# CHALLENGING HEALTH CARE SYSTEM SUSTAINABILITY IN OMAN

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**ABSTRACT**

The healthcare system in Oman is being reformed. During last three decades, the system has demonstrated and reported great achievements in health care services, preventive and curative medicine. In 2001, WHO ranked Oman first because of what was described as a "spectacular performance" in reducing infant mortality rate over the past three decades. The healthcare system in Oman is facing a challenge of sustainability of achievement. In this paper, current health status indicators are presented along with effort to maintain health outcomes. Threats of sustainability are identified and international financing approaches are reviewed to develop a model for sustaining reform in Oman

The Sultanate of Oman is the third largest country (309,500 square km) in the Arabian Peninsula after Saudi Arabia and the Republic of Yemen. The Sultanate is composed of varying topographic areas consisting of plains, dry riverbeds and mountains. The most important area is the plain overlooking the Gulf of Oman and the Arabian Sea with an area of about 3% of the total area. The mountain ranges occupy almost 15% of the total land of Oman and are inhabited by about 5% of the population. It has a coastal line extending almost 1,700 kilometers from the Strait of Hormuz in the North to the borders of the Republic of Yemen, overlooking three seas; the Arabian Gulf, Gulf of Oman and the Arabian Sea. The Sultanate of Oman is administratively divided into five Regions and three Governorates with 59 Wilayats (districts). It is further divided for purposes of health administration into ten health Directorates *(8)*.

Total Population of Oman according to the last census is 2,402,000. 74% of the population are citizens and about 41.2 % of the population is under 15 years and 4.9 % over 60 years. Life Expectancy at birth is 74 years. Oman has a young population with more than 50% of the people below 25 years of age. The problems of the elderly are still not obvious. This is due to family structure and lack of social programs for the elderly. Table1 & Figure1 presents some demographic indicators relevant to the discussion on sustainability.

The Oman economy is growing with large oil and gas resources, a substantial trade surplus, and low inflation. The government is moving ahead with privatization of its utilities, including the health sector. In order to limit the dependence on foreign countries, the government is encouraging the replacement of expatriate workers with local people, i.e., the process of omanization especially in the nursing profession, training in information technology, and business management.

## Organization of the Healt hcare System in Oman

Before 1970, there was no special agency taking the responsibility for healthcare in Oman. The pattern of illness was characterized with:

- High mortality and morbidity rates mainly due to communicable diseases; the proportion of disease burden due to non-communicable diseases being relatively low.
- Infant Mortality Rate (IMR) was estimated to be 118 per 1000 live

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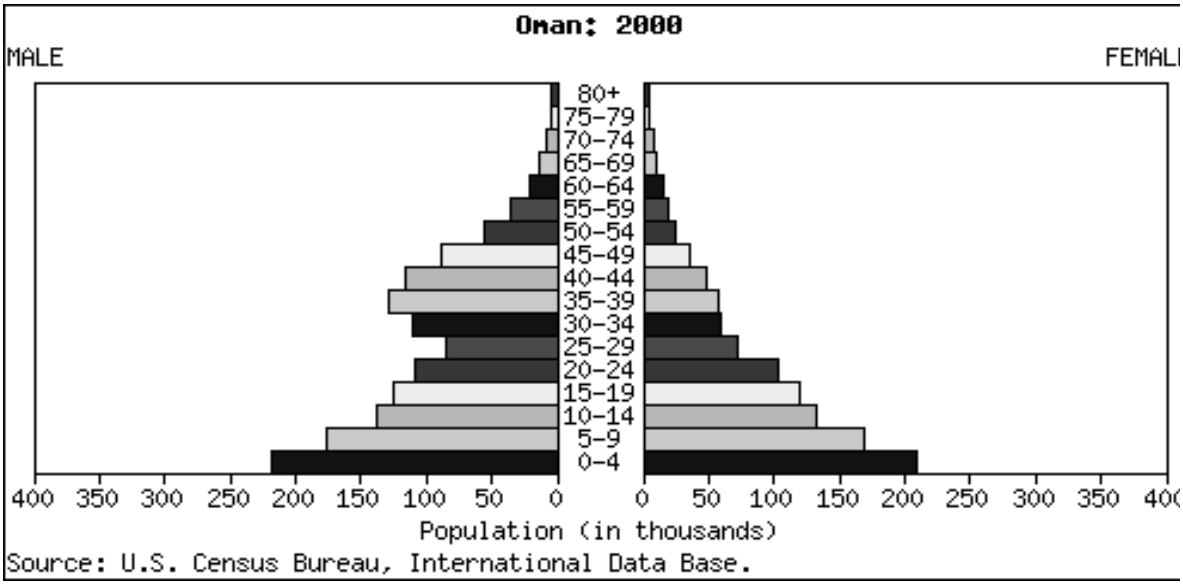
***Table 1.*** **Demographic Indicators of Oman**

| Indicator | 2002 | 2001 | 2000 |
|---|---|---|---|
| Total Population Estimate (mid year) | 2,538 | 2,478 | 2,402 |
| Sex Ratio (males Per 100 females) | 103 | 103.5 | 103 |
| Under 5 Years (% of Omani Population) | 13.6 | 13.9 | 14.0 |
| Under 15 Years (% of Omani Population) | 41.2 | 42.3 | 43.2 |
| 60 Years and Over (% of Omani Population) | 4.9 | 4.8 | 4.8 |
| Men aged 15 to 49 Years (% of Omani Population) | 25.1 | 24.6 | 24.1 |
| Women aged 15 to 49 Years (% of Omani Population) | 24.4 | 23.9 | 23.5 |
| Crude Birth Rate (per 1000 Pop.) | 26 | 28 | 33 |
| Total Fertility Rate (Birth per women 15-49 years) | 3.64 | 4.2 | 4.7 |
| Crude Death Rate (per 1000 Population.) | 3.47 | 3.5 | 3.65 |
| Infant Mortality Rate (per 1000 live birth) | 16 | 16 | 17 |
| Life Expectancy at Birth | 73.78 | 73.82 | 73.38 |

**Figure 1.Population Pyramid for Oman**

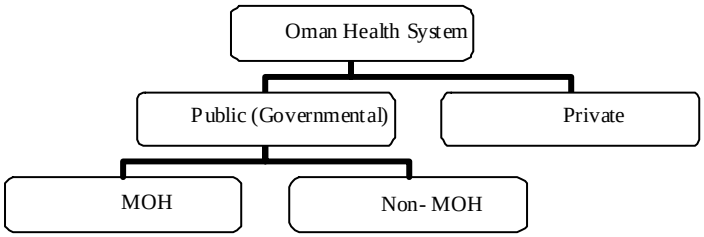



births and Under 5 Mortality Rate (U5MR) was 181 per 1000 live birth.

- Childhood diseases were highly prevalent during the 1970s e.g. , Acute Poliomyelitis, Tetanus, Diphtheria, Measles, Mumps, Pertussis, Pulmonary Tuberculosis and Malaria

In 1970, a Royal Decree was issued to establish the Ministry of Health (MOH) in Oman. This was the beginning of a modern health system. The MOH is the Sultanate's main agency responsible for provision, coordination and stewardship of the health sector. The MOH is required to ensure overall development of the health sector per se in relation to other key social sectors. In keeping with this role, The MOH acts as the principal architect of health system design and takes responsibility for achieving inter-sectoral coordination. It develops policies and programs for the health sector. It implements these in coordination with all other related ministries, health services institutions under the government as well as in the private sector. The MOH also advocates to all other public systems to make policies favorable to the health sector, and to refrain from making policies that may adversely affect the health of the

**Figure 2. Components of Oman Health System**




people. Figure 2 illustrates the health care organizational structure in Oman.

## Healthcare Services in Oman

The MOH serves as the main agency of the government for providing curative care to the people of Oman. It runs hospitals and health centers at national, regional, sub-regional and local levels that are integrated in a referral chain (continuum of care). The curative care services provided in MOH hospitals is supplemented by other government hospitals and clinics such as those run by the Sultan Qaboos University, Ministry of Defense, Royal Oman Police and the Petroleum Development Oman. There are also three private hospitals and several clinics that play an increasingly important role in providing care. All these institutions are linked with the MOH system through a continuum of care referral system**.**

The MOH makes primary medical care available through local health centers, extended health centers and local hospitals. The regional referral hospitals mainly provide secondary medical care, while the four national referral hospitals provide tertiary medical care. The MOH ensures that no Omani is left without the benefit of medical care. It sponsors patients for treatment abroad, if the required treatment facilities are not available in the country. The MOH recognizes the importance of the preventive, promotive and rehabilitative components of health care, and provides all the required services through its newly equipped infrastructure to the fullest extent possible.

Although, The MOH supports and encourages private healthcare sector participation in the healthcare system, this effort is not well cultivated and organized at present. The private sector represents about 12% of the total health care system. Table 2. presents growth in private health sector services in Oman (*5*).

## Financing Healthcare System in Oman

The healthcare system in Oman is a government funded system. More than 80 per cent of the country's healthcare services are being provided by the government. As of 2002, the Ministry of Health (MOH) accounted for 5.75 per cent of total government expenditure for healthcare in Oman. Public financing of the healthcare system is coming from general country revenues. Private resources for healthcare are coming from "out of pocket payments" for private health services and co-payment for public health services. Health insurance in Oman is not established. Some types of road traffic accident medical coverage are included in the automobile insurance system. 60% of total MOH budget is allocated to acute care services and one third of this goes to primary healthcare (*8*).

**Table2. Growth in Private Services**

| | 2001 | 2000 | 1999 | 1998 | 1997 | 1996 | 1995 |
|---|---|---|---|---|---|---|---|
| Hospitals | 3 | 3 | 2 | 2 | 2 | 2 | 1 |
| Clinics/ Diagnostic clinics | 641 | 560 | 491 | 475 | 461 | 439 | 471 |
| Pharmacies | 326 | 321 | 302 | 311 | 279 | 275 | 254 |

As it is for other governments sectors, the system of financing is central. Each ministry's budget is allocated by the ministry of National Economy. Key budgetary and financial indicators as of 2002 are as follows:

- Allocated to MOH from Total Government Budget (%) - 1.8 (2002)
- MOH Expenditure As % of GNP - 1.9 (2002)
- Health Expenditure as % of GNP - 5.7 (2002)
- Budget of MOH (Per Capita USD) - 153 (2002)
- Expenditure on Health (per capita USD) - 325 (1998)
- Revenue of MOH (million USD) - 25 (2001)

**Healthcare System achievements and performance**

Oman has achieved significant improvements in health status. Over the past three decades, infant and child mortality rates have fallen, health service delivery has improved, and overall life expectancy has risen. The number of children dying before the age of five has declined. People are living 13 years longer, on average, demonstrating life expectancy rates comparable to other European countries.

The epidemiological profile as of 2002 reveals (*8*):

- The Sultanate of Oman is witnessing an epidemiological change in diseases pattern. The communicable diseases have declined to low levels and the non-communicable diseases have started to emerge.
- Oman has shown a remarkable success in reducing the burden of various vaccine preventable diseases to the extent that some reached the level of eradication.
- Non-communicable diseases constitute 54.5% of outpatient morbidity and 40.8% of inpatient morbidity in MOH institutions.
- Cancer cases among inpatients accounted for 9 per 10,000 population
- Cardiovascular diseases accoun-ted for 63 per 10,000 population.
- Diabetes mellitus accounted for 14 per 10,000 population.
- Cardiovascular diseases were the main cause of hospital deaths. They have accounted for 34.5% of all hospital deaths followed by cancer that accounted for 13.2% of all hospital death.
- Road traffic accidents (RTA) represented about 27% of all causes of injuries among inpatients in MOH hospitals and it costs 3% of MOH budget (National Workshop in Road Safety, October, 2004)

## Achievements in Oman Healthcare System

The international community and agencies have praised the health services development of the Sultanate of Oman. The "Nations Progress Report" issued in 1997 by UNICEF has acknowledged the Omani achievements in child health and has ranked The Sultanate among the leading countries in the Middle East, Africa and even the whole World that have achieved control of childhood diseases as poliomyelitis, diphtheria and tetanus neonaturm. The "Human Development Report" issued by United Nations Development Program has ranked the Sultanate number one country for its achievement in reducing under age 5 mortalities and increasing immunization coverage to almost 99% of the population. It has considered the Sultanate as a model for human development.

From 1975, the MOH established and implemented a long term 5 year strategic plans (*8*). The 6$^{th}$ year Plan (2001-2006) focuses on consolidating and sustaining previous gains and targeting new challenges. It is worth mentioning that Oman, where

healthcare services are free of charge to all Omani nationals, was awarded first place in healthcare delivery efficiency and utilization of financial resources by the World Health Organization (WHO) in its analysis of 191 national systems in July 2000. Oman was also rated in the top 10 of the world's most effective healthcare systems overall.*(18)*.

The Sixth Health Development Plan is expected to concentrate on expanding and improving primary healthcare facilities in the villages and townships, and providing additional specialist treatment centers, thus further reducing the number of cases sent abroad for treatment. However, even with these accomplishments Oman still faces a number of obstacles in sustaining these achievements.

## Healthcare system sustainability

Sustainability is an important long-range goal for any healthcare system. UNICIF Policy Review Document (UNICIF 1992) uses a definition of sustainability proposed by the International Development Management Center: The ability of the system to produce benefits valued sufficiently by users and stakeholder to ensure enough resources to continue activities with long- term benefits. The Canadian Public Health Association identified five main components required to achieve sustainability development: technical sustainability, social sustainability, political sustainability, financial sustainability and managerial sustainability (CPHA, 1990).

The Center for Partnership in Development (DiS, 1998) integrates all components of sustainability in one definition: A health service is sustainable when operated by an organizational system with the long-term ability to mobilize and allocate sufficient and appropriate resources (Manpower, Technology, Information and Finance) for activities that meet individual or public health needs and demands.

Financial sustainability in health systems is: having enough reliable funding to maintain current quality health outcomes and health services for a growing population and to cover the costs of raising quality and expanding availability to acceptable levels (USAID, 1995). To be sustainable, such funding should be generated from a country's own resources. Most definitions of sustainability also include the additional requirement that the system be able to expand its activities as needed to keep up with increases in demand due to economic and population growth. Sustainability includes both financial and institutional dimensions. For the Oman health care system, sustainability means maintaining the gains achieved and making incremental change for future quality outcomes (table 3).

**Table 3. Achievements in Oman Healthcare Services**

| Indicator | 1970 | 1975 | 1980 | 1985 | 1990 | 1995 | 2000 | 2002 |
|---|---|---|---|---|---|---|---|---|
| Hospital | 2 | 24 | 28 | 40 | 47 | 47 | 56 | 56 |
| Hospital beds | 12 | 1,000 | 1,784 | 2,861 | 3,419 | 3,958 | 5168 | 5200 |
| Bed / 1000 Population | 0.02 | 1.3 | 1.8 | 2.1 | 2.1 | 2.1 | 2.10 | 2.24 |
| Doctor / 10000 Population | 0.2 | 5.1 | 9.0 | 11.8 | 13.6 | 13.7 | 13.9 | 16.0 |
| Nurses/10000 Population | 5.6 | 10.8 | 16.0 | 26 | 28 | 32.3 | 32.5 | 32.9 |
| Bed / Doctor | 0.9 | 6.8 | 3.5 | 3.1 | 2.5 | 1.7 | 1.6 | 1.5 |
| Bed / Nurse | Na | 2.2 | 1.6 | 1.4 | 0.9 | 0.7 | 0.6 | 0.6 |
| Health Centers | 19 | 40 | 55 | 79 | 94 | 120 | 118 | 119 |
| Extended Health Centers | 0 | 0 | 0 | 0 | 0 | 5 | 10 | 10 |
| Private clinics | na | na | na | 255 | 334 | 471 | 560 | 641 |

## Majors issues influencing sustainability of health system in Oman

Challenges to healthcare sustainability include, on the demand side, increased consumer expectations; increased cost of treatment (mainly from the development of new technologies rather than health-specific cost increases); and on the supply side, resource constraints including funding, workforce and capital infrastructure.

To analyze the challenges that face sustainability of the health system in Oman, a model is proposed in Figure 2 that consists of four major issues influencing healthcare system sustainability: these issues are enabling environment, financial instability, institutional problems and demand to healthcare services (*4*).

*Enabling Environment*

Oman enjoys a stable political, economic, and social system. An enabling environment supports the formulation and implementation of sound policy; ensures coordination and collaboration among providers (public and private) to promote efficient and effective use of resources; and guarantees community participation and empowerment. It also ensures that laws and regulations do not delay the supply of demand for services. Such a context or environment fosters the sustainability of health service provision. Whereas the elements of an enabling environment are often considered directly associated with institutions and systems, they also apply to sustainability of demand issues; increased community involvement promotes greater community support for MOH programs and health services and healthy behaviors. Four aspects of enabling environment are relevant to Oman: the policy process (encompassing policy formulation, implementation, and evaluation), legal and regulatory environment, health sector reforms, and community empowerment (table 3).

*Financial Sustainability*

Under financial sustainability are public sector financing and private sector financing categories. Resource mobilization and efficient allocation and use of resources are sub-elements (*5*). All of these affect both public and private sector resources in the health system. Financial sustainability must also be supported by an enabling environment. For example, laws must allow cost recovery if that is the strategy chosen. Similarly, institutions must have the capability to collect and account for revenues so generated and demand should not be compromised (table 4).

*Institutional Sustainability*

One key element of the sustainability of the health care system is the capacity of the service delivery system to meet the needs of patients. This means that the supply side must be able to provide quality services that reflect the needs and desires of those who ask for or use healthcare. "Institution" is used in the broadest sense, going beyond the definition linked to a physical structure (*16*). MOH hospitals are the main institutions for health service delivery in Oman.

**Figure 2. Simplified Sustainability Framework**

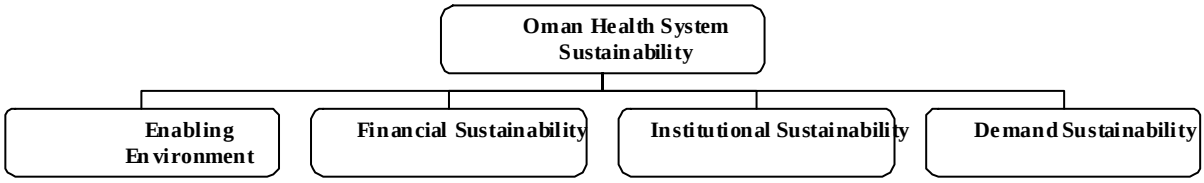


***Table 3.***

| Favorable factors for sustainability | Unfavorable factors for sustainability |
|---|---|
| ***Policy Process***<br>• Supportive leadership<br>• Attention and concern of the top leadership<br>MOH focus on long-term planning in relation to Sustainability (five years planning started in 1976) | • Lack of continuity in leadership<br>• Private health sector is not involved in policy formulation.<br>• Information is not fully utilized effectively in policy making<br>• Introduction of user-fees is a politically sensitive issue |
| ***Legal and Regulatory Environment***<br>• Presents of comprehensive legal and regulatory mechanisms for the private sector.<br>• MOH encourage and has an incentive system for the private health sector | • Quality control program in government health organization is still at early stage.<br>• No quality control program for the private sector. |
| ***Health Sector Reforms***<br>• Integrated healthcare services (primary, secondary and tertiary).<br>• An effective referral system between services<br>• Co-payment for primary healthcare | • No health insurance programs.<br>• No accreditation system of providers<br>• No utilization review programs |

***Table 4.***

| Favorable factors for sustainability | Non Favorable factors for sustainability |
|---|---|
| ***Allocation and Use of Resources***<br>• Hospital autonomy (management and budgeting and some purchasing authority).<br>• Central planning and financing | • No competition between public sector and private sector.<br>• Slow growth of private sector due to less investment. |
| ***Mobilization of Resources***<br>• There is an increase in total real health expenditure per capita and it is likely to increase further | • Proportional spending between public and private is more than 3:1 |
| ***Efficient allocation***<br>• MOH at present conducts 14 health related programs directed to priority problems. | • 60% of MOH budget go to acute healthcare.<br>• No specific budget allocated for each program. |

Institutions with well-developed systems are more likely to be effective and survive in the future than institutions without well-developed systems. Sustainable institutional capacity includes four categories: Planning and Management, Human Resources, Information Systems, and Logistics (table 5) (*3*).

The human resources production system of the Sultanate still suffers from a number of inadequacies. The current Omanization level of physicians is only 16.1%. The expected yearly average of physicians graduating from the College of Medicine SQU (2001-2005) is 90. This graduation rate is inefficient to speed the Omanization process. Because of this constraint, the MOH is forced to discontinue services of highly qualified and experienced non-Omani medical staff to enable the recruitment of newly graduated Omani physicians. This strains the MOH's capacity to deliver high quality health services.

***Demand Sustainability***

Demand sustainability has several components. The costs to users can affect demand as with any good or service, but also travel costs, waiting time, and laboratory costs in some cases (table 6).

*Table 5.*

| Favorable factors for sustainability | Non Favorable factors for sustainability |
|---|---|
| ***Facilities*** | |
| • Extensive network of primary, secondary, tertiary health care facilities<br>• New network of secondary care hospital in every health regions with high standard infrastructure. | • Equal market split between public and private sector<br>• Lack of coordination between public and private sector<br>• Unequal distribution of private sector clinics/ hospital in rural/urban areas. |
| ***Human Resources*** | |
| • Building of managerial capacity in strategic planning, resource allocation, management and human resources development, and supervision.<br>• MOH has 16 training institutes; 13 of these are nursing institutes – nurses comprise over 75% of MOH institute students | • Subjective decision-making processes and not information based; lack of quality improvement process.<br>• About 75% of qualified, trained and professional staff in healthcare system are non citizens.<br>• Weak capacity in strategic planning, investment management, cost accounting, and budgeting at the regional level.<br>• Inadequate incentive schemes for personnel<br>• Central employment system<br>• Not all professional categories have job description.<br>• Ineffective appraisal system for performance. |
| ***Management System*** | |
| • Regional health directorates have their own budgets, staffing patterns, training and education priorities depending on the needs of the areas they serve.<br>• Early implementation of hospital autonomy. Inducing accountability with resources allocated. | • Unqualified managers running health service facilities (hospitals, health centers, etc.)<br>• Deficiency in the information required for Human Resources development. |
| ***Information systems*** | |
| • Good electronic health information system at all levels of healthcare services.<br>• In process to implement telemedicine between major hospitals. | • Limited utilization of information in decision making and planning.<br>• Health and medical researches are limited. |

***Table 6.***

| Favorable factors for sustainability | Not Favorable factors for sustainability |
|---|---|
| **Demand management** | |
| • Increase awareness leads to increased use of private health sector.<br>• Increase level of education<br>• High tendency to practice healthy behaviors | • Larger number of consumer who are not willing to pay for healthcare. Especially the poor.<br>• Public health care system is affordable and poor are exempt from fees ($ 0.50). This encourages misuses and over utilization of resources.<br>• Increased consumer expectations<br>• Dual burden of both communicable and non-communicable diseases.<br>• Road traffic accidents (Trauma) are new burden on the health system, consuming 3% of MOH budget.<br>• High cost of new technology.<br>• Consumer pressure on governments to provide new treatments (such as pharmaceuticals and diagnostic services) as soon as they are developed |

## International approaches of health finansing

Health care is one of the largest economic sectors in OECD countries, and at present accounts for over 8 % of GDP on the average (*11*). In theory there is a continuum of possible government approaches ranging from taking no responsibility for health care (so citizens insure privately or pay for services themselves) to funding health care fully through general revenue as is the case in Oman and other countries. In practice, most governments fund a significant level of health care coverage for the majority of their citizens, but also allow some user funding options (table 7). Among developed countries, the United States (US) system is closest to the "market end" (although with publicly-funded assistance for the poor, the elderly, and people with disabilities). The United Kingdom (UK) government like Oman is closer to the "centrally planned" end, with health services funds and provided through the National Health Service (albeit with a small private health insurance system).

The Australian health care system is somewhere in the middle, sharing features with the US and UK systems. It combines universal access to publicly funded health care through Medicare, market like financing incentives and support for the private sector.

Singapore is the first economy in the world to implement medical savings accounts on a nationwide basis (known as Medisave and established in 1984). It is the only country which integrates a medical savings account program within the national health financing structure. Medisave accounts are embedded in a broader framework that backs up the medical savings accounts with a cross-sectional catastrophic risk pooling scheme called Medishield and a means tested safety net for the poor called Medifund .This three-tier package (Medisave, Medishield and Medifund) is backed up by government financing of supply-side subsidies to public providers aimed at lowering the net prices charged to patients (*7*).

Health care systems in most European countries (EU) depend on a mix of funding sources, mainly derived from public expenditure, i.e. taxation and social health insurance. Table 8 below shows the proportion of total health expenditure from social health insurance and taxation, and the proportion from private sources in selected countries. (OECD, 2003).

## Recommended approach to Oman healthcare system sustainability

A sustainable healthcare system is one that can continue to achieve its objectives over time. This is not just a matter of matching the quantum of resources to expected needs, as a ratio of health expenditure to GDP. There is no 'mechanistic' relationship between

***Table 7.*** **Percentages of Healthcare Expenditure in Selected Countries**

| Economy | GDP per capita1 (USD) | Highest rates for personal income tax | Health care expenditure | | |
|---|---|---|---|---|---|
| | | | % of GDP | Public funding (% of total) | Private funding (% of total) |
| Hong Kong | 24,850 | 17.0% | 4.6 | 53.8 | 46.2 |
| Singapore | 22,680 | 28.0% | 3.9 | 33.5 | 66.5 |
| Austria | $29,000 | 27.2 | …….. | 42.5 | 30.3 |
| France | $27,600 | 59.8 | 9.7 | 15.8 | 24.4 |
| Spain | $22,000 | 64.9 | 7.5 | 6.6 | 28.5 |
| United Kingdom | $27,700 | ---- | …….. | 82.2 | 17.8 |
| Oman | $13,100 | 0.0 | 5.7 | 88.0 | 12.0 |
| USA | $35,991 | ----- | 14.0 | 46.0 | 54.0 |

***Table 8.*** **Health Insurance in Selected OECD Countries and Oman**

| Economy | General Taxation | Social health insurance | other private sources |
|---|---|---|---|
| France | 2.7 | 73.4 | 23.9 |
| Netherlands | 3.9 | 59.4 | 36.7 |
| Germany | 6.2 | 68.8 | 25.0 |
| Luxembourg | 15.1 | 72.7 | 12.2 |
| Austria | 27.2 | 42.5 | 30.3 |
| Finland | 59.8 | 15.8 | 24.4 |
| Spain | 64.9 | 6.6 | 28.5 |
| Italy | 75.1 | 0.2 | 24.7 |
| Ireland | 75.2 | 0.8 | 24.0 |
| United Kingdom | 82.2 | 0.0 | 17.8 |
| Denmark | 82.4 | 0.0 | 17.0 |
| Oman | 88.0 | 0.0 | 12.0 |

need, level of health care and level of health care expenditure. Whether a given level of service provision is 'sustainable' also depends on: (Richardson 1990).

- How much the community is willing and able to pay for health.
- The availability of other resources such as workforce and capital infrastructure, not only in gross amounts but in the right places.
- Efficiency, improving the ratio of inputs to outcomes.
- The source of inputs, notably the relative contributions of individuals, governments and other private sources such as insurers and employers.
- An effective management system with concentration on an accountability, utilization review, quality improvement , human resources, and accreditation system.
- A greater commitment to address non-medical factors such as road traffic accidents, trauma, malnutrition, obesity, smoking etc.
- Evidence-based health care should be considered. Knowledge from scientific survey and research should be employed to improve the efficiency and effectiveness of health services.

***Healthcare Financial Sustainability***

Adequate financial resource is a foundation for any health system sustainability. The Oman health system should consider some important points:

- Need to direct more resources for disease prevention and health promotion.
- Private sector should be encouraged to invest more in the healthcare industry.
- Alternative resources and raise revenues through user fees, insurance plans, or private sector employer-supported health plans. A pluralistic model should be considered using different financing options or mixed of financing options.

***Health Care Financing Options***

1. General taxation

The financing of health care through general taxation is widely regarded as being highly efficient from a macroeconomic perspective. It delivers strong cost containment and forces prioritization through the overall cash-limited health care budgets set by the government. Under tax financing, the government has both a strong incentive and the capacity to control costs (*1*). General taxation is also an efficient way of funding health care from a microeconomic perspective. It typically involves low administrative costs. It is sometimes suggested that a reliance on general tax financing can leave a health system vulnerable in times of economic and fiscal difficulties. Funding healthcare through general taxation ensures universal access to services irrespective of ability to pay, with minimum separation between an individual's financial contributions and utilizations of health care services. It will be difficult to implement a taxation system in Oman due to low per capita income. Funding from general revenue is already implemented.

2. Social health insurance

In social insurance systems, employer and/or employee earnings-related contributions are usually paid to and managed by social insurance or sickness funds. Social insurance contributions are raised from a narrower base than general taxation, with the costs falling mainly on employers and employees rather than the wider group of taxpayers. A criticism of traditional social insurance systems is that these sickness funds produce little incentive to seek to contain the payments they make to health care providers because of their ability to raise contribution rates. As a result, many argue that cost control under traditional social insurance models has been weak and has resulted in inefficient use of resource. Sharply

rising costs and emerging deficits in social insurance funds in recent years have led several countries to introduce reforms to their social insurance systems moving towards financing arrangements where they can exert greater control on the overall level of health spending (*9*)

3. Private health insurance

Private health insurance schemes are taken out by individuals or by employers on their behalf. The extent to which private health insurance finances health spending and the nature and coverage of private insurance varies considerably across countries. In some countries like US, private insurance is relied on by a majority of the population as their sole means of cover. In other countries, private insurance is largely taken out by higher income groups, either in place of social insurance or in addition to cover provided by the government. The level of access to health services is determined by the level of insurance cover which an individual can afford to purchase, and contributions are based not on ability to pay but on an individual's health risk rating as assessed by the insurer. It will usually be the poorer, older and less healthy in societies who are considered by private insurers to have the greatest health risk and therefore face the highest insurance premiums. Such private insurance financing is highly regressive and inequitable (*17*).

4. Out-of-pocket payments

Out-of-pocket payments are made directly by patients for the use of particular health services, in either the public or private sector. Patients may be required to pay for all or part of the cost of a particular publicly provided service through user charges. In addition, individuals are increasingly choosing to pay privately for specific interventions as and when they need them. An efficiency argument in favor of such charges is that they can help to encourage the responsible use of resources by limiting wasteful and unnecessary activity and contain the total amount of health expenditure which the government has to finance publicly. However, there is also evidence that high charges can discourage people from seeking treatment at all, or can direct them to other areas of a health system where charges are not levied (Maxwell et al, 2000 ).

5. Medical savings accounts

Medical savings accounts are personalized accounts into which individuals contribute a proportion of their income regularly in order to save for future medical costs. Medical savings accounts can be defined as the voluntary or compulsory contribution of payments by individuals, households or firms into personalized savings account that serve to spread the financial risk of poor health over time. Savings in this account can be withdrawn for health care expenditures. The medical savings accounts scheme alone is similar to any savings account scheme, with no horizontal pooling of risk. Thus, individuals are still at risk for high expenditures from a catastrophic or chronic injury or illness. In Singapore, the problems faced by low-income households in financing health services led to the establishment of a public fund (Medifund) to finance the costs of health care for poor people. Thus, to minimize this risk, medical saving accounts are usually accompanied by a health insurance against catastrophic costs. (*9*).

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**ПРОБЛЕМЫ СОХРАНЕНИЯ УСТОЙЧИВОСТИ СИСТЕМЫ ЗДРАВООХРАНЕНИЯ В ОМАНЕ**

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Итоги реформирования системы здравоохранения в Омане в течение прошлых трех десятилетий позволяет заключить, что она существенно преобразована и в настоящее время демонстрирует значительные достижения как в области профилактической так и куративной медицины.

В статье обсуждаются проблемы, касающиеся оценки основных индикаторов, отражающих состояние здоровья населения страны. По мнению автора положительная динамика, характеризующая их значительную часть связана с процессом реформ в социальной сфере, что на данном этапе ставит целый ряд новых серьезных проблем, связанных с сохранением устойчивой динамики развития сферы оказания медицинских услуг.