighting the requirement to promote wider consciousness of the system and prove its practicality. (Alsahafi et al., 2020). Six objects and studies deliberated the adoption, adoption and acceptance of electronic medical records (EMR) among both healthcare professionals and patients in the Saudi Arabia. The revisions showed that while EMR is being introduced into hospitals in Saudi Arabia, its adoption and acceptance is slow and low and faced numerous obstacles (Alsahafi et al., 2020)
As can be seen from the results, many issues affect the acceptance of eHealth in Saudi Arabia. Thus, some of the issues pointed out by Almuayqil et al. (2016) National, personnel and bureaucratic matters are the biggest obstacles to e-health adoption. Cultural obstacles in the country also make it difficult to raise her eHealth consciousness, particularly between women and those living in remote parts.
Additionally, bureaucracy often delays e-health related projects. When hiring a new medical informatics professional, it can be difficult to get top management approval. These results are largely related to those reported in other readings, such as the study of Almigbal et al. Who discovered this to be the case Participants with poor health awareness are more likely to adopt diabetes self-management strategies, probably because they understand the risk of diabetic problems (Almigbal et al., 2019). Cruz et al. presented that in most hospitals in the country he showed an unorganized eHealth planning process. The study also hypothesizes that certain clinics and other medical institutions in the republic are fronting funding problems despite the large budget allocations for e-health services. (Cruz et al., 2018).
Regarding dental informatics, AlNasser et al. (2014) showed a study to measure the adoption of modern dental informatics in the Saudi Arabia and to identify the problems facing the expansion of dental informatics in Saudi Arabia. The results showed that digital radiography/analysis and management used common technology. Dental education uses web-based learning stages, computer-assisted assessment, and digital technology to teach scientific skills. Absence of IT

infrastructure/provision, community acceptance, and monetary costs are issues opposite dental informatics in Saudi Arabia (Al-Nasseret al., 2014).
Likewise, Almaiman et al. led a study that provided an overview of Electronic Dental Records (EDR) program being implemented in clinics of the Saudi National Guard (MNGHA) Department of Health. Various evidence has been collated, including interviews with leading computer scientists and dentists. Study convoluted 20 people, each questioned for 30-45 minutes. The consequences are reliable with previous answers, indicating low adherence to electric dental records and low acceptance of the system. Clinic staff were reluctant to use technology and needed computer skills. Lastly, respondents identified convenience problems, lack of administrative development policies, and absence of attention in using the program (Almaiman et al., 2014b). In addition, Sayed (2019) conducted a survey that provided data on dentist demographics, electronic health record (EHR) maintenance, and effectiveness. Data were collected from her 270 participants in the five areas in Saudi Arabia. Privacy matters, staff obedience, and cost have been labelled as factors influencing providers' outlooks toward EHR implementation (Sayed, 2019).
There are several key areas in eHealth that impact healthcare outcomes. One of the key areas is patient access and information sharing. Rendering to the answers of Al-Rayes et al. (2019), e-health is predictable to recover patient data storing and admittance. The second part of focus in eHealth is patient interaction and observing. The use of e-health is expected to improve interaction among patients and the healthcare workers.
It can also be used efficiently for watching. Healthcare competence is also a key area of his eHealth. This is for e-health is predictable to accelerate the rapidity at which medical facilities are transported to patients in different sites (Almalki et al., 2011). Similarly, e-health is predictable to improve healthcare security as it facilitates the operational usage of data in patient care. Though, these key areas are predictable to alter the healthcare system through the deployment of e-health. (Sayed, 2019).
Regarding teledermatology, the Kaliyadan et al. assessed the use of 4G smartphones in mobile teledermatology. The dermatologist appropriated a picture of the skin by a mobile phone and made a personal analysis. The descriptions were sent to the additional dermatologist, who watched them on an alike cell phone and made their own analysis for contrast. Photos were taken and distributed merely afterward patients gave written agreement. A whole of 166 patients participated in the education. A patient gratification questionnaire was given to all patient. Maximum respondents were very pleased by teledermatology. Though, 23 patients (14%) refused to have their skin cuts photographed. Denial of photography, which is not a unique issue in teledermatology, should be considered when developing teledermatology protocols that are more broadly applicable in regions like Middle East (Kaliyadan et al., 2013).
Private health insurance companies in Saudi Arabia usually make payments using the FFS payment method. At first glance, this payment mechanism is simple and has certain advantages, such as expediting service delivery and giving doctors incentives to treat more patients. However, fee structures are unregulated and encouraging treatment can lead to over-provision and inefficiency, resulting in high healthcare costs. Physicians may ignore simple and effective treatments because they are less rewarding and take longer to administer. The majority of public hospitals employ a salary scale model to reward medical professionals. (Kaliyadan et al., 2013).
A payroll model can better control the economic impact of health care professional costs, but health care professionals have no incentive to treat optimal numbers of patients, resulting in lower productivity for individual professionals. There are mixed salary models and other models Per Person Fee. It should be considered whenever the funding model changes. The need for policymakers to consider these other options is supported by respondents to our survey and others. According to the literature, the following criteria are important when deciding on new payment or reimbursement models: providing accessible, safe and effective care. Ensure efficient medical care to curb unnecessary consumption. Compensation based on perceived quality of care. Considering the cost, time and complexity of treating each patient. Reduced incentives for physicians to perform expensive and ineffective diagnostic tests. Promoting and Enhancing Accountability and Adequacy of Care (Friedberg, 2015)

Discussion

All health policies should aim to improve well-being and achieve fairness and productivity within policy limits. Some countries are preparing significant improvements to their health systems to meet these goals. Healthcare reform is inherently hampered by conflicting and not always reconcilable priorities. For example, providing affordable health care can conflict with the goal of quality care. Given the great diversity among countries in social standards, national trends, degree of social and economic growth, and the inherent difficulties in formulating and implementing reforms, there is an absence of common agreement on the concept of health reporting. Against this background, WHO identifies changes that intentionally, sustainably and systematically transform one or more main health subsystems into systemic transformational mechanisms. (Friedberg, 2015)

Key welfares of NHI application in KSA include reduced morbidity and increased health professional satisfaction due to the introduction of complementary capabilities and progressive tools within the clinic that increase treatment efficiency and value. Moreover, Saudi Arabia has a large gap for national health insurance due to the inequality of the majority of the population. They don't have enough resources to sustain themselves over time, and poverty rates are high, leaving them lacking medical facilities when they need them. The right method is therefore vital to minimizing lack and promoting a system of health facilities in society to connect persons and health administrations on one stage so that they can enjoy quality facilities and healthy well-being from all registered institutions. (Kaliyadan et al., 2013).

Seeing the influence of the NHI on the nationwide budget, employment in NHI will limit spending in the health sector and help government workers achieve the consequences envisaged in the cheap, thus promoting national economic growth. Important to with medical insurance, hospitals can purchase various tools to help operate on their patients. In addition, state investment in various projects outside the health sector has also increased.

In the future, hospitals will be less burdened, financed better, and a spirit of cooperation and solidarity between social roles will be promoted. Moreover, for low-income people, it is worth using such services for treatment of diseases and routine check-ups in low-paid and high-quality clinics and hospitals. Saudi Arabia's health financing system faces trials common to many nations. Rising prices due to changing demographics, inequalities, aging populations, rising non-communicable diseases, rising prices of health facilities, and increased community demand for better health care are challenges facing the public segment.

There are concerns that current approaches, which are largely state-financed, will not allow existing public revenues to meet increased demand. The planned solution to this is to move to a mainly private health coverage model, but the facts are indistinct. From the viewpoint of Non Communicable Diseases, perhaps the largest determinants of healthcare demand, such a method poses risks in terms of both excellence of care, treatment and price factors. (Hazazi, 2022)

The biggest problems in implementing national health cover in Saudi Arabia are absence of consciousness in Saudi society, absence of scarce and hereditary specialties, absence of technical manpower, lack of capable cadres, lack of sympathetic of minority assurance, and lack of information about the welfares of health amenities. Respondents emphasized potential obstacles in the insurance industry, including the lack of qualified domestic professionals, the Saudi public's awareness of insurance, price differentials, the number of insurers, and the rise of ignorant judicial authorities. (Hazazi, 2022)

The Ministry of Health has taken many steps towards reforming the Saudi health upkeep system, but many trials continue. These relay to health workers, funding and spending, altering disease arrangements, access to health facilities, introduction of supportive health insurance systems, transfer of public clinics, use of electric health strategies (e-health), and growth of national fitness info systems. Saudi Arabia's fitness care arrangement is challenged through a lack of local health specialists such as doctors, fosters and chemists. The mainstream of healthcare workers are foreigners, leading to high income and staff unpredictability. The aptitude to develop and apply applied plans to recall and appeal more Saudis to the medicinal and fitness care occupations, especially treatment, is

a clear importance in order to effectively improvement the Saudi health care arrangement. Saudi government has made many efforts to educate and train Saudis for health workers. (Hazazi, 2022)
Efforts to found such universities are consistent with training agendas primarily aimed at replacing foreign workers with qualified Saudis in all fields, counting health care. Increased budget allocations for exercise and allowances have given many Ministry of Health staff the opportunity to continue studying abroad. The strategy is expected to recover the skills of the present workforce, improve the quality of upkeep, and reduce turnover among healthcare workers. Though, these efforts may not be sufficient to solve the trials. Saudi Arabia's fitness workers' share of the Department of Health's workforce is predictable to decline in the upcoming as the growth of health amenities across the nation means a further shortage of scarce resources. The Ministry of Health needs to work with governments and the private sector to strengthen more truthful planning and long-term plans. A good instance of such collaboration is the King Abdullah International Scholarship Package recognized through the Ministry of Higher Teaching. At this phase, importance was given to health professionals, counting medicine, treatment, chemists and other fitness specialties. But more medical schools and preparation agendas must to be recognized across the nation. New rules and guidelines are urgently needed to develop and reorder medical staff capitals through the Ministry of Health. (Hazazi, 2022)
The public fitness sector is primarily funded, functioned, managed, monitored and controlled by the Ministry of Health. Unless serious and well-thought-out plans are put in place to separate these multiple roles, this management model may continue to meet people's health needs well into the future. Potential solutions include strengthening the powers of regional executives, applying obliging health cover schemes, and promoting the transfer of public clinics.
In response to increasing pressure on the Ministry of Health, local departments were given more autonomy over planning, hiring professionals, formulating contracts with fitness care suppliers (operating businesses), and limited monetary discretion. It has been optional that the operative of regional executives is hampered by the absence of separate budget and expenditure power. Spending on most activities requires Ministry of Health approval, which undermines the autonomy of local boards and prevents operative decision-making.
Regarding hospital independence, the Office of Health has strained many strategies over the past decades to recover the management of public clinics, containing direct management through the Ministry of Health, collaboration with other administrations such as the Netherlands, Germany and Thailand, incomplete management by medical companies, complete management by medical companies, and hospital autonomy. Considering the pros and cons of these methods, the Ministry of Health has consistent an independent clinic system for 31 public clinics in different areas. (Friedberg, 2015)
The Independent Hospital System for Public Clinics aims to increase effectiveness in presentation in both medical and administrative roles, achieve monetary and managerial flexibility by accepting direct economic strategies, apply quality insurance agendas, and shorten the procedure of contracting capable medical specialists. In 2009, the Ministry of Health enacted new rules for self-operated public clinics to safeguard high standards of management performs and recover the quality of facilities provided. Increasing hospital independence will ease the transition to full transfer of Saudi Arabia's public clinics. This will give public clinics more knowledge in managing budgets, quality of care and staff. Funding health services is a key issue for the Office of Health.
All spending on public health services is paid for by the state, and the services are free, putting significant cost pressures on states, especially given rapid population growth, high prices for new technologies, and growing public awareness of health and disease. Funding health services is a key issue for the Ministry of Health. Because all spending on public health services is paid for by the state and the services are free, states are under significant cost pressures, especially given rapid population growth, high prices for new technologies, and growing public awareness of health and disease.
There are growing concerns about the underutilization of eHealth methods in Saudi Arabia. Many hospitals and administrations, such as King Faisal Specialty Hospital, Investigation Canter National Guard Well-being Service, Military Medical Facilities, and University Hospitals, have already begun implementing e-health and electric information systems. The introduction of e-health arrangements

in MOH facilities has been slow, but there are many information systems in local offices and central clinics. Inappropriately, these information systems are not linked to each other, nor to other secluded or professional medical institutions. (Friedberg, 2015)

To improve e-health services in the public segment, MOH has allocated a budget of SR4 billion and implemented a four-year development program (2008-2011). In addition, the Saudi Medical Information Suggestion has held a sequence of e-health sessions, highlighting the importance of e-health in improving the quality of health care, and considering necessary strategies, policies, applications and infrastructure. To improve the usage of e-health plans and establish a complete national health information system, there is a need to strengthen coordination among various health care providers. A high degree of coordination with other relevant departments must be achieved to deliver the necessary infrastructure such as internet and telephone facilities. To address the trials of Saudi Arabia's health system and improve the quality of health facilities, the Ministry of Health has established a National Plan on Health Facilities. (Mohammed Khaled Al-Hanawi 2019).

The focus is on diversifying funding causes. Development of data systems. The growth of human resources. Enable the role of management and oversight over health services for the Ministry of Health. Encourage the private sector to establish its position in the provision of health facilities. Improve the quality of defensive, curative and rehabilitative upkeep and to evenly distribute medical services to all areas.

The Nationwide Health Services Strategy is to be applied by the Ministry of Health in collaboration with other fitness service suppliers and overseen by the Health Services Council. A period of 20 years has been set to achieve the goals of this strategy. With continued consideration and support from the administration, Saudi Arabia's health facilities have evolved significantly in new years across all levels of main, secondary and tertiary care. As a result, the health status of the Saudi population has enhanced significantly. MOH has presented many improvements to its facilities, especially PHC. Notwithstanding these attainments, health facilities, especially public sector health facilities, still face many trials. (Mohammed Khaled Al-Hanawi 2019).

These include: Separation of multiple MOH roles (financing, delivery, administration and oversight of health care). Diversification of funding sources. Implementation of supportive health protection, privatization of public clinics, effective treatment of chronic diseases. Develop practical guidelines for national disasters. Establishment of an well-organized national medical data system and overview of e-health.

To speech these challenges and further progress the health system situation in Saudi Arabia, the Office of Health and other relevant departments need to organize their efforts to implement and safeguard the success of the new health plan. There has been a main shift in rule in Saudi Arabia recently, with the government taking a very rigorous approach to balancing spending and budget deficits. The different Vision 2030 accepted in 2016 attests to the new steps the government has taken in all areas. The healthcare segment is also undergoing a major change in its approach and expectations. As part of efforts to develop human resources in healthcare, the government has established a number of plans, guidelines and standards to ensure efficiency for all investors. Strategic objectives, KPIs and KPTs have been published that give a very clear way to the healthcare subdivision. (Mohammed Khaled Al-Hanawi 2019).

The government aims to generate R4 billion over the next four years (2016-2020) from the use of facilities by the private segment. By 2020, private sector participation in health spending is expected to increase by 10% (25-35%). The government has taken a number of steps that will certainly lead to greater engagement of the Saudi staff in the health area. NPT 2020 obviously defines the areas of education and training, career preparation and human resource administration for health professionals. The long-felt essential to combat the country's rising youth joblessness rate is sure to be answered in these plans. Second, the optimal transition from the current one-third Saudi-foreign labor force ratio to the projected two-thirds by 2030 must be carefully implemented through sustainable policy approaches to turn challenges into opportunities. There is great potential to involve educated Saudi youth in the health sector. (Mohammad F. Alharb (2018).

The part of the private segment in creating more medical, treatment and dental colleges and other professional educational organizations is both a challenge and an chance for pioneers in this field. The need for health professionals has grown tremendously, and government-private sector partnerships will accelerate this procedure by providing more knowledge and growth opportunities to meet the growing need for health professionals. The part of the private segment in staff training therefore also requirements to be strengthened and redefined in the new setting, particularly in long-term upkeep, rehabilitation facilities, day clinics and secondary upkeep hospitals where the difficulty of service delivery is partial.

Rather than increasing funding, hospital couches, technology and medical care, it is necessary to properly build capacity for human resource development alongside aggressive rule regulation. It is also significant to ensure that upcoming investments in the health sector meet local health workforce development needs. Introducing a public-private partnership model will be a real challenge in the assortment of future organizations for sharing resources, containing human assets. Though, the policy way set out in the new idea is an overarching goal of creating synergies between all stakeholders, diversifying the economy and allowing the private sector to play a better role. It is intended to facilitate the provision of the impetus necessary to achieve Time will tell how credible and consistent this role is with new initiatives. (Mohammad F. Alharb 2018).

Funding mechanisms must fund and sell incorporated care to interact extra correctly with number one, secondary, and/or tertiary prevention of NCDs. The cap potential of PHI to interact in NCDs prevention is increasing , now no longer simplest in programmers that specialize in number one and secondary prevention, however additionally in self-management, which performs an essential position in correctly treating persistent ailments to save you the recurrence of signs or consequences Saudi Arabia has advanced a totally a success excessive insurance number one care quarter and it's far critical this isn't misplaced in a personal medical insurance model. Good integration of offerings way that sufferers with NCDs may be correctly and properly controlled with inside the enormously decrease price putting of number one care even as preserving ease of get entry to better stage and extra highly-priced care while required.

There must be an incorporated complete character digital fitness file this is on hand to clinicians and sufferers anywhere it's far wished with inside the fitness system, this is, throughout public and personal providers. This will help with continuity of care, assists tracking excellent of care, and enables to lessen pointless duplicative servicing. Insured offerings must encompass the entire variety of medical care required through sufferers with NCDs, which include allied fitness offerings, inclusive of dietetics, in addition to assisting affected person engagement in self-care thru affected person schooling and network assist programs. (Mohammed Khaled Al-Hanawi 2019).

Result

Healthcare funding in Saudi Arabia has improved significantly at all levels of healthcare over the past three years. Saudi Arabia, like some other countries, has three key characteristics of her that affect healthcare financing. First, due to the large number of expatriates relative to the country's population, Saudi Arabia employs different methods of monitoring expatriate medical spending. High government revenues and correspondingly high government spending on health services and large government revenues. Saudi Arabia is one of the few GCC (Gulf Council) countries to change its private healthcare system and limit foreigners' access to government services. If CEBHI proves successful in its programs to improve access to health care for expatriates, it could be adopted by other GCC countries, especially since most of the GCC countries are now exploring various mechanisms to fund health services.

Several communal and economic issues have led the Saudi administration to make determined efforts to expand the private health care arrangement. These factors contain economic improvements, public-private companies, a growing middle lesson, and demand for healthier health care facing the public segment, and macroeconomic strength and liberalization. Consecutive governments sustained to implement rules that encouraged private sector growth, but some shortcomings in private sector health care became apparent. In addition to failing to ensure fairness, cost-effectiveness and

answerability in service delivery, the private health sector has violated standards of medical practice, increasing the likelihood of poor patient consequences.
The public segment plays a key role in funding and bringing universal health care. Governments should so introduce administrative, managerial, governance and administrative reforms to ensure quality health care for all. A growing private health area is no answer for Saudi Arabia's below-average health services. On the other side, it also leads to higher prices, widening inequalities and general consumer displeasure. Timely government intervention is critical to alleviate the negative impacts of this development. Though, the shortcomings of the public sector in terms of quality service delivery, patient care and clinical efficiency can only be alleviated through strong political will-driven action.
Key perspectives of e-health. It should be looked into to see what impact it will have on the Saudi healthcare arrangement. The current writings on electronic health in Saudi Arabia also does not adequately address the exchange of health data. One of the causes e-health is becoming mainstream in the healthcare is to facilitate the conversation of health-related data between various investors. Preceding research has not adequately assessed this point, and this suggests that upcoming research requirements to be directed toward accepting how eHealth impacts the exchange of health information among stakeholders. Future research on eHealth in Saudi Arabia should address these areas to provide a comprehensive view of how eHealth is impacting the Saudi healthcare system. Such assessments also help define implementation strategies for promoting e-health innovation within the nation.
As the welfares of eHealth endure to spread in numerous parts of the world, the healthcare specialists and institutions will also drive acceptance of eHealth revolutions. Therefore, the upcoming e-health coverage in Kingdom is expected to shelter various clinical application parts. It is very important to note that eHealth adoption in general faces several challenges, according to numerous studies. For example, we know that bureaucratic, personnel, and cultural issues tend to be significant barriers to eHealth adoption and implementation.
A closer look at the research revealed a lack of awareness of the use of eHealth, which is a major difficult for healthcare. In general, if these trials can be efficiently addressed, it will facilitate the adoption of eHealth in various healthcare areas transversely the country. The first step is to ensure that awareness of the use of eHealth spreads between both patients and the healthcare professionals. It is very significant to note that it is also important to safeguard that staff and employee skills are developed and upgraded to guarantee that the use of eHealth can be supported. These interventions help implement eHealth

Conclusion and Recommendation

Saudi Arabia faces the trial of given that quality healthcare to its rapidly rising population. Funding for healthcare is becoming an increasing challenge for administrations as prices last to rise and occurrence of existence connected diseases increases. Overall, Saudi Arabia aims to expand it's the healthcare infrastructure and increase private segment involvement in both funding and the healthcare delivery. Saudi Arabia is descended from GCC. In detail, Saudi Arabia was the main GCC country to present compulsory private health assurance for expats. The paramount step in healthcare improvement was the application of the Supportive Health Insurance Action of 2004.
The transition from the National Health Assurance system to the National Fitness Insurance system was calculated in three phases. The first phase has come into force, making employer-based well-being insurance obligatory in the UK. All expatriates residing in UK are obligatory to have health reporting in order to be able to matter or reintroduce the Residence Certificate (Iqama). Policy creators are still knowledge the educations of phase one and considering how best to approach national health insurance. (Rashad 2014).
Saudi Arabia's health insurance experience helped provide admittance to medical facilities for expatriates. It is reflected in the amount of insured people increasing year by year and the fast development of health coverage market. Prior to the application of this rule, it was difficult for expats to access medical services. Expats had to pay their own medical bills in the private segment.

Numerous of them are low-income and have to wage full out-of-pocket costs, so they will postpone seeking cure except in extreme crises. Though, the arrangement is still in development and faces many trials. Admittance has improved, but the quality of facilities delivered remains poor, particularly for foreigners with basic health coverage. There are monetary concerns about co-payments that expatriates have to wage and this part needs further assessment. (Rashad 2014).

One of the problems to the expansion of the health coverage system to Saudi Arabia is lack of consciousness of health coverage. Co-operative insurance is the only kind of insurance permitted in the Islam. As a spiritual country, numerous citizens may be unaware of the countryside of health coverage in Saudi Arabia and may be unwilling to purchase it, believing it to be contrary to Islamic teachings. (Rashad 2014).

Efforts should therefore be made to teach the public about the obliging health insurance system and its observance of Islamic teachings. CCHI has developed media relationships to communicate its mission, values and role. Expanding medical infrastructure through the construction of new clinics and hospitals will increase employment chances for Saudi fitness workers. It has been recommended that the private segment would favor to hire foreign health workers who have lower salaries. Meanwhile, the government obliges each facility to accept a certain number of Saudis. Ultimately, Saudi health workers may compete with foreign migrants for the jobs.

As the well-being insurance system enlarges, the need for trained health care workers and administrators will grow even more. Many Saudi universities have integrated health administration departments into economics departments. It is significant to have a Saudi health caretaker to reduce the need on distant caretakers. But it will yield time to train sufficient Saudi health directors to encounter request. As numerous health administrators are now doctors in Saudi Arabia, emphasis would be placed on given that them by appropriate management preparation to keep up with changes in the new arrangement. (Rashad 2014).

By the increasing occurrence of lifestyle diseases, different programs must emphasis on disease anticipation and fitness advancement to improve public fitness. There is certainly an essential for new technologies and progressive treatments, however the continued emphasis on prevention is needed to avoid the limitless demand for specialized action and the high prices associated with it. There seems to be a consensus that strict government rule and oversight of the new fitness insurance system is necessary to guarantee that it not only achieves its goals of price reduction, however also ensures admittance and quality assurance of the healthcare for all the Saudis and expatriates.

Both CCHI and the SAMA work to ensure the proper process of obliging health insurance schemes. As Fitness insurance in Saudi Arabia is still evolving, teachings are learned and rules are in place. The community health significance of this issue is founded on the premise that well-being care reform aims to achieve better health consequences for the population. By way of Saudi Arabia embraces this alteration, it will be useful to understand if it has the wanted impact.

Health care for émigrés is also a challenge in numerous countries, and if the Saudi Arabia can provide value health care to its citizens, other nations in Middle East could track the Saudi model. To develop e-health facilities in the public segment, MOH has allocated a financial plan of SR4 billion and implemented a four-year development package (2008-2011).

In addition, Saudi Medical Information Relationship has held a sequence of e-health sessions, highlighting the importance of e-health in improving the quality of health care, and considering necessary strategies, policies, applications and infrastructure. In fact, Saudi Arabia currently spends a higher percentage of its budget on health care than most high-income countries. In addition, study identifies benefits and barriers to future implementation and seeks to remove barriers to future National Health Insurance (NHI) implementation and promote its benefits. This recommendation is aimed at Saudi Arabia's state agencies and insurance companies.

We believe that limited businesses, inadequate structures, procedures without political promise, inadequate assets, improved health quality, benefit management and authorization are not yet fully established in Saudi Arabia. Governments must seek to meet emerging socio-political, financial, economic and national challenges to build improved and well-organized health systems that uphold equity and the value of impartiality in service delivery. Although the management may face

complications in various economic segments, the Ministry of Health must endure to play its role in the development of the health segment in collaboration with other departments. It includes academia, expert associations, the private segment and civil society administrations. Saudi Arabia has great concerns about the proper use of eHealth facilities.

The application of e-health and electronic data systems has previously started in many hospitals and organizations. However, adoption of eHealth services in MOH organizations has been slow. Hospital managers and investigators are beginning to use electric databases to examine the availability, excellence and impact of healthcare. Numerous studies have examined the precision of electric databases created for over-all administrative determinations (Youssef and Alharthi, 2013).
Saudi Arabia has taken a positive stance on eHealth adoption, but additional steps need to be taken to improve adoption. Future tactics for the expansion of her eHealth nation in UK will need to take a holistic approach and take into account the various factors that influence the successful implementation process. Government responsibilities, the role of health care suppliers, and patient approval and capacity need to be highlighted.

Appropriate preparation, funding and investment in policies that promote ICT infrastructure, legalization and cultural edition of eHealth are extremely impactful and critical to growth. Privacy issues and privacy worries are amongst the most pressing features affecting user adoption and adaptation of eHealth systems. Therefore, the involvement of state regulators is essential to increase confidence in this system. Aligning e-health service delivery with Saudi Arabia's national and social standards will reinforce fundamental faith in the use of big data, additional influencing the growth and deployment of e-health methods.
Saudi fitness services have made great strides in modern years at all levels of main, secondary and tertiary health services. As the result, the well-being status of the Saudi population has developed significantly. MOH has presented many reforms to its facilities, especially PHC.
Despite these successes, health facilities, especially public sector health facilities, still face many trials. These contain: Separation of multiple MOH parts (financing, delivery, administration and oversight of health maintenance). Diversification of funding bases. Implementation of obliging health insurance, transfer of public clinics, effective treatment of long-lasting diseases. Develop applied guidelines for national disasters. Founding of a well-organized national medical information system and introduction of e-health. To speech these challenges and further recover the health system situation in Saudi Arabia, the Department of Health and other relevant departments need to coordinate their determinations to implement and ensure the achievement of the new health plan.

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