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Evaluating Oman's Health Financing System: Challenges and Pathways to Universal Health Coverage

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"Evaluating Oman's Health Financing System: Challenges and Pathways to Universal Health Coverage"

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ABSTRACT

Background: This study assesses Oman's current healthcare financing scheme and explores future directions for sustainable and equitable financing.

Method: A mixed method approach was utilized, comprising semi-structured interviews with 25 key stakeholders. Descriptive statistics, compound annual growth rate (CAGR), correlation, and regression modelling were used for quantitative analysis, and thematic analysis was conducted on the qualitative data.

Result: The primary source of financing is government revenue, which accounts for 84% of current health expenditure (CHE). There was zero real growth of per capita CHE (CAGR = -0.35%) relative to gross domestic product. Regression analyses found that a decline in out-of-pocket payments (-0.42, $p < 0.01$) and an increase in voluntary health insurance and enterprise financing (0.38, $p < 0.01$) had statistically significant effects on financing transition. Stakeholder interviews revealed that affordability is a major issue, particularly for small- and medium-sized enterprises (78% uninsured). Besides that, informal employees and low-income expatriates, combined with regulatory weaknesses, are the major challenge to health financing.

Conclusion: Although the system in Oman provides financial protection, it is undermined by fiscal unsustainability. The main recommendations, including compulsory private insurance, subsidies to vulnerable groups, and strengthening regulation, are necessary to achieve Vision 2040.

Keywords: *Health financing, government funding, health insurance, out-of-pocket payments, public–private partnerships*

Background

A country's health financing system is key to achieving equity, financial protection, and long-term fiscal sustainability (WHO, 2010). The WHO described health financing as the mechanism by which revenue is collected, pooled, and allocated in the country in pursuit of universal health care while maintaining equity in health and financial protection. It will be very difficult to achieve universal health coverage without appropriate health financing arrangements. (WHO, 2010). As suggested by Lai et al. (2024), the financing structure controls how resources are mobilized in the country, how revenue is pooled, and how purchasing is conducted, thereby determining financial risk coverage and access to quality services. (Evans et al., 2023; Larrain et al., 2023), Organization for Economic Cooperation and Development (OECD, 2025) reported that increasing healthcare costs, epidemiological, demographic shifts, and economic uncertainty are putting pressure on the health system worldwide. Considering the above situation, there is a need to reevaluate the country's health financing structure to maintain health equity and to satisfy the rising demand for health care. (Perazzini, 2020; Lai et al., 2024) also recommended that countries adopt a mix of health financing, such as general taxation, social health insurance, and private health insurance, and each schemes have different levels of risk pooling, coverage, and financial security. The study conducted by (Lai et al., 2024) indicated that government funding has been identified as the main source of health funding in Oman; however, the role of private providers, private health insurance companies, and public–private partnerships (PPPs) in relation to health expenditures has also affected the financing mix in terms of the amount and source(s) of funding used to provide health services. As a result, this ongoing change will continue to affect the regional and global health environment (Ariffin et al., 2024). In line with Oman, a study by Perazzini (2020) found that the health financing systems in the United Kingdom and Nordic countries are also mostly government-funded, providing a high degree of financial protection and equity compared with out-of-pocket or private insurance. This finding indicates that heavy reliance on OOP and private insurance is creating health inequity and barriers to accessing basic health care, which are not good signs of achieving universal health coverage. Additionally, GCC nations are characterized by a high degree of state-funded healthcare, numerous benefits for citizens, and significant dependence on non-nationals, which raises serious concerns about social health equity and requires urgent policy attention. Oman is unique among the GCC countries because of its long-standing public investment, low out-of-pocket costs, and almost full access for citizens. According to Al Dhawi et al. (2007) and WHO (2001, 2010), high life expectancy, a low infant mortality rate, high population coverage, and high investment in infrastructure are the result of a centralized government financing system. Financial protection remains relatively high because almost 80% of total health expenditure is financed by the government (OECD, 2023; Larrain et al., 2023; Al-Asfoor et al., 2023; Lai et al., 2024). Which supports equity, but fiscal sustainability remains a challenge (McIntyre et al., 2017). Nevertheless, oil price fluctuations, demographics, and the absence of expatriates and informal workers emphasize the need to diversify financing and reinforce risk pooling by extending social health insurance and PPPs (Perazzini et al., 2020; Lai et al., 2024). Even though the country is in a phase of transition, the Financial Services Authority reported that insurance coverage in Oman is 12.1% among active workers and 6.6% among elderly recipients (Ibrahim et al., 2020), which remains very low. The FSA Report, 2024, revealed that SPF (Social Protection Fund) coverage had increased to approximately 555,000 beneficiaries, with additional extensions planned, representing a significant step towards a more sustainable and inclusive health financing system by mid-2025 (FSA Report 2023). In Oman, along with public

funding, the private sector has also become a key player. Private hospitals, clinics, and insurance companies provide service diversification, save resources, and promote patient satisfaction (Shriram et al., 2024; Gandhar et al., 2023; Ades et al., 2024). Through public–private partnerships (PPPs), private funds and expertise are used to fill gaps in infrastructure and to increase access, especially in geographically isolated areas (Matteis et al., 2024; Abdul et al., 2024; Ghasemi et al., 2022; Joudyian et al., 2021).

The third component of health insurance is private health insurance (PHI), which is quite weak and underdeveloped. PHI is voluntary, and only high-income employers are being enrolled, leaving low-income people underserved. (OECD 2025; Larrain et al., 2023). However, such progress has not effectively insulated Oman's health financing model from structural, fiscal, and equity challenges. However, inadequate regulatory frameworks, fragmentation of risk pooling, and competing interests have raised concerns about fiscal sustainability, equity, and access (Abdul et al., 2024; Basbih et al., 2022; Ghasemi et al., 2022; WHO Regional Office for the East Mediterranean, 2024). Moreover, Oman's Health Vision 2040 is also progressing towards sustainable health financing, which is based on social, economic, and environmental objectives (Vision 2040 Secretariat, 2020; Ariffin et al., 2024). The plans associated with Vision 2040 include coverage for low-income and SME workers, regulation of private insurance, and strengthening PPPs to create an equitable, efficient, and sustainable health financing system (Lai et al., 2024; Alkhamis et al., 2014; Askarzade et al., 2024). Moreover, health technology assessment (HTA) has been suggested as one of the best methods for aligning public and private investment with needs (Rashdi et al., 2024). The Ministry of Health Reports, 2023, stated that the country is struggling with rising rates of noncommunicable diseases, growing populations, rising service costs, and volatile oil prices, all of which negatively affect the health system. Even health expenditure as a percentage of GDP is decreasing, along with per capita health expenditure, which is again a major concern in maintaining equity and promoting coverage. (Al Dhawi et al., 2007). Almost 3/4 of the ministry budget is spent on salaries rather than strategic investment, which is quite alarming (MOH, 2023). Even though services are free for citizens, more than 1.5 million expatriates experience financial hardship due to high out-of-pocket costs (Lai et al., 2024). However, there is limited empirical evidence assessing the adequacy and sustainability of Oman's evolving health financing arrangements. This empirical research fills a gap in the Oman health financing structure by adopting quantitative and qualitative analysis for a period of last 10 years. This research has analysed the government financing scheme, voluntary health insurance (VHI), enterprise financing scheme (EFS), and out-of-pocket expenditure for the period 2014-2022, during a structural transition. Building on this literary work, this study makes three substantive arguments. First, Oman is transitioning from almost entirely public finance to greater reliance on private prepaid and household financing. Second, financially vulnerable populations (including employees of SMEs and informal workers, as well as lower-income expatriates) are also overlooked in financing frameworks. Third, integrating quantitative trends with stakeholder viewpoints helps explain why reforms to date have been unable to achieve financially sustainable, inclusive, universal health coverage. Therefore, this research focused on two major objectives. (1) To assess Oman's current economic and healthcare financing landscape and (2) to identify key challenges and knowledge gaps in health financing coverage in Oman.

Methods

A mixed methods approach was adopted to conduct a systematic analysis of the health financing system in Oman. The research design was descriptive and exploratory to understand the current health financing structure and interpret the country's situation in terms of financial protection, equity of access, and long-term fiscal sustainability. The secondary dataset for a ten-year period (2014--2022) was obtained from the MOH report 2023, the WHO (World Health Organization) report 2023, and the Financial Services Authority (FSA) index report 2023. To ensure broad perspectives on the current health financing system of Oman and the challenges the country faces in order to achieve universal health coverage, well-structured interviews were conducted regarding the current financing structure, the possibility of implementing mandatory health insurance, and challenges in the current system with different stakeholders, including MOH officials (3), executives from insurance companies (10), CMA authority representatives (4), and directors of private hospitals (8). Later, the qualitative data were coded using thematic analysis, as recommended by Braun and Clarke (2006), to pinpoint the health financing challenge in Oman. The compound annual growth rate (CAGR) method, as suggested by Sahoo et al. (2023), was adopted to statistically analyse the health financing indicators, current health expenditure (CHE), and CHE as percentages of GDP and CHE per capita for medium-term trend analysis.

Furthermore, time-series regression analysis was carried out to examine and understand relationships among key sources of financing and to further examine the determinants of the health financing mix, as suggested by Gujarati et al. (2009). This approach is commonly adopted in health financing and macro health evaluations to estimate the long-term relationships among public expenditures, private insurance growth, and out-of-pocket expenditures (MaIntyre et al., 2017; Gujarati and Porter, 2009; Mathauer et al., 2019). A further graphical presentation is presented to estimate the relative contribution of each financing mix to the health financing structure, temporal trends, and shifts in the structure and equilibrium of Oman's health financing system in relation to Universal Health Coverage (UHC) objectives. The dependent variable was defined as the balance of financing sources to achieve Universal Health coverage. Three primary independent variables were specified: (i) the share of government spending (GS), reflecting public sector commitment; (ii) voluntary health insurance and enterprise-based financing schemes (VHI+EFS), representing private sector expansion; and (iii) out-of-pocket expenditure (OOP), serving as an indicator of household financial burden. A regression model, as recommended by Behera et al. (2019), was employed to quantify the marginal contribution of each financing source to UHC progress, complemented by sensitivity analyses to account for fiscal-cycle volatility and enhance the robustness of the estimates.

Results

Quantitative analysis

Table 1 presents an ex post analysis of changes in health spending in Oman over the past 25 years. Between 2000 and 2023, Oman's GDP, which is primarily based on oil revenue, rose from OMR 4.7 billion to OMR 39.8 billion. During this time, the Ministry of Health's budget increased from OMR 145.7 million to OMR 1 billion, indicative of the sultanate's commitment to healthcare. Although health expenditure as a percentage of GDP has fallen to 2.52% by 2023 from 4.21% in

2015, the share of the health sector within the economy has diminished despite rising health expenditures. More than 80% of the health budget is allocated to recurrent spending; as a result, limited funds are available for investment in health care projects. Likewise, per capita health spending has increased from OMR 60.7 (2000) to an impressive OMR 194.3 in 2023; this highlights the concern for increasing access to and quality of health care. Unfortunately, because there is no large-scale health insurance program and public investment as a share of GDP, sustainability issues arise regarding equity, especially for expatriates and residents of remote areas.

Table 1: Health care expenditures, 2000--2023

Indicator	2023	2022	2021	2020	2015	2010	2005	2000
GDP at Current Prices(million R.O.)	42,145.7	43,717.7	33,909.8	29,187.2	26,850.3	22,547.6	11,882.9	7,639.2
GDP per Capita (R.O.)	8,158.3	8,860.5	7,490.0	6,341.2	6,455.8	6,964.6	4,736.4	3,181.0
Total Government Expenditures (million R.O.)	11,606.0	13,329.0	12,418.0	13,211.2	13,698.9	7,965.30	4,207.60	2,656.2
Ministry of Health Expenditures (million R.O.)	1,003.5	805.3	975.6	970.6	892.2	376	199.6	145.7
MoH Expenditures (% of Gov't Expenditures)	8.60%	6.00%	7.90%	7.30%	6.50%	4.70%	4.70%	6.20%
MoH Expenditures per Capita (R.O.)	194.3	163.2	215.5	211.9	214.5	116.2	79.5	60.7
MOH Expenditure as % of GDP	2.3810	1.8420	2.8770	3.3254	3.3228	1.6675	1.6797	1.9072

Source: MOH Oman Health report (2023)

Table 2: Health financing expenditures, 2014--2022

Indicators	2014	2015	2016	2017	2018	2019	2020	2021	2022	Avg	CAGR
Current Health Expenditure (CHE) as %	3	4	4	4	3	4	5	4	3	4	0%

Gross Domestic Product (GDP)											
Current Health Expenditure (CHE) per Capita in US$	727	767	714	705	640	730	859	856	707	745	-0.35%
Current health expenditure by financing schemes (GS+CCHFS+VHI+OOP)	100	100	100	100	100	100	100	100	100	100	0
Government schemes and compulsory contributory health care financing schemes (GS+CCHFS)	90	90	90	89	88	88	89	87	84	88	-0.87%
Voluntary health care payment schemes and Enterprise Financing Scheme (VHI+EFS)	4	4	5	5	7	6	6	7	8	6	+8.7%
Voluntary health insurance schemes (VHI)	2	3	3	3	5	4	4	5	5	4	+12.2%
Enterprise financing schemes (EFS)	2	2	2	2	2	2	2	2	3	2	+5.2%

Household out-of-pocket (payments (OOPS)	6	5	6	6	6	6	5	6	7	6	+1.96 %

Source-WHO data explorer,https://apps.who.int/nha/database/viewdata/indicators/en

$$CAGR = \left(\frac{Final}{Initial}\right)^{\frac{1}{n}} - 1$$

----------Equation-1

707/727=0.97 n =08

$=0.97246^{1/8}=0.99651-1=-0.00349*100=-0.35\%$

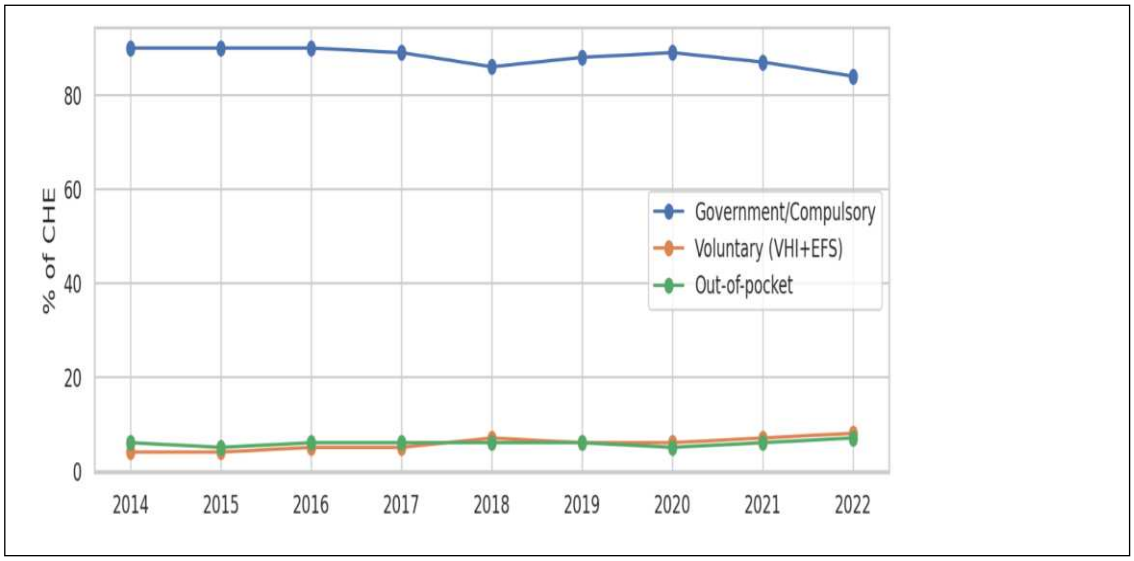


Figure 1: Health financing scheme in Oman. Source: Author's own elaboration

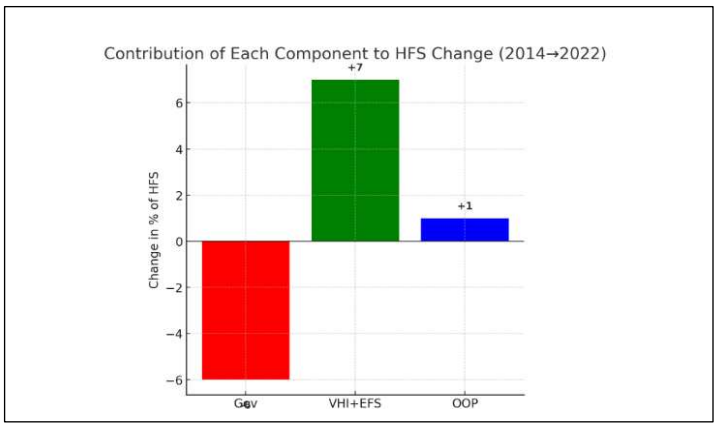
Table 2 provides a quantitative summary of trends in current health financing in Oman between 2014 and 2022. The financing structure (Table 2) reveals the dominance of the public sector in funding, which, although it has fallen from 90% to 84% of the total CHE, continues to be the driving force for universal health coverage (UHC). Meanwhile, the share of voluntary private insurance has nearly doubled from 4% to 11%, suggesting greater prospects for voluntary health insurance (VHI) in the future. In the meantime, out-of-pocket (OOP) payments have remained at a very low level of 6-7%, indicating that Oman offers financial protection that is much higher than in the GCC region. The temporary increase in CHE to 5% of GDP in 2020, driven by the COVID-19 pandemic, confirms that the health system is resilient. Table 1 demonstrates that Oman has a solid background in government-based financing, a growing role for private insurance, and continues to protect households. This joint model will broaden the financing base, improve sustainability, and help achieve Vision 2040 and universal health coverage in the country.

Table 3: Contribution % of HFS

Component	2014	2022	Absolute change (AC)	Contribution %=AC/8*100
Gov	90	84	−6	75%
VHI+EFS	4	11	+7	87.5%
OOP	6	7	+1	12.5%
HFS	100	100	0	100

Source: Own elaboration

Figure 2: Changes in the contribution of each component



Source: Own elaboration.

Table 3 and Figure 2 show that the shift in financing between 2014 and 2022 indicates a decline in equity and financial protection. Government funding, the most equitable source, decreased by 6 %, whereas voluntary and employer-based financing increased by 90% of the net change. While these private schemes may cover some groups, they exclude unorganized and marginalized populations. The slight increase in out-of-pocket payments, although small, adds to households' financial burden. Overall, the financing mix is moving away from pooled and progressive sources to more fragmented and regressive sources, which will be a challenge for universal health coverage and protection against catastrophic health expenditures.

Table 4: Regression Analysis -Health Financing Expenditure (2014--2022) Contribution change, 2014--2022

Variable	Coeff (β)	Standard Error (SE)	t-Stat	p value (Prob.)	Interpretation
GFS (Government Funding Scheme)	0.026	0.256	0.080	0.939	Not statistically significant. There is no evidence that government funding scheme has a significant linear relationship with the year in this model.
Household out-of-pocket-payments	-1.1827	0.378648	-3.123	0.035	Statistically significant at the 5% level ($p < 0.05$). This suggests that as household out-of-pocket payments increase, the predicted

					"year" value decreases, holding other variables constant.
Voluntary healthcare payment	2.355	0.3215	7.325	0.001	Highly statistically significant ($p < 0.01$). This indicates a strong positive relationship; as voluntary health care payments increase, the predicted "year" value increases significantly.
C (Constant)	2009.872	25.67655	78.27658	0	Highly statistically significant. This represents the predicted value of the dependent variable (YEAR) when all independent variables are zero.

Source: Own elaboration

Year=0.026*GFS-1.18*OOP+2.35*VHI&EFS+2009.8724…….. Eq-1

Table 4 and Equation 1 show that the overall model is highly significant ($F = 110.7$, $p < 0.001$) and that financing mix government funding (GFS), household out-of-pocket spending (OOP), and voluntary insurance plus employer-based schemes (VHI&EFS) explain a significant portion of the variation over time. However, the explanatory power of each component is not equal. The OOP coefficient is negative (-1.18), indicating that a reduction in OOP is strongly associated with forward movement in the health financing trajectory, and that financial protection is the key driver of progress. The VHI&EFS coefficient is positive (2.36) and statistically significant, indicating that even a small increase in prepaid private financing has a large effect on the temporal transition, consistent with recent reforms such as Dhamani. The coefficients also amount to tangible "time shifts": a 5% drop in OOP would move the system forward by almost 6 years (5×1.1828), and a 5% increase in VHI would move it forward by almost 12 years (5×2.3552). The government funding share, which accounts for approximately 85% of current health expenditure, has a nearly zero coefficient (0.02) and an insignificant effect ($p \approx 0.94$). Generally, the results show that government spending provides stability to Universal Health Coverage and increasingly relies on private prepaid contributions, such as voluntary health insurance (VHI), to strengthen financial protection and facilitate Oman's transition toward Universal Health Coverage (UHC). The persistence of publicly financed funding likely supports that stability, as VHI instruments are likely to be unstable and unsustainable in the long term, particularly given their need for wide and equal coverage.

Qualitative analysis

The findings of the interviews (Supplementary File 1) with 25 key stakeholders indicate that the system today heavily depends on public funding, with the government covering 80–90% of all health expenditures. This shows steady health access across the country, but it has also raised serious concerns about fiscal sustainability, especially for low-income groups, informal workers, and SMEs, who cannot afford the premium, creating a major coverage gap in the health insurance system. SMEs cannot afford workers' coverage; expatriate insurance is not linked to visas, unlike in other GCC states; and low, rural, and informal-sector populations are underserved. Low health

literacy and cultural barriers marginalize migrants, and informal workers are the key coverage gaps that threaten equity and sustainability. At present, they either pay out of pocket or are primarily uninsured. This weakens efforts to pool economic risk and to reform Oman's health system, as care-seeking moves towards emergency care due to rising out-of-pocket costs. There was consensus among stakeholders that reforms should be gradual and regulated to establish a fairer, far more sustainable system. Some of the recommendations linked employer-based insurance with the granting of visas to increase compliance, the provision of subsidies and products specifically targeted to SMEs and low-income earners, and a model of inclusive public–private partnership that would be able to bring together private providers and affordable care to rural and underprivileged regions.

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Findings and discussion

Oman healthcare financing is primarily government funded, with public schemes covering 84% of the CHE between 2014 to 2022. This has previously provided extensive population coverage and very low out-of-pocket payments (OOP ~6%), well below the world average. Nevertheless, the government share is declining (6%), whereas the shares of voluntary health insurance (VHI) and employer financing schemes (EFS) are increasing (+7% and 87.5% of the net change, respectively). Out-of-Pocket payments are still reasonably low, indicating strong household financial protection, but the recent rise is an alarming sign for health equity. Table 2 shows that CHE per capita is almost constant, with a -0.35% CAGR and no real long-term growth. Health spending as a percentage of GDP is 4%, the lowest in the GCC, and a fiscal constraint. Regression analysis shows that the main sources of transition are Out-of -Pocket (OOP) spending and growth in voluntary health insurance and enterprise-based financing (VHI&EFS), whereas government funding, although the predominant source, remains statistically stable. This should be interpreted as a sign of continuity and efficiency rather than weakness, and its impact should be evaluated in the context of health outcomes. This indicates that the financing mix is changing; however, the system is not stable in the long run, as VHI is highly volatile, posing a risk to both equity and sustainability. Likewise, health expenditure as a percentage of GDP reached a peak of 5% in 2020 and fell to 3% in 2022, so the increase in allocations was mainly due to the crisis and was not sustainable, as indicated in the figure. The evidence shows that although out-of-pocket expenses are low, the recent rise is a threat to the financial safety of households, particularly vulnerable groups. The interview analysis shows that the voluntary and employer-based schemes are mainly available to formal-sector employees, resulting in fragmentation and leaving informal workers, SME employees, and low-income expatriates without affordable coverage, since there are no compulsory contributory schemes or visa-linked insurance mandates. Disparities in both geographic and social aspects are clear; people living in rural areas and those who are marginalized have limited access to private services and often depend on public facilities or emergency care. From a fiscal point of view, the heavy reliance on public funding is a concern for long-term sustainability, as healthcare costs are rising. Overall, these challenges reveal the need for diversified, equitable, and well-regulated financing reforms. The present study validates and adds to the evidence on Oman's health financing context. As in the literature referred to above, Oman's health financing system is primarily government-funded, with more than 80% of current health expenditure (CHE) attributable to government funding (Alshishtawy, 2010; MOH, 2023). In this state-based funding approach, Oman has benefited from nearly universal access to services for its

nationals, as well as lower out-of-pocket (OOP) payments, which is an advantage compared with other countries, as found by Ibrahim (2020) and Larrain et al. (2023). The result also concurs with the evidence (WHO, 2010) that Oman still relies on recurrent government revenue to finance its health expenditure and continues to provide strong financial protection to households. Moreover, our results show several important shifts and emerging gaps. First, in line with recent regional trends, Oman is witnessing gradual diversification, with voluntary health insurance (VHI) and employer-based financing (EFS) increasing their contribution (+7% between 2014 and 2022). Previous studies have anticipated the role of private insurance as a supplement to public provision (Ibrahim & Devesh, 2020; Askarzade et al., 2024), but the present analysis estimates its growing impact and shows how it now represents the majority of net financing change (87.5%).

This analysis verifies and extends the literature on Oman's health financing system. First, previous studies have made claims for tighter regulation of private insurance (Askarzade et al., 2024). However, we provide new evidence that voluntary and employer-based schemes are no longer marginal but are now very significant drivers of the system transition. Second, low out-of-pocket (OOP) payments identify a recent upward trend in OOP payments, but this poses emerging risks to household financial protection and equity, as evidenced by global linkages between rising OOP and catastrophic health expenditure, as noted in studies by WHO (2010) and Ibrahim (2020).First, earlier studies have indicated the crippling effect of oil-dependent public finance activities on the fiscal vulnerability of GCC states (Rushdi et al., 2024; Ariffin et al., 2024).which matches our result .Moreover, Oman's income is also based on oil, and our findings say stagnation in real per capita health spending (CAGR −0.35%) and a decline in the health expenditure share of GDP to the lowest level in the GCC (~4%), indicating that in spite of economic growth, the fiscal capacity of the countries is being constrained.

Qualitative results show critical implementation gaps that were not highlighted in previous studies. These include the absence of insurance linked to visas, and the lack of affordable coverage for workers from small and medium-sized enterprises, the informal sector, and low-income expatriates. This has led to exclusion even though there is a policy emphasis on public-private partnerships and digital solutions (Matteis et al., 2024; Joudyian et al., 2021). Overall, this study pinpoints three key policy gaps requiring attention under Vision 2040 that are not well recognized: (i) rising OOP expenses that jeopardize equity, ii) stagnating per capita health spending in the context of overall economic growth, and iii) regulatory and Fiscal gap failures that exclude the poor from coverage. Filling these gaps would help Oman achieve sustainable and fair health financing.

Conclusion

According to the results of this research study, Oman's Health Financing architecture is in transition, from a publicly funded healthcare system to a mixed model combining private health insurance and enterprise-financed healthcare. The current system provides sound financial protection but is threatened by the rising challenge of fiscal sustainability, as government healthcare expenditure declines despite the economy continuing to grow. Moreover, rising burden of NCD (non communicable Disease), ageing, lack of adequate insurance coverage, and inequity, all of which create concern for the long-term stability of the system, Oman is prepared to substantially transform or change through risk pooling, regulations, and policy design that are in

line with their Vision 2040 and Universal Health Coverage (UHC) goals. The limitations of the research derive from the limited availability of secondary source data on hospitals and the potential biases of interviewees in qualitative interviews. Nevertheless, adopting international best practices, mandatory insurance, integrated risk pooling, well-governed public-private partnerships, and strong regulation will lead the country to equitable universal health coverage.

Declaration

Abbreviation
UHC: Universal Health Coverage
OOP: Out of Pocket
GCC: Gulf cooperation council
CAGR: Compound Annual Growth rate
EFS: Enterprise Financing scheme
VHI: Voluntary Health Insurance
CHE: Current Health expenditure
GFS: Government Funding Scheme
GS: Government Scheme

Ethical Approval and Consent to Participate: Ethical approval has been taken from the Ministry of Health for this study under Ethical approval grant MOH/CSR/24/29387.The study was conducted with the principal declaration of Helsinki. Participant's consent was taken before the interview. Before the consent all the participants were clearly informed about the study objective. . Interview was developed for this study and has not published anywhere. Interview is provided as supplementary File.

Availability of Data and Material: Data is available on request

Conflict of interest: "The authors declare that there are no conflicts of interest".

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Author Contribution:(NK, NZ were responsible for Conceptualization, data collection and analysis., methodology and SS and HN was responsible for data interpretation and Project Management. NK wrote the first draft of the article.").

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