Analysis of Cooperative Health Insurance in Saudi Arabia

Mubarak Aldosari, Yusnidah Ibrahim, Norlida Abdul Manab and Rabiul Islam

School of Economics, Finance and Banking, College of Business, University Utara Malaysia, 06010 UUM, Sintok, Kedah, Malaysia.

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ABSTRACT

This review considered the analysis of cooperative health insurance in Saudi Arabia. Health insurance protects an individual against the cost of hospital and medical care arising from an injury or illness. Health insurance provides protection from financial fees of bodily injury and illness. It covered expenses for medicine, doctor visits, hospital stays and other medical expenses that are dependent on the conditions covered and the benefits available under that policy. The review has three parts. First, we considered the health insurance, categories of health insurance, community health insurance, and social health insurance. Secondly, we reviewed theory of the research and research framework. Thirdly, we discussed the cooperative health insurance in Saudi Arabia. We conclude that this will in turn help these policy makers to direct their strategies in a way that leads to better customer satisfaction and in turn better performance of the cooperative health insurance programme.

INTRODUCTION

This paper represents the review of literature on the study’s main constructs as a comprehensive literature review is an important requirement to understand the perspectives of other authors, researchers, scientists, and the general society on a research question of interest. It is important to remind here that the primary goal of the present research is to examine the perceptions of foreign workers in Saudi Arabia regarding the implementation of Cooperative Health Insurance (CHI) programme and the most influential factors that relate to their satisfaction with CHI. The impact of these factors will be investigated through the moderating influence of the two constructs of knowledge and culture. The present chapter is constructed in a way that meets the objectives set for the study. Specifically, the chapter begins with an overview about the concept health insurance in which the concept’s definition and foundations are presented. A detailed section on the categories and types of health insurance is then presented. The CHI category, which is the focus of the study, is then introduced including its definition, foundations and its determinant factors. CHI in Saudi Arabia is then presented in which an overview about CHI and its historical development and current application are addressed. The chapter concludes with presenting the construct of customer satisfaction with health insurance services including some related factors that influence satisfaction such as the moderating impact of knowledge and culture. The following section presents and overview about health insurance.

1.1 Health Insurance:

According to the World Health Organization, a person’s overall well-being includes multidimensional factors including health, which both contribute to and is an outcome of personal well-being (WHO, 2013). Well-being in this conceptualization is a separate concept, with health as both a determinant and an outcome; well-being includes the social, psychological and the physical well-being exclusive of infirmly and/ or diseases (WHO, 2013). Health is a basis for the day-by-day survival and in order to be healthy, both the individual and the general population need to settle on healthy discipline that include issues of developing healthy habits, progressing in those habits, and enhancing them as appropriate.

Bovbjerg and Hadley (2007) argue that insurance coverage is strongly related to better health outcomes for people when it makes health care affordable and helps consumers use care appropriately while on the other hand uninsured people generally receive much less care, either preventive or for acute and chronic conditions, than insured people. In particular, uninsured adults report lower levels of self-perceived wellness and functioning. Thus, realizing the significant role health plays in developing the nations and economies, countries around the
world pay a great deal of attention to the level of health among their citizens and even among the residents who are working in these countries as these residents contribute to the welfare of the country and come into direct contact with the citizens. Such courtiers strive to provide affordable health insurance for their citizens and workers.

Bergthhold (1995) has defined insurance as the equitable transfer of a risk from the insured person or entity normally referred to as the policyholder to the insurer or the insurance company in exchange for a payment. Lynch (1995), on the other hand, defined insurance as a contractual coverage where one party is indemnified by another party against a loss that could be caused by a contingency. Other definitions of insurance derive from the underwriters who determine using statistics the amount of premium that should be paid during the insurance period.

The insurance premium, or the amount paid by the insured to the insurance company, is determined by the insurance rate that particular company uses on the insured party. There are various categories of insurance such as life insurance, health insurance, employment insurance, accident insurance, home insurance, and disability insurance, among other categories of insurance (Barbra et al., 2007). There are also principles that determine whether a particular risk is insurable or not and these range from such factors as insurability to legal factors as explained by Barbra et al. (2007).

Insurability means that there must be a large number of exposures to an insured risk so as to allow for pooling together of risks. Another principle that is used in the insurance policy is a definite loss must exist (John, 2007). This refers to the fact that for a loss to be insurable it must occur at a given known time and place, such as, for example, the death of a person in a life insurance policy.

The principle of indemnity means that one may only be compensated by the insurance company to the level of the person’s interest. John (2007) also states that insurable interest is a legal requirement of insurance, meaning that the insured must directly suffer from the loss in order to be compensated. Utmost good faith must exist too, which means that there must be honesty from all involved parties to the insurance agreement. Proximate cause means that for the insured to be compensated by the insuring company the cause of the occurrence of the loss must have resulted from a cause that is among the causes listed in the agreement. Subrogation refers to the legal rights to pursue the recovery program. This could also involve engaging in lawsuits to recover from the parties who were involved in the loss of the given property life or right (Charles, 2009).

The first basic insurance coverage was different from the present day insurance contracts but it held the same principles as those that are held in today’s insurance. It happened in 2100 B.C. in the Code of Hammurabi, now deemed to be the first insurance policy (Charles, 2009). The traders paid cash in form of a loan for the safe arrival of their goods in a caravan. This was to cover them from the loss of their goods either through breakdowns, robbery, or any other risk such as bad weather that would damage their goods. Charles (2009) called the practice in Babylon the Contract of Bottomry. He attributed the large trading levels that took place in Babylon as having been caused by the fact that Babylon’s lack of local natural resources, so it thus had to import jewels, skins, and cotton among other products. Charles (2009) further explained that The Phoenicians and the Greeks who were trading across the seas wanted to protect their goods, and they developed similar basic insurance policies. Later, Romans got into burial insurance in which burial clubs were formed and, upon the death of a member, the club paid for burial costs.

In the Medieval period, professional guilds protected their members from losses by providing support during burial ceremonies and other forms of support in times of sicknesses or other problems. They also had surplus manufactures which needed to be traded. The first contract on insurance occurred in Genoa in the year 1347 where people signed these contracts as groups or as individuals (Charles, 2009). The term underwriter came into existence during this period as people would write against their names the amount of risk that they were willing to be insured against. Edmond Halley was the first person to design a mortality table.

With respect to health insurance, however, Bergthhold (1995) refuted the notion that medical necessity ensured that the service providers or the medical practitioners are paid as asserted by other scholars. On the contrary, her thesis holds that it is used to control use of scares health resources. Bergthhold asserted that it is not recorded when the issue of medical necessity began but she indicated it was sometime during the 1940s when private insurance was emerging in the U.S. These were due to the existence of conflicting regulations at the time arising from the pressures of the rising costs of medication and the demands by the consumers to be covered (Bergthhold, 1995). The states of South Dakota, Florida and Minnesota are developed the concept of cost effectiveness in the medical care necessity.

Some private insurers in 1978 started offering their contractors a letter in which they addressed some maladies such as incertus index and instructed that the above should not be routinely covered. John (2007) explained that before the introduction of insurance people could only depend on their savings or money borrowed from charity or co-workers to cope with medical emergencies. Progressive reformers gathered together and debated on the need of workers to be provided with medical cover in cases of sickness (John, 2007). In the years 1915 to 1920 reformers intensified their campaigns. As a result of the campaign effort failing
to bear fruit, the government was added (John, 2007). Over the years, workers shunned the government insurance due to the sickness funds that have been provided to them.

In the United States, Charles (2009) suggested that health insurance began during the Civil War (1861 to 1865). The policies offered coverage against accidents initially. Later, the health insurance programs started offering services covering other forms of sickness, with Massachusetts Health Insurance in Boston offering the first group policy in the year 1847. The present format of modern insurance was first offered in 1929 (Charles 2009). Many companies started offering health insurance between 1930 and 1940 while employee benefit plans started taking effect between 1940 and 1950.

1.2 Categories of Health Insurance:

Health insurance protects an individual against the cost of hospital and medical care arising from an injury or illness. Health insurance provides protection from financial fees of bodily injury and illness. It covered expenses for medicine, doctor visits, hospital stays and other medical expenses that are dependent on the conditions covered and the benefits available under that policy. Health insurance works like other insurance, where people collectively pool their risk, which in this case is the risk of incurring medical expenses.

Health insurance provides risk coverage for unforeseen health expenditures that normally results in financial hardship (Barger, 2000). Health insurance is a contract between an individual, a group, and an insurance company wherein the insurance company undertakes to pay for some or all of the healthcare costs of that person or group for an agreed regular fee called premium. Most large companies in the United States provide insurance for their employees as a benefit, but this not the case for all the population because some companies, both large and small do not. For example, even very large companies generally do not cover health insurance for employees who work less than a fixed number of hours per week, usually 25 or 30 hours. Thus, employees who have multiple part-time jobs likely would not be covered by any of their employers, even if they work considerably more than the standard 40-hour work week. Other people often left without employer-provided health insurance include those who are not working at all, and those who are self-employed, or who work in small businesses. This large pool of uninsured people has prompted insurance companies to provide suitable options for this large group of people that do not have insurance. These plans have laid out the available options for each insurance need (Carr, 2010).

There are countries that have enacted legislation to ensure that all or a majority of the population is covered by insurance. The reason most uninsured people lack health insurance is the cost. In the United States, small businesses find it difficult to provide insurance for their employees because of the staggering cost associated with insurance. However, these small businesses have been able to modify their plans for greater affordability, and employees have been required to pay more of their monthly premium costs.

1.2.1 Public Health Insurance Vs Private Health Insurance:

Public health insurance covers both the high- and low-risk insured (i.e., those with and without expensive chronic conditions or with likelihood of developing such conditions) are equally covered in a public health insurance policy regardless to their health. This results in the elimination of adverse selection and moral hazard amplification through high quality standards (John, 2007). Contained by the public extent, the NHS (National Health Services) in Britain provides the majority of the healthcare service for universal practitioners to the disaster, accidents, and dentistry.

On the other hand, private insurance companies privately provide healthcare insurance policies. This type of policy is vulnerable to the concept of ex-post moral hazard. This type of hazard refers to a situation where someone with insurance is more likely to behave hazardously simply because the policy exists. For example, someone with health insurance may choose to keep smoking in part because they know that any health hazards that result from smoking will be covered by their insurance policy. A similar person without health insurance might instead choose to quit smoking in order to avoid having to pay for expensive treatments for lung cancer, emphysema, or heart disease. Any private insurance system will face those two inherent challenges of adverse selection and ex-post moral hazard. The ex-post moral hazard may arise after the conclusion of the policy contract; for example, the insured may reject the policy arguing that there are low hence of the occurrence of the risk covered.

1.2.2 Employer Sponsored Health Insurance Vs Individual Health Insurance:

Individuals who feel healthy may not see the sense of paying expensive health insurance premiums when healthcare is not needed; these people tend to make use of healthcare practitioners only when illness or accident requires it. They may also only apply for health insurance when they sense they may be becoming ill, thus avoiding paying health insurance premiums during their healthy years and increasing the risk pool of the insured policyholders. Due to adverse selection, insurance companies have traditionally indulged into thorough screening of the insured before taking the policy, requiring a highly detailed and very comprehensive form on the medical history. This information used to determine the premium coverage, for those who may be a financial
burden; they either denied the policy or charge high premium to compensate (Jutting, 2005). However, in the United States the 2010 passage of the Patient Protection and Affordable Care Act means that as of January 2014 such screening for pre-existing conditions will be illegal for all insurance companies.

Employer sponsored insurance includes the following characteristics (Ron et al., 1990):

- It is sponsored by the employer as a form of employment benefit. In 2012, just under 60 percent of Americans under the age of 65 (when government-sponsored Medicare insurance takes effect) get health insurance in this way; this is a decline of 10 percent from just under 70 percent of Americans under the age of 65 with such coverage in the year 2000 (Gould, 2012).
- It is administered by private companies for profit and non-profit.
- Employee sponsored insurance is financed through both the employers and employees. The employers pay the majority of the premium while the employees pay the remainder of the premium.
- The benefits of such insurance vary with the specific health plan. Some health plans cover nearly all medical expenses while other policies cover only catastrophic healthcare costs. Virtually all policies require some contribution toward expenses from the patient in the form of co-pays, fixed-fees for office visits or other services, and partial payments for prescription drugs.

Employer health insurance entails employer purchasing health plans for their employees, or self-insuring by setting aside an expected amount of expenses, and then usually hiring an insurance manager to handle details of claims and payouts (Matteo, 2009). This form of health insurance is offered by employers to motivate their employees, to retain them and attract new qualified and skilled potential employees (Armstrong, 2006). It has been noted that many employees remain in jobs that do not inspire them, and others join certain jobs in particular companies, primarily because they offer health insurance benefits. Employer sponsored health benefits are only effective if the employees perceive them as important, and are applicable in not only their professional lives but also their personal lives (Matteo, 2009). CHI and employer health insurance are great way of easing the high costs of accessing healthcare and allowing as many people as possible to access it.

On the other hand, the individual health insurance market covers those segments of the population who are unemployed, working for small business, working part-time, or self-employed. It also covers those employees who are unable to get insurance from their employers (Individuals who are considered disabled and thus unemployable, or who have extremely low incomes that make them unable to afford health insurance, are often, but not always, covered by the government-sponsored program Medicaid). Until January 2014, health insurance companies are allowed to deny an individual insurance based on pre-existing conditions or set extremely high rates to cover such individuals. As noted earlier, however, starting in January 2014, denial of insurance coverage or raising rates based on pre-existing conditions will no longer be allowed. Private non-group insurance has the following key characteristics:

- Their administration is by private insurance companies.
- Individuals pay for insurance from their own pockets. The higher the risk the higher the premium but the lower the risk the lower the premium. The risk basically is focused on gender, location of residence, sometimes occupation, and age of the insured.
- The benefits of such insurance vary with the different plans that an individual opts to take.

Individual health insurance entails an individual purchasing a health insurance plan and paying monthly premiums. The premium and joining fees are usually higher than those charged to a large employer-provided plan because individuals do not have the bargaining power cooperative and employer health insurance have (Armstrong, 2006). Individual health insurance is mostly used by self-employed individuals, those whose employers do not provide health insurance, or those who work part-time (or multiple part-time) positions where they are not eligible for employer-provided health insurance. Other users of individual health insurance include those who want better or different health coverage for their families, or individuals who prefer individual health insurance over all other forms of health insurance (Matteo, 2009). Due to increased costs of medical procedures, expensive diagnosis and medical care coupling with hard economic and financial times, improved quality of service and service delivery in other forms of health insurance, more and more people are opting out of individual health insurance due to its lack of affordability.

1.2.3 Social Health Insurance:

Social insurance is primarily used by low- and middle-income earners (Jeffrey, 2001). Social insurance is relatively cheaper than CHI since social insurance is usually a government venture, while cooperative insurance is composed of policyholders who are not necessarily civil servants (Jutting, 2005). In most of the countries world-wide, social health insurance is compulsory for every individual, but CHI is an option one can decide to take or not.

Social health insurance, unlike CHI, is public, tax-funded system. As with any other government parastatals, social health insurance are often more able to withstand hard economic and financial times (Jutting, 2005). Social health insurance is a good way for the government to ease the public burden on its resources in the public sector. Although social health insurance is similar to CHI in that both insurance types are meant to ease
access of health insurance to the public by offering a cheaper and accessible alternative to private insurance, they have differences (Jutting, 2005). Among the major difference is that CHI is pooling of risks by existing policyholders, generally small or large employers. CHI often is more effective than social insurance. This is because policyholders own the policies and thus will work hard to ensure it succeeds. This is unlike social insurance which is government-run and thus faced with political and management wrangles, misappropriation of funds, and inefficient service delivery (Jeffrey, 2001).

1.2.4 Community Health Insurance:
Community health insurance is a form of insurance that charges nominal fees to allow even the poorest access to medical care irrespective of their income (Jeffrey, 2001). It gives individuals a choice of seeking medical care in either public hospitals or private medical facilities (Jutting, 2005). Accountability of local government and management improves the degree of equity in provision of community health insurance according to research done on community health insurance. Moreover, it provides an avenue for primary health investment for poor resource setups. It allows affordability of healthcare by providing a group purchasing power, thus improving delivery systems, ability to negotiate for payments based on individual’s ability, and low cost due to reduced administrative overheads. The following section addresses CHI, the focus of the study.

2. Theory of the Research:
2.1 Theories of Customer Satisfaction in Insurance Industry:
Many theories have been used to understand the process through which customers form satisfaction judgments. Athiyaman (2004) argues that the heart of the satisfaction process is the comparison of what was expected with the product or service’s performance—this process has traditionally been described as the ‘confirmation/disconfirmation’ process. First, customers would form expectations prior to purchasing a product or service. Second, consumption of or experience with the product or service produces a level of perceived quality that is influenced by expectations.

Generally, the theories that govern the satisfaction process can be broadly classified under three main groups: Expectancy disconfirmation, Equity, and Attribution (Oliver, 1980). The expectancy disconfirmation theory suggests that consumers form satisfaction judgments by evaluating actual product/service (Anderson, 1973). Anderson identified four psychological theories that can be used to explain the impact of expectancy or satisfaction: Assimilation, Contrast, Generalised Negativity, and Assimilation-Contrast. These four theories are referred to as the consistency theories which suggest that when the expectations and the actual product performance do not match, the consumer will feel some degree of tension. In order to relieve this tension the consumer will make adjustments either in expectations or in the perceptions of the product’s actual performance. The following sections address these four consistency theories.

2.1.1 Assimilation theory:
Assimilation theory is based on Festinger’s (1957) dissonance theory and the theory posits that consumers make some kind of cognitive comparison between expectations about the product and the perceived product performance (Payton et al., 2003). This view of the consumer post-usage evaluation was introduced into the satisfaction literature in the form of assimilation theory. According to Anderson (1973), consumers seek to avoid dissonance by adjusting perceptions about a given product to bring it more in line with expectations. Consumers can also reduce the tension resulting from a discrepancy between expectations and product performance either by distorting expectations so that they coincide with perceived product performance or by raising the level of satisfaction by minimizing the relative importance of the disconfirmation experienced (Olson & Dover, 1979).

However, a number of shortcomings for the theory of Assimilation have been identified. In this context, Payton et al (2000) argues that the Assimilation theory approach assumes that there is a relationship between expectation and satisfaction but does not specify how disconfirmation of an expectation leads to either satisfaction or dissatisfaction. In addition, the theory also assumes that consumers are motivated enough to adjust either their expectations or their perceptions about the performance of the product. However, a number of researchers have found that controlling for actual product performance can lead to a positive relationship between expectation and satisfaction. Therefore, it would appear that dissatisfaction could never occur unless the evaluative processes were to begin with negative consumer expectations Payton et al (2000).

2.1.2 Contrast theory:
Dawes et al (1972) define contrast theory as the tendency to magnify the discrepancy between one’s own attitudes and the attitudes represented by opinion statements. Contrast theory presents an alternative view of the consumer post-usage evaluation process than was presented in assimilation theory in that post-usage evaluations lead to results in opposite predictions for the effects of expectations on satisfaction (Payton et al., 2000). While assimilation theory posits that consumers will seek to minimize the discrepancy between expectation and
performance, contrast theory holds that a surprise effect occurs leading to the discrepancy being magnified or exaggerated. According to the contrast theory, any discrepancy of experience from expectations will be exaggerated in the direction of discrepancy. If the firm raises expectations in his advertising, and then a customer’s experience is only slightly less than that promised, the product/service would be rejected as totally unsatisfactory. Conversely, under-promising in advertising and over-delivering will cause positive disconfirmation also to be exaggerated (Vavra, 1997).

2.1.3 Assimilation contrast theory:

The assimilation-contrast theory has been proposed as yet another way to explain the relationships among the variables in the disconfirmation model. This theory is a combination of both the assimilation and the contrast theories (Vavra, 1997). This paradigm posits that satisfaction is a function of the magnitude of the discrepancy between expected and perceived performance. As with assimilation theory, the consumers will tend to assimilate or adjust differences in perceptions about product performance to bring it in line with prior expectations but only if the discrepancy is relatively small (Bitner, 1987).

Assimilation-Contrast theory suggests that if performance is within a customer’s latitude (range) of acceptance, even though it may fall short of expectation the discrepancy will be disregarded – assimilation will operate and the performance will be deemed as acceptable. If performance falls within the latitude of rejection (no matter how close to expectation), contrast will prevail and the difference will be exaggerated, the product deemed unacceptable (Yau, 1994).

2.1.4 Negativity theory:

This theory developed by Aronson & Carlsmith (1963) suggests that any discrepancy of performance from expectations will disrupt the individual, producing ‘negative energy’. Negative theory has its foundations in the disconfirmation process. Negative theory states that when expectations are strongly held, consumers will respond negatively to any disconfirmation. “Accordingly dissatisfaction will occur if perceived performance is less than expectations or if perceived performance exceeds expectations (Vavra, 1997).

2.2 Equity Theory:

This theory is built upon the argument that a “man’s rewards in exchange with others should be proportional to his investments”. An early recognition of this theory first came out of research by Stouffer and his colleagues in military administration. They referred to ‘relative deprivation’ (equity) as the reaction to an imbalance or disparity between what an individual perceives to be the actuality and what he believes should be the case, especially where his own situation is concerned (Yau, 1994).

In other words, the equity concept suggests that the ratio of outcomes to inputs should be constant across participants in an exchange. As applied to customer satisfaction research, satisfaction is thought to exist when the customer believes that his outcomes to input ratio is equal to that of the exchange person. In the handful of studies that have examined the effect of equity on customer satisfaction, equity appears to have a moderate effect on customer satisfaction and post-purchase communication behaviour (Athiyaman, 2004). This theory is the one that is adopted to form the ground of this study is the theory addresses the reaction a disparity between what an individual (foreign worker) perceives to be the actuality and what he believes should be the case. This basic principle is the form upon which the satisfaction formation is constructed in foreign workers’ minds.

Equity theory suggests that parties involved in an exchange feel equitably treated and thus satisfied if their amount of input to the exchange is somewhat in balance with their output of the exchange (Andreassen, 2000). In contrast to disconfirmation where the satisfaction judgment is a function of expectations prior to consumption compared to perceived outcome, equity is a relative dimension. Disconfirmation is the result of comparing predictive expectations to performance whereas perceived justice is the result of comparing normative standards to performance. In equity theory the outcome of the interaction is seen as a function of input to the interaction and relative to the outcome of the other party in the interaction. Equity judgment is based on two steps; first, the consumer compares their outcome to their input, second, they perform a relative comparison of this to the other exchange party (Andreassen, 2000).

This is supported by the literature in sociology, psychology, social psychology, organizational psychology, and marketing (Cook & Messick, 1983). Satisfaction or dissatisfaction judgment is believed to be formed as a summary of equity/inequity of one's own outcome relative to the other party's outcome, given input. Key to this comparison is the perception of fairness as it explicitly implies a form of distributive justice whereby individuals get what they deserve based on their inputs (Cook & Messick, 1983). The customer will have expectations with regard to the outcome, e.g. fairness of the process of the complaint handling. Seen from the customer's point of view the outcome may be perceived as fair or unfair. An unfavourable outcome will be perceived as unfair and create low satisfaction with service recovery. A favourable outcome will be perceived as fair and thus create positive satisfaction with service recovery (Andreassen, 2000).
In the Saudi context and as the study targets the foreign workers in the country, these foreign workers provide an ‘input’ keeping in mind that part of their salaries is deducted by their employers to cover the whole or part of their CHI coverage. Foreign workers compare this input to the ‘output’ or the outcome they receive when they go to different hospitals and medical centres that are covered under CHI programme. If the outcome received is perceived as unfair, satisfaction level is perceived to be low while this satisfaction is perceived to be high when the outcome received is perceived to be fair. This fairness is assessed through the antecedent factors proposed for the study in terms of CHI characteristics (AAAQ), choice of CHI plan, and financing. In addition, this fairness is assessed through foreign workers’ knowledge about CHI practices and regulations. Thus and based on these arguments, equity theory was adopted to form the theoretical ground of the study. The following section addresses the hypotheses development in the study.

3. Research Framework:

In general, research on the use of health care services and facilities is associated with medical, social and behavioural sciences and also with health economics (Purola, 1972). The use of health services has been accounted for in terms of patients’ personal factors (health or illness, symptoms, knowledge and understanding, beliefs, etc.), social factors (socio-demographic factors, family factors, etc.) and factors related to the health care system (distance, availability, accessibility, costs, etc).

![Fig. 1: Theoretical Framework of the Study.](image)

In this study, an attempt in made to examine the impact of a number of antecedent factors (independent variables) on foreign workers’ satisfaction with CHI (dependent variable). In addition, the impact of these factors will be investigated through the moderating influence of the two constructs of knowledge and culture (moderating variables). The antecedent factors include: CHI service characteristics (availability, accessibility, acceptability, and quality (AAAQ) of health service), the choice of CHI insurance plan, and financing of CHI. Thus and based on all the variables in the study, the framework upon which the present study is grounded has been designed. The following figure (Figure 1) represents the theoretical framework upon which the present study is grounded.

4. Cooperative Health Insurance:

Cooperative health insurance (CHI) consists of structures and frameworks that assist in health payment by policyholders, who collectively pool their resources in an effort to achieve reduced costs while maintaining quality healthcare (Hassanaly, 2006). CHI, as with other forms of insurance, provides protection to policyholders against the costs of treating injuries and illnesses. Policyholders typically pay an annual premium under a CHI program.

CHI companies are owned by the policyholders, who join up and cost-share and at the same time compete with other privately owned insurance (I.L.O, 2000). CHI is more beneficial to policyholders because they are not profit-oriented and therefore costs incurred are real and not influenced by administrative costs which generally inflate insurance costs. The costs are further lowered since they are tax liability free, due to the fact that CHI collect only actual or estimated costs, with no extra collected for profit (Birchall, 1997).

The main objectives of conducting a literature review on CHI is first to understand the concept of CHI (Novkovic & Sena, 2007). This will help highlight the key features, advantages, and disadvantages of CHI. The second objective is to evaluate the importance of having CHI to an insurance policyholder, and to discover the limitations associated with the practice. Other objectives include a comparison of purchasing individual health insurance over CHI, development of hypotheses that arise from an investigation of CHI, and to identify the implications of CHI compared obtaining health insurance in general. The following sections present an insight of CHI.
4.1 Concepts of Cooperative Health Insurance:

The concept of CHI is based on lowering costs realized by health insurance policyholders from spreading out the costs and risks, reducing administrative costs to a minimum, and constructing a non-profit program in which only the money required to cover actual expenses is ever collected (Novkovic & Sena, 2007). The concept of collective purchasing of health insurance and payments of premiums has been necessitated by drastic increment of employee insurance costs and health costs arising from dramatically increasing costs of treatment, and increased consumer demand for health insurance due to increased risks. Moreover, the technologies used in diagnosis and treatment are more capable but also more expensive, and new pharmaceutical medicines are highly expensive. These trends are compounded when individuals prefer the purchase of health insurance from private profit-making insurers rather than publicly owned insurance (Pilzer, 2007).

As a result of these factors, employers and governments have embarked on CHI programs in order to leverage economies of scale and therefore reduce associated healthcare and health insurance costs (Dieng, 2000). The concept CHI has been suggested by governments and medical administrations to allow even the poorest of population have access to quality medical care, stabilize costs incurred in health insurance claims, offer a platform for negotiations with medical services providers, and reduce administrative costs (I.L.O, 2000).

4.2 Applications of Cooperative Health Insurance:

CHI has been adopted and implemented by both developed and developing countries. This type of insurance can be created by any group, including local, state or national organizations, as long as the group has some type of common denominator. This means a group of farmers, car owners, of small enterprises in a given industry, or even groups of home owners can all establish CHI programs if they desire to do so (Novkovic & Sena, 2007).

In developed countries like the U.S., New York State has authorized local and municipal governments to establish mutual cooperative health benefit plans (MCHBP), which in effect are cooperative insurance programs for municipal employees. In the New York state cooperative insurance program various local municipal areas collectively pool their risks and share in costs incurred (U.S.G.A., 2000). There are restrictions and guidelines that have been imposed to safeguard this programs cooperative insurance in New York, which includes size requirements; with a minimum of not less than five municipalities and at least 2000 employees being required to maintain the cooperative. Other characteristics of this program include the development of at least a 25 per cent reserve against future expenses based on current and expected outlays. The cooperative must also maintain additional reserves against such factors as unearned premium equivalents; claim stabilization factor, and other obligations reserves (U.S.G.A., 2000). Moreover, participating municipalities are required to have a surplus account with at least 6 percent premium equivalents earned annually for those MCHBPs with at least five participating municipal areas, and at least 8 percent for those MCHBPs with fewer than five participating municipal groups (Novkovic & Sena, 2007).

The rating methodology applied on group and individual health insurance plans influences premiums in health insurance. Rating methodology can be done by either (a) rating groups by actual experience of the insured members of the group, or (b) rating from the collective claims of the entire community, including those community members not part of the group (U.S.G.A., 2000). In community rating, the experience of claims processing by covered policyholders in the collective pool despite their gender, age, occupation and health status, and the rating is not group-specific which determines the premiums to be paid. In ratings by experience, insurance premiums are influenced by the experience of specific claims by the group members (Novkovic & Sena, 2007). Although CHI applied in municipalities has been beneficial in promotion of health and reducing costs per municipal, studies show that more needs to be done in terms of easing provisions on municipal CHI and insurance plans. Actuarial assessments to be the basis, under which requirements for reserves are formed on, reduce the size requirement to less than five, use experience rating to determine insurance premiums rather than community-based rating and evaluate the feasibilities on cooperative creation (I. L. O., 2000).

CHI, which is consumer operated and consumer oriented, has also been applied in small employer purchasers of insurance plans in order to ease their access to health insurance and be able to afford it as a health reform. This is done to ease access to a variety of insurance providers, while at the same time providing the ability to negotiate for low premiums that would otherwise only be accessible by large employer purchasers (U.S.G.A., 2000). In essence, groups of small businesses band together to create a larger group that has more ability to negotiate better rates for its members.

According to the International Labor Organization (I. L. O., 2000), common characteristics of CHI for small employer purchasers include a governing board comprised of representatives for both the employees covered and the employers purchasing the insurance, and allowing active participation of insurance providers through competitive and fair processes. Cooperatives typically contract the administration of the program to unaffiliated insurance providers that provide health plans that are fully insured, thus incurring no financial risk from compliance with healthcare provision. These administrators can negotiate for lower premiums, and accept health plans that will help reduce costs and allow covered individuals the choice of various insurance providers and


insurance plans (U.S.G.A., 2000). CHI is beneficial to small employers because it offers them administrative services that would otherwise be beyond their means and reduces their overall healthcare costs by negotiating improved terms with suitable insurance providers. They also help in standardization of benefits and negotiating rates of reserves and premiums on behalf of policyholders. Moreover, employees under CHI typically have a wider choice of variety of health plans than employees of businesses which individually purchase health insurance for their employees (U.S.G.A., 2000).

However, CHI for small employers has faced hurdles in its execution (U.S.G.A., 2000). The major reason small employer purchase health insurance products by cooperatives, is due to the ability of cooperatives to negotiate and offer low premiums. This has been difficult in practice because of insufficient leveraging by cooperative’s relatively small market share, the inability to cut administrative costs sufficiently, stringent rate and coverage requirements by the government, and increased enrolment of high-risk individuals who have been denied coverage by the government or private insurers (U.S.G.A., 2000).

4.3 Criticism and Challenges Facing Cooperative Health Insurance:

Health insurance cooperatives have their own limitations. These limitations include high enrolment of high-risk individuals since the cooperatives are required to accept any member of the group who chooses to participate, and changes in legislation safeguarding operations of such cooperatives from private or state owned insurance providers (Preker, 2004). There is additional risk arising from CHI plans shouldering substantial financial risk when any members pull out. Furthermore, they have small market shares thus unable to cut rates of premiums as much as anticipated and thus are unable to lure clients who use this service in anticipation of reduced premiums costs.

Many have criticized the efficacy and efficiency level of health insurance cooperatives citing possibilities of them being politically influenced to favour those in authority. Furthermore, although hopes were high, such cooperatives have proved unable to achieve significant improvements in healthcare costs and policies of other insurers (Pilzer, 2007). Additionally, establishing CHI firms is not easy since it requires the creation of a quality brand name and brand image, an understanding of healthcare claims processing, development of significant actuarial expertise, the ability to afford reserves, the ability to understand and comply with extremely complex licensing and legislative requirements, and the ability to not only meet solvency requirements but also to bear any excess costs if the need arises (Ron, et al. 1990). Furthermore, most health insurance cooperatives are unable to find and retain insurance providers who would effectively work under cooperative’s constraints such as enrolling high-risk individuals. Cooperatives also have difficulty finding insurers willing to implement the specific components necessary for health insurance cooperatives such as complete cost transparency. Finally, cooperatives may lack effective powers to negotiate and thus efficiently compete with private health insurance companies (Pilzer, 2007).

Similarities between CHI and Individual Health Insurance can be made by referring to studies previously done which have highlighted differences between health insurance cooperatives and individual health insurance. It has been argued that differences between CHI and individual plans are more a matter of paper format and theory, and less in actual implementation (OECD, 2004). Economists have questioned the ability of such cooperatives to absorb and effectively function and serve the increasing number of people seeking their service, or to deal with the high numbers of the uninsured who will seek their service after the 2010 health reforms bill is fully implemented in 2014 law.

CHI has offered the same of premium rates as those offered by individual insurance due to stringent legislation, low market share, and absorption of high risk individuals. Cooperatives also typically offer the same health plans as those accessible to individual policyholders (OECD, 2004). They are similar in that they protect the policyholder from risk and entail payment of premiums annually, which are determined by community rating or rating by experience.

In order to ease the challenges and criticism of CHI, the programme is believed to possess a number of characteristics; the following section addresses the characteristics of CHI taking into account that these characteristics are investigated in this study.

4.4 Characteristics of Cooperative Health Insurance:

A key to success here is facilitating eligible citizens and workers to be able to effectively use CHI as a mechanism to achieve relevant health goals. These goals specifically relate to the accessibility, acceptability, availability and quality of the health care services that are provided to them by CHI programme (Germain, 2013). Further discussion of each of these concepts is provided in the following sections.

- **Accessibility** – Accessibility refers to the ease in which patients are able to effectively obtain health care services. The accessibility of health care can vary from location to location in Saudi Arabia due to the existence of significant rural areas that pepper the country. In order to ensure the effectiveness of the CHI system, the government must ensure that all citizens and eligible employees are able to access adequate health care services, regardless of their physical location within the country.
• **Acceptability** – Acceptability refers to the list of specific health care providers that readily accept the policyholder’s CHI. Although a myriad of health care providers exist within Saudi Arabia, many of these providers exercise extreme discretion in determining which health insurance plans to accept and which plans not to accept with regards to billing for health care services rendered to patients. If a CHI policyholder obtains health care services from a provider that does not accept their CHI policy, the policyholder will be held liable for all the associated costs of the services they received. As such, it is critical for policyholders to be knowledgeable and well aware of the specific health care providers that accept their CHI policy. In addition, the government and other relevant agencies should ensure that the list of health care providers that accept a specific insurance policy is not limited to an extent that provides hardship on the policyholder or otherwise reduces the accessibility to health care services.

• **Availability** – Availability refers to the ease in which policy holders are able to obtain the specific health care services that they are seeking. As such, although accessibility and acceptability might be plentiful, it might be extremely difficult for patients to find the specific health care services that they need the most. Radiological equipment such as MRI and CT, as well as highly technical services such as heart surgery, respiratory therapy and other critical care may not be available at all health care facilities due to budgetary constraints and population density and patient volumes. As such, the government should ensure that policy holders are knowledgeable about where such critical health care services can be obtained. Additionally, the government should further ensure that these services have wide enough availability to avoid a hardship on the policyholder.

• **Quality of Healthcare Services** – Quality of healthcare services refers to the overall level and thoroughness of care that policyholders receive when obtaining services from health care providers. It is critical that policyholders become knowledgeable about the standards of acceptable healthcare. If this does not occur, policyholders can develop misconceptions about the characteristics of quality healthcare, which can ultimately lower their expectations to a degree that is contrary to the universal standard. In order to ensure policyholders become knowledgeable of healthcare standards and the true characteristics of quality healthcare, the government should establish a code of ethics and quality standards for all healthcare service providers that accept CHI. The code of ethics and quality standards should be posted in a location that all patients can view them. This will improve the overall awareness and knowledge among patients and policyholders as to the specific quality standards that must be met. This will enable policy holders to develop accurate perceptions relating to quality of healthcare services so that true levels of customer satisfaction can be evaluated.

These characteristics have been hypothesised to be related to customers’ satisfaction with the provision of their health insurance. In this context, Germain (2013) argues that the right to the highest attainable standard of health requires that these four attributes be achieved for all without discrimination and that these attributes of health service should be investigated in future work studies as they are regarded as strong determinants of customer satisfaction. Another important factor that has been hypothesised to be related to customers’ satisfaction with the services provided by their insurance providers is the choice of plans of health insurance. The following section addresses the factors of customers’ choice of insurance plans.

4.5 Types of Cooperative Health Insurance Plans:

CHI involves cooperatives formed by healthcare providers and health insurance providers, health insurance cooperatives formed by small employers for their employees, health insurance cooperative created by large employers for their employees, and health insurance cooperatives formed by a group of individual policyholders with a common denominator (OECD, 2004). There are diverse selections of health insurance plans available to members of CHI. These health plans include personal accident plans which are policies that protect against the risk of partial or permanent disability or death that occur as a direct result of accidents (Gitman & McDaniel, 2008).

Healthcare savings programs allow pre-tax money to be set aside each year to help cover premiums and other non-insured healthcare costs; typically, this money must be used in the year it is saved and may not roll over until the following year (Stevens, 2003). Critical care insurance, sometimes called catastrophic illness care, offers assistance only for very expensive diseases and conditions such as cancer, stroke, or kidney failure among other conditions. Typically, the insured must first pay many thousands of dollars in healthcare costs before critical care insurance policies begin to provide coverage (Pilzer, 2007).

When a person is hospitalized for an extended period of time, or must undergo rehabilitation over an extended period, personal income may drop because the person is unable to work. Furthermore, insurance rarely covers all medical care costs encountered in the event of a serious, long-lasting illness. Personal guards policies address this problem by offering additional protection against the risk of injuries or chronic illnesses by paying daily allowances directly to the insured (rather than to the healthcare provider) when the individual is hospitalized or meets other conditions. These cash plans are not restricted by use; the insured can use them to help meet any costs they have, from paying rent or a mortgage to buying groceries or paying any uninsured portions of their medical care costs (Pilzer, 2007).
Thus, it is the purpose of the study to examine the perceptions of foreign workers in Saudi Arabia regarding the CHI plans they are offered and whether they are satisfied with the variety of plans offered and if they have the freedom to choose between the offered plans.

4.6 Financing of Healthcare in Cooperative Health Insurance:
Financing health is a critical component of any healthcare system. The financial basis of healthcare which deals with the systematizing individuals, resources and institutions with a view of supplying healthcare services to cater for health needs of the population (Tryfos, 1996). To achieve optimum health and to ensure a cost effective equality and accessibility to healthcare is provided to the population, governments, charities, private entities and trade unions collaborate in generating cost-effective healthcare plans (Guerrero, 2010).

The healthcare available for individuals and the quality of care accessible to the entire population of a particular society is influenced by how that particular society pays for healthcare, plus the amount of resources it allocates to its healthcare systems, programs, and structures. Health insurance, which is a type of indemnity paid for medical costs, can be financed by various means that includes overt taxation by the state, single-payer systems, out-of-pocket payments and fees, or market-based financing. These types of health payment plans are intended to safeguard the insured from rising or unpredictable healthcare costs (Tryfos, 1996).

Through approximation of the general cost of healthcare costs, a financing system is established to ensure that sufficient funds are available to cover expected healthcare benefits stipulated in the insurance contract. The majority of commercial health insurance contracts limit costs by controlling the healthcare benefits paid. These limits are accomplished by co-payments paid by the insured, deductibles, policy exclusions, co-insurance and refusal to cover pre-existing conditions (Tryfos, 1996). In industrialized economies such as the United Kingdom, the government or its agency is charged with the role of paying for healthcare through a single-payer system, while in economies such as Germany, the state pay for part of the health insurance costs, while the employer or individuals pay the remaining costs (Guerrero, 2010).

In economies such as the United States, health insurance is market-based, meaning it is paid for through a partnership between the government and the private sector that includes the employer and individuals. Additionally, in the US, the federal funds are provided to support vulnerable groups such as the elderly, low-income individuals, and the disabled. Government-based and market-based systems of health insurance payments offer varied benefits and limitations (Guerrero, 2010).

Market-based financing systems are characterized by funding contributed by private entities and individuals. This system is associated with increased competition since there are varied health insurance payers, care providers, care suppliers; in addition, the insured individuals have the liberty to select which health insurance plan most effectively satisfies their healthcare needs (Tryfos, 1996). Alternatively, care providers have the advantage of adhering to best-practice policies that stipulate when and to whom varied care and treatment should be administered. Furthermore, insurance companies may insist on deciding treatments based on case-by-case basis centered on each patient’s medical situation (Guerrero, 2010). Since market-based financing systems give financial inducements for formulation of innovative medical advances, theoretically, this results in improved progress while patients are able to access new advances quicker.

It is the purpose of the study to examine the perceptions of foreign workers in Saudi Arabia regarding the financing of their CHI and whether they are satisfied with the structure of financing their CHI. The following section addresses CHI in Saudi Arabia.

There are multiple ways in which health insurance program can be structured within a society, among other are cooperative health insurance, employer-paid health insurance, and individually purchased health insurance (H.S.F & EIP, 2004). The Kingdom of Bahrain, for example, provides, per the nation’s constitution, comprehensive healthcare for all Bahraini citizens and provides most healthcare for foreign workers and foreign residents of the Kingdom (Hamza, 2008). Overall, in 2007 the Bahrain government covered more than 70% of all healthcare costs for those in the country, whether citizen or foreigners, with private insurance paying about 5% of costs, and individual out-of-pocket expenses covering the remaining healthcare expenditures (Hamza, 2008).

The explosive growth of non-citizen workers and residents in the nation, combined with worldwide increases in the overall cost of healthcare, have caused the financial burden of such universal healthcare to grow, leading Bahrain to consider requiring the provision of health insurance to all foreigners in Bahrain as a condition of obtaining residency rights; this could be via either a financial arrangement with the country’s Ministry of Health or a contract with a private insurance company (Hamza, 2008).

Similarly, Saudi Arabia has witnessed a dramatic increase of foreign workers and residents in the past few decades which also put pressure on the country’s economy. In Saudi Arabia, expenditure on health insurance as a percentage of total expenditure on healthcare was 76.2%, and private expenditure was 23.8% (Walker, 2009).

The following figure (Figure 2) shows the Ministry of Health expenditure as a percentage of the Saudi GDP between 2005 and 2010.
The percentage of GDP total expenditure spent on healthcare in 2008 was 5.6 % (MOH, 2008). Figure 1 shows how the Ministry of Health budget has increased as a percentage of the Saudi GDP in the years from 2005 to 2010. The trend line on the figure illustrates the problem of rising healthcare costs faced by the Saudi Ministry of Health (MoH).

5. **Cooperative Health Insurance in Saudi Arabia:**

In Saudi Arabia access to healthcare is regarded as fundamental rights for all citizens. The Saudis regard as a right the provision of health services and they expect the government to provide these services free; this presumption that healthcare should be free is an extension of their understanding that Saudi Arabia is oil-rich and therefore healthcare should be provided as an outgrowth of that wealth (Alexander et al., 2010). The government therefore funds the health services for Saudi nationals. This expense accounts for approximately 80% of the healthcare services used in the country. For foreign workers, healthcare is provided through CHI programme and normally either employers pay for healthcare services or foreign workers pay themselves through cuts from their salaries depending on the contract signed with the employers (CDSI, 2010).

Foreign nationals in Saudi Arabia are typically workers imported to perform jobs in specialized fields; these are most often persons from Sri Lanka, Philippines, India, Indonesia, Africa, and Bangladesh, and also from most Arabic countries in the region (CDSI, 2010). In some cases where workers are imported for highly specialized jobs, their families are brought in as well, but for workers brought in to do labour such as construction, housecleaning, gardening, and other low-status jobs, only workers are welcome and not their families if any. According to previous studies done, most of these lower status workers have high prevalence rates of intestinal parasites. This can be a public health hazard because most such workers work as food handlers in restaurants or private homes, housekeepers, housemaids, babysitters, or private chefs and cooks. Studies indicate the intestinal parasites prevalence rates were more than 50 percent in Riyadh, at least 40 percent in Jeddah, and more than 45 percent in Abha. Foreign workers in food handler positions had an infestation rate of at least 10 percent in Al-Medina, more than 7.5 percent in Dammam, and more than 7 percent in Al-Khobar (CDSI, 2010).

According to Dr. Hamad bin Abdullah Al-Manaa, the Minister for Health, for the sake of public health it is imperative to have compulsory enforcement of health insurance for drivers, housekeepers, and similar workers within this group. Two proposals are being considered to address this problem (Oxford, 2007). The first proposal entails offering insurance coverage from the Ministry of Health by the Ministry for such foreign workers for annual premiums of SR 500. The second proposal is to offer healthcare insurance coverage for SR 1200 per year, with that coverage coming from local insurers, which would cover health services from private institutions. Although the policies differ in contributions and benefits, they cover diagnosis, check-ups, medications, treatments, surgeries, admissions, deliveries, and dental work. Moreover, they include vaccination, post-natal care, maternity coverage, and costs incurred during repatriation of a corpse to the foreign worker’s country of origin.

Other foreign workers who work in Saudi Arabia currently are taken care of by the Ministry of Labour in the country. This category of people is protected until their working period in this nation is completed as the Sharia—the moral code and religious law of Islam—and convention rules specify. Saudi Arabia provides a free market economy to citizens as well foreign workers’ as long as they satisfy the health insurance requirements;
coverage can be obtained from any licensed source that is preferred. Other requirements that they have to satisfy are occupational requirements, educational as well as training requirements (Alexander et al., 2007).

Foreign workers are required to ensure that their employer has begun the process of obtaining a required work permit and a residence permit (Iqama) within 90 days of their arrival in the country. However in the place of a work license, other permits or authorizations that are required by other bodies to qualify one for work practice or profession are acceptable under different circumstances (Alexander, Richard, Mark, 2007, p. 150). In addition, foreign workers should not work for other than their sponsoring employers until they have satisfied the required procedures. They should also not work in other jobs apart from the ones that are outlined in their work licenses. Foreign workers are also asked to report to the nearest labour office in case of grievances in work place that are not settled amicably (Anthony et al., 2004). Trafficking in visas and persons is also prohibited by the law for foreign workers.

The Ministry of Labour also insists that employers should bear the medical costs of its workers (Oxford, 2007). The employing firms should also subscribe all the employees in Occupational Hazards Branch of Social Insurance Law. This law is applied in case of accidents within the workplace as well as in case of occupational diseases. The labour law stipulates that if an employer does not issue a work license within the 90 days, the employer and not the foreign employee becomes liable for any fines that may arise as a result. If a worker’s service is deemed in breach of the rule of land concerning the employment of non-Saudis the nearest labour office is contacted by the workers (Andrew, 2002). The labour office in turn carries out the appropriate action against the employers of the foreign workers.

Specifically excluded from the provisions of this act, for example, were those foreign workers hired as household help, such as housemaids and nannies. Beneficiaries of CHI include the following categories:

1. Non-Saudis working for the non-government sector.
2. Persons unemployed in the non-government sector, who are residing in the Kingdom.
3. Family dependents of persons specified in paragraphs 1 and 2, who are holding a residence permit in the Kingdom.
4. Saudis working in the private sector and individuals with whom they have labour contracts or proof of employment, regardless of the form of remuneration.
5. Family members of Saudis referred to in paragraph 4 of this Article as determined by the Cooperative Health Insurance Council (CHIC).

The following categories shall be excluded from the CHI in Saudi Arabia:

1. Non-Saudi employees working for government bodies and those whose work contract do not provide for health care services shall be obligated to obtain insurance coverage in accordance with approved insurance policies.
2. Family dependents of employees specified in paragraph 1 of this Article. The scope of treatment specified in the above paragraph shall at least conform to the provisions of Article (7) of the Law and the quality standard provided for in Chapter 9 of these Regulations.

Taking into account that the Saudi government has plans to include the Saudi citizens in the coverage of CHI in the near future and early attempts have already been done to include Saudi citizens who are working in the private sector (not compulsory yet), it is important to examine the perceptions of foreign workers who are currently experiencing the services provided by CHI. It is also important to examine the level of foreign workers’ satisfaction with the services provided by CHI. The following section addresses the construct of customers’ satisfaction with health insurance and its importance to the overall performance of insurance providers.

6. Conclusion:

As the present study attempts to examine whether the Saudi CHI program is meeting the needs of the group that it is intended to serve, namely the foreign workers in Saudi Arabia and keeping in mind that the CHI program is still relatively young, it is important to understand how it is perceived by those that are most affected by it. Consequently, the present study is expected to provide useful understanding of the attitudes and perceptions of several groups of stakeholders, including customers, healthcare workers, CHI management, insurance providers, and policy makers.

The present research is expected to be significant for healthcare customers in Saudi Arabia, namely the foreign workers in the country. This is because satisfaction has become an important measure for outcomes assessment research. In the new role of marketing, as is the case in outcomes assessment, patient satisfaction is used to assess the quality of care from the patients’ perspectives. For marketing and administrative purposes, satisfaction is useful for patient compliant management and as baseline data for foreign worker benefit. For outcomes assessment purposes satisfaction, it is becoming a measure of performance evaluation in the delivery of healthcare services. It can be used as a goal for reimbursement and other rewards incentives.

Finally, it has been stated earlier that the Saudi government represented by the MoH have plans to apply CHI on all Saudi citizens in the near future (Council of Cooperative Health Insurance, 2013); thus, it is believed
that the study will help policy makers who are in charge of making these changes to the structure of CHI to include Saudi citizens in the coverage to be exposed to the current customers’ perceptions and evaluations of the performance of CHI through viewing their satisfaction level with CHI. This will in turn help these policy makers to direct their strategies in a way that leads to better customer satisfaction and in turn better performance of the CHI programme.

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