

Management of Healthcare in the Gulf Cooperation Council (GCC) countries with special reference to Saudi Arabia

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DOI: 10.6007/IJARBSS/v4-i11/1326 URL: <http://dx.doi.org/10.6007/IJARBSS/v4-i11/1326>

Abstract

The Gulf Cooperation Council's (GCC) countries healthcare service sector is likely to witness a major transition in the quality of services provided, and in competitiveness on a global basis. The region's attempts to setting up integrated healthcare facilities in the form of healthcare cities and medical hubs, along with continuous improvement in technology and infrastructure, will significantly improve the availability and quality of healthcare provision in the region. However, an efficient institutional framework and effective regulatory environment need to be prioritized to encourage private sector participation in the sector. This paper presents a comparative analysis of the main indicators of the GCC healthcare systems, mostly using secondary data from the World Health Organization, and Saudi Ministry of Health database, and attempts to provide some recommendations for healthcare policy makers.

Key Words: GCC, Healthcare, Millennium Development Goals

1. Introduction

The healthcare sector in the Gulf Cooperation Council (GCC) countries—Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates is all set for a strong growth along with fundamental and structural changes. Healthcare in the region is characterized by a huge demand supply gap and with high entry barriers, which gives rise to abundant regional opportunities for the private sector to play a responsible role to support the government strategies and vision in healthcare. The GCC countries are likely to experience a sharp increase in healthcare needs in the coming years, mainly due to a growing and ageing population and a rise in chronic non-communicable 'lifestyle' diseases. The governments in the region need to display political will and strong intent to create infrastructure and promote innovation.

2. Current GCC Healthcare Scenario

According to the World Health Organization (WHO), the size of the GCC healthcare services sector in value terms in 2008, was about US\$ 18 billion and in 2013 it was US\$ 41.6 billion. According to their estimates, the GCC healthcare market is projected to grow at 12.0% p.a. to US\$ 69.4 billion by 2018. The growth will be driven by both an increase in demand (increased number of treatments) and the cost of healthcare provision (average cost per treatment). Outpatient market is expected to account for 79%, and inpatient markets are expected to account for 21% of the overall market size. Income levels in the GCC region are broadly comparable to developed economies. However, despite the strong growth in healthcare expenditure in GCC, it remains lower than developed countries in terms of per capita spend. The government's share in GCC healthcare spending is on an average 73%. On the other hand, in major developed nations, the private sector is the dominant investor in this industry. Per capita healthcare spending in the GCC was US\$ 631 in 2006, below the global average of US\$ 716. The US and the UK registered per capita healthcare spending of US\$ 6,719 and US\$ 3,332 respectively in the same period. Apart from the abovementioned general drivers, some regions in the GCC have started actively promoting medical tourism. Dubai has taken a lead by creation of the Dubai Healthcare City. UAE's medical tourism sector is growing strongly and reached US\$ 1.69 billion in 2013 from US\$ 1.58 billion in 2012. Dubai Healthcare City (DHCC) is one of the largest healthcare tourist destinations in the region. According to DHCC, they handled around 500,000 patients in 2011, 20% of which were medical tourists. The Emirate already has an edge over its GCC neighbors as a well-established tourist destination. Moreover, the ongoing insurance sector reforms are expected to play a pivotal role in catalyzing growth in the healthcare sector. All these factors have created a vibrant investment opportunity. However, only a few healthcare stocks are listed on the capital markets. Thus, investors have limited options to participate in the booming GCC healthcare market.

Even though GCC health-care systems are far better today than they were about twenty five years ago, many residents remain unsatisfied with the availability and quality of care at government-run hospitals and clinics, since these are not adequately equipped to meet the growing and evolving demand. Government-run hospitals and clinics are ill prepared for a rapidly growing and aging population, nor are they prepared for the rise in chronic diseases such as diabetes whose prevalence has grown as countries have developed. This creates a strong need for private sector participation, making the GCC healthcare sector an attractive investment destination. To augment services and raise standards of care, some GCC governments have already encouraged internationally renowned academic institutions to set up health-care facilities in their countries. Many more private health-care providers are required, however, to meet future demand. Although differences exist from country to country, the overall improvement has been impressive.

The changes in demographic profile and disease mix, call for higher growth in healthcare services. Changing lifestyles and high disposable incomes have resulted in 'lifestyle diseases' such as obesity, diabetes and other cardiovascular diseases. In addition, those in the '65 plus' age group is emerging as the fastest growing age group in the GCC. Given the robust demand

growth, governments in the region are actively looking at ways to boost private sector participation in healthcare services. Qatar, Bahrain, and the UAE have been most proactive in this regard, by providing concrete incentives to attract private investment, including commitments to reimburse a minimum number of patient visits to such hospitals, even if the number of patients is less. Moreover, they have helped private players by engaging them in the management of public facilities and reimbursing them for treating patients. While growth in the region's insurance premium outpaces the growth in the global market, the insurance penetration remains one of the lowest in the world.

3. Factors driving health-care demand in the Gulf Cooperation Council countries

The GCC countries, especially the UAE and Qatar, have one of the highest growth rates of healthcare costs due to the advent of new medical technologies and longer length of stay, along with better healthcare facilities. New technologies such as e-health services are being increasingly adopted to lower healthcare costs in the region, besides improving the quality of services. Healthcare IT expenditure in the GCC region is estimated to increase from US\$ 444 million in 2011 to US\$ 551 million by 2015. Inbound medical tourism is expected to grow, driven by high quality health infrastructure.

GCC governments have made substantial investments in health-care infrastructure during the past 25 years, building large medical cities and complexes, hospitals and clinics to not only raise the supply of medical infrastructure but also to raise the quality of healthcare services in the region. The Saudi Arabian Ministry for Health, for instance, is currently executing five major (more than US\$ 500 million in value) healthcare projects. These projects are essentially medical cities. The largest of them all, the King Fahad Medical City, encompasses four hospitals with a total of more than thousand beds and other primary care clinics. Once completed, it is expected to treat 2 million outpatients and 50,000 inpatients, annually. Similarly the new Sheikh Khalifa Medical City will comprise three hospitals with a total of 838 beds, spread over 300,000 square meters.

Although differences exist from country to country, the overall improvement has been impressive, and this was augmented by higher life expectancy, which rose from 60.5 years in 1978 to 73 years in 2004 to 76.4 years in 2011. Also, infant mortality in the GCC fell from 110 per 10,000 live births in 2000 to 78 in 2012. But GCC health-care systems still struggle today. The primary reason is that governments are not equipped to manage health-care providers and feel little pressure to set quality, service, or financial-performance targets. More troubling is the fact that the GCC faces three drivers that will dramatically increase health-care demand in the region: population growth, aging, and unique health-risk factors: Rising income levels and sedentary lifestyles have led to a higher prevalence of obesity and diabetes leading to a demand for specialized healthcare services.

Population growth. The IMF estimates that the region's population would cross the 50 million mark by 2020, providing impetus to the consumption of healthcare services. Until 2015, the size of the population will increase at a compound annual growth rate (CAGR) of around 3.0 percent, one of the highest in the world. In the longer term, the growth in population will ease back to 1.8 percent CAGR. As a result, total GCC population in 2025 will be almost twice the size it is today. GCC markets are witnessing a population boom. The region's oil wealth and government's efforts to diversify the economies are expected to aid economic growth and prosperity. This, in turn, would help maintain a steady inflow of expatriates and population growth. A rapid rise in population is expected to create additional demand pressures on the region's healthcare market.

High per capita income

In addition to a fast growing population, the region also enjoys high per capita income, which is growing at a healthy pace. Growing purchasing power increases demand for healthcare. GCC's per capita income is expected to rise, to reach US\$ 37,925 by 2018.

Drop in mortality and increase in life expectancy

The older age population will rise faster than the younger peers. Further impetus to the ageing phenomena is expected to come from advancement in medical technologies, in the form of increased life expectancy. The GCC population of 65 years and above is expected to surge from 1.2 million in 2015 to 14.2 million in 2050.

With a higher life expectancy, the demand for healthcare services has also risen, because of a longer period over which an average GCC resident requires such services, and a higher proportion of elderly population that typically requires intensive healthcare services. Healthcare requirements of elderly population are much higher than the younger population, as the body tends to become frail and prone to diseases. About 80% of a person's health care demands typically arise after the age of 50 years. Hence a huge population of elderly persons will raise the demand for healthcare services many folds, going forward. In Saudi Arabia, for example, the number of people over 65 will increase more than sevenfold during the next 25 years.

Health-risk factors. The GCC shows a unique pattern of risk factors. Among GCC nationals, the prevalence of Type 2 diabetes and obesity is unusually high relative to the rest of the world. For example, a joint study between the UAE Ministry of Health and the World Health Organization in 2001 showed that 25 percent of UAE citizens suffer from diabetes (as compared with an average of 5 to 7 percent globally). This figure rises to an unprecedented level of 40 percent for those aged 60 or above. This prevalence has been described as being of crisis proportions. In addition, the obesity rate for GCC nationals stands at 40 percent, one of the highest in the world. The health complications of both diabetes and obesity will correlate with much higher medical costs in the coming years. The WHO estimates that every year, 2.8 million people die as a result of being overweight or obese. The organization estimates that by 2015, the global overweight and obese population will rise to 2.3 billion and 700 million adults, respectively. Consequently, the anti-obesity drug market, which was valued at US\$ 1.4 billion in 2009, will more than double to US\$ 3.1 billion by 2016.

Continued high dependence on foreign medical professionals

The GCC region is highly dependent on foreign medical professionals, and this scenario has not changed much. For instance, around 76% of physicians in Saudi Arabia are expatriates. Non-Saudi physicians still comprise 75% of the total physician workforce in institutions managed by the ministry. Dependence on expat healthcare workforce is driven by: (a) insufficient local medical students to cater to the population, (b) a huge rise in the incidence of lifestyle-related diseases and (c) reluctance of local nationals to accept lower-paying jobs. Hence, increasing the capacity of medical colleges and attracting local youth to pursue a career in medicine would be key steps the governments could take in order to help build a larger pool of local physicians and cater to the ever growing.

4. GCC and the World Health Organization's 'Millennium Development Goals (MDGs)

The Millennium Declaration agreed on by world leaders upholds equity as one of the fundamental principles of progress. More than a decade after they adopted the Millennium Development Goals (MDGs) and associated targets, substantial progress has been made in reducing child and maternal mortality, improving nutrition, and reducing morbidity and mortality due to HIV infection, tuberculosis and malaria. Although progress has accelerated in recent years in many countries which earlier had the highest rates of mortality, large gaps persist both among and within countries. Comparatively speaking, the oil-rich six Gulf Cooperation Countries (GCC), have done very well in meeting many of the targets set by WHO. To understand this in perspective let us make a comparative study of the achievement of health care targets among the six GCC Countries, with respect to some selected indicators.

Table1: Comparative Health Statistics among GCC countries (1990-2011)

	Bahrain	Kuwait	Oman	Qatar	KSA	UAE
Life Expectancy at Birth (years)-1990 (Male & Female)	73	73	70	75	69	71
Life Expectancy at Birth (years)-2011 (Male & Female)	79	80	72	82	75	76
Life Expectancy at 60 (years)-1990 (Male & Female)	18	18	20	19	17	18
Life Expectancy at 60 (years)-2011 (Male & Female)	22	23	17	25	19	19
Total Fertility Rate per woman -2011	2.5	2.3	2.2	2.2	2.7	1.7
Annual Average Rate of Decline (AARD) % in under-five mortality rate (1990–2011) expressed as the total number of such deaths per 1000 live births-WHO Target rate is 4.3 %	10	11	9	8	9	7
Measles immunization coverage among 1-year-olds (%). WHO Target is 90 % coverage	exceeded 90 % coverage	exceeded 90 % coverage	exceeded 90 % coverage	exceeded 90 % coverage	exceeded 90 % coverage	exceeded 90 % coverage
AARD (%) in maternal mortality ratio, (1990–2011) expressed as the number of maternal deaths per100,000 live births - WHO Target rate is 5.5 %	20	14	32	7	24	12
AARD (%) in tuberculosis mortality rate, per 100,000 population (excluding deaths among HIV-positive people) 1990–2011 - WHO Target rate is 2.7 %	0.6	0.9	0.9	0.1	4.0	0.3
AARD (%) in proportion of population without access to improved drinking-water sources - WHO Target rate is 2.7 %.	<2	<2	8	<2	3	<2
AARD (%) in proportion of population without access to improved sanitation-WHO Target rate is 2.7 %	<2	<2	3	<2	<2	2

Source : World Health Statistics 2013- World Health Organization.

As can be seen from the above table, some of the WHO health targets have been achieved by the GCC nations, whereas others are still a long way off. Saudi Arabia's Total fertility rate per woman is highest as compared to other GCC nations. Even among the GCC countries, while the Annual Average Rate of Decline (AARD) in maternal mortality ratio (1990-2011) expressed as the number of maternal deaths per 100,000 live births ,is 24% for Kingdom of Saudi Arabia (KSA), it is much higher than that of Qatar, which is only 7%, whereas the WHO target is 5.5 %,. Similarly, the AARD in tuberculosis mortality rate, per 100,000 population (excluding deaths

among HIV-positive people) is as high as 4 % for KSA, whereas it is only 0.1 % for Qatar, whereas the WHO target is 2.7 %. For AARD (%) in proportion of population without access to improved drinking-water sources, KSA's performance is better than Oman, though not as good as that of the other GCC countries. Therefore it can be observed that KSA in spite of spending such huge amount of funds and other resources for its healthcare has still a long way to go before it achieves many of the MDG's set by WHO. Let us now review the current scenario of the healthcare sector in Saudi Arabia.

Table 2: Comparative Health Expenditure Ratios among GCC countries – Years 2000 & 2010

Health Expenditure Ratios	Bahrain		Kuwait		Oman		Qatar		KSA		UAE	
	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010	2000	2010
Total expenditure on health as % of gross domestic product	3.9	4.3	2.5	2.6	3.1	2.7	2.2	2.1	4.3	4.0	2.2	3.7
General government expenditure on health as % of total expenditure on health	67.5	71.1	76.0	80.4	81.8	81.1	72.3	77.5	71.6	66.0	76.7	73.0
Private expenditure on health as % of total expenditure on health	32.5	28.9	24.0	19.6	18.2	18.9	27.7	22.5	28.4	34.0	23.3	27.0
General government expenditure on health as % of total government expenditure	10.2	9.6	5.5	6.9	7.1	6.2	5.0	5.2	9.2	6.8	7.6	8.8
Out-of-pocket expenditure as % of private expenditure on health	68.7	60.9	93.2	90.6	64.4	61.4	100	71.0	66.7	57.3	69.4	63.2
Private prepaid plans as % of private expenditure on health	25.4	21.1	6.8	9.4	21.3	23.2	–	27.9	10.4	23.6	20.2	27.3
Per capita total expenditure on health at average exchange rate (US\$)	497	748	488	1225	264	568	655	1489	400	659	752	1467
Per capita total expenditure on health (PPP int. \$)	767	937	705	1133	657	591	1443	1621	768	914	865	1562
Per capita government expenditure on health at average exchange rate (US\$)	335	531	371	984	216	461	473	1153	287	435	577	1071
Per capita government expenditure on health (PPP int. \$)	518	666	535	910	537	479	1044	1256	550	603	664	1140

Source : World Health Statistics 2013- World Health Organization.

Table 3 : Comparative Health Workforce Statistics among GCC countries – Years 2005-2012

Health Workforce per 10,000 population 2005–2012	Bahrain	Kuwait	Oman	Qatar	KSA	UAE
Physicians	14.9	17.9	20.5	27.6	9.4	19.3
Nursing and midwifery personnel	38.6	45.5	44.9	73.7	21.0	40.9
Dentists	1.5	3.5	2.3	5.8	2.3	4.3
Pharmacists	2.5	3.0	4.4	12.6	0.6	5.9
Psychiatrists	0.8	0.3	0.2	0.2	0.3	<0.05

Source : World Health Statistics 2013- World Health Organization.

Table 4: Comparative Health Statistics among GCC countries (Infrastructures and technologies)

Infrastructures and technologies	Bahrain	Kuwait	Oman	Qatar	KSA	UAE
Hospital per 100,000 population - 2010	NA	NA	1.8	NA	1.1	NA
Hospital beds per 10,000 population (2005-2012)	18	20	18	12	22	19
Psychiatric beds per 10,000 population (2005-2010)	2.8	3.3	0.3	0.4	1.2	0.2
Computed tomography units per million population (2010)	NA	NA	8.6	10.2	4.0	NA
Radiotherapy units per million population (2010)	NA	1.5	0.7	1.1	0.1	0.8

Source : World Health Statistics 2013- World Health Organization.

5. Kingdom of Saudi Arabia – Healthcare scenario

The Kingdom of Saudi Arabia is, by far, the largest healthcare market in the GCC. At about US\$ 24.7 billion in 2011, it accounted for more than half (52.3%) the region’s market. On the other hand, Saudi Arabia, lags behind most GCC peers in terms of per capita spending (US\$ 758 in 2011). . The government is playing an increasingly active role in the provision of healthcare in Saudi Arabia, thus positioning itself as a vital factor in terms of the sectors’ outlook. As Saudi Arabia’s population continues to expand rapidly and urbanization continues, millions of new healthcare consumers will be added to KSA’s existing cities as well as the new Economic Cities.

Aided by large budget surpluses, the public sector is set to make unprecedented investments to support healthcare provision and complementary sectors such as scientific research. Such investments will require strong private sector partnerships as well, to sustain and capitalize on expected demand. Driven by growing population and increased government spending, the healthcare expenditure by the government has grown at a CAGR of 18.0 percent between 2005 and 2012. Saudi Arabia had the lowest government share in total healthcare spending. However, to improve the country's healthcare profile, the government substantially raised the healthcare budget after the 2009 economic slowdown. In 2010, budget allocation to health care jumped 51% to SAR 61.2 billion. Between 2009 and 2011, total healthcare budgetary allocation surged 70%. The total Saudi budget came in at SR690 billion in 2012, versus SR580 billion in 2011, a YoY increase of 19 percent. However, total spending on the healthcare sector increased 26 percent YoY, from SR68.7 billion in 2011 to SR86.5 billion in 2012. This represented 12.5 percent of the total budget in 2012 compared to 11.8 percent in 2011. The Saudi Cabinet approved the 9th Development Plan for the Period 2010-2014 with an overall budget amounting to SR 1.4 Trillion. About 19 percent, or SAR273.9 billion was allocated during this period for various social and healthcare investments, such as construction of 121 hospitals, 700 primary healthcare centers, and 400 emergency centers. The budget allocation to health and social affairs rose from SAR100 billion in 2013 to SAR108 billion in 2014. In the ninth development plan, the government aims to achieve a hospital beds-to-population ratio of 3.50 beds per 1000 population by 2014. In order to achieve this target, 41,603 beds must be added between the public and private sectors to reach a total of 97,535 beds from the current level of 55,932 beds.

Going forward, with rising income level and growing healthcare needs, the per capita spend in all GCC nations is expected to rise. The demand for number of hospital beds is expected to be 115,544 in 2018, an addition of 11,241 beds from 2013, which is in line with the expected supply looking at the number of projects in the pipeline. Among GCC countries, KSA has one of the most developed and technologically advanced medical sectors in the Middle East with modern equipment and amenities. The healthcare professionals are internationally recognized and familiar with Western practices and standards.

A growing and aging population is a key driver for the healthcare sector in Saudi Arabia. The population is expected to have surged 35% over 2002–12 to 29 million. It is likely to increase to 32.7 million by 2018. Life expectancy in KSA increased to 75.3 years from 72.6 over 2000–2011, thus contributing to a growing elderly population. Lifestyle-related diseases such as diabetes and cardiovascular ailments are highly prevalent in Saudi Arabia. This would primarily drive the Saudi healthcare sector in the coming years. Obesity is a huge problem in the country: 35.2% of the Saudi population is obese. Given the rising demand for healthcare services, Saudi Arabia's government has been aggressively implementing policies to increase private sector participation. The private sector's share in health expenditure rose from 25.3% in 2006 to 31.1% by 2011. In 2013, the Saudi Ministry of Health signed an agreement with the British Medical Journal, one of the world's most respected medical journals, for cooperation in health learning and research. In February 2014, the government launched a comprehensive online database for medical/clinical information for healthcare providers and patients. The

government introduced compulsory medical insurance for the dependents of expatriates in 2013 as part of its healthcare reform plan.

6. Saudi Health Statistics

Following are the demographic, economic, health resource and workforce indicators which show the impact of the health policies of the Saudi Ministry of Health in the past few years.

Table 5: Demographic Indicators – Year 2006-2011

Indicators	2006	2007	2008	2009	2010	2011
Estimated Population	23678849	24242578	24807273	25373512	27136000	28376355
Crude birth rate /1000 pop.	24.9	24.5	24.1	23.7	23.3	22.9
Population Growth Rate (%)	2.32	2.28	2.23	2.2	2.21	NA
Population Under 5 years %	11.60	11.60	11.56	11.56	11.39	11.22
Population Under 15 years %	32.9	32.6	32.26	31.97	31.69	31.14
Population 15- 64 years %	64.4	64.6	64.95	65.22	NA	65.37
Population from 65 & above %	2.8	2.8	2.79	2.81	2.83	2.86
Total Fertility Rate	3.22	3.17	3.04	3.04	2.98	2,93

Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

Table 6: Economic Indicators - Year 2006-2011

Indicators	2006	2007	2008	2009	2010	2011
G D P per capita in USD \$	14653	15724	19206	14550	15770	20328
MoH Budget (% of Govt. Budget)	5.9	6.0	5.6	6.2	6.5	6.9
MoH Expenditure per capita in USD \$	257	277	271	271	345	375

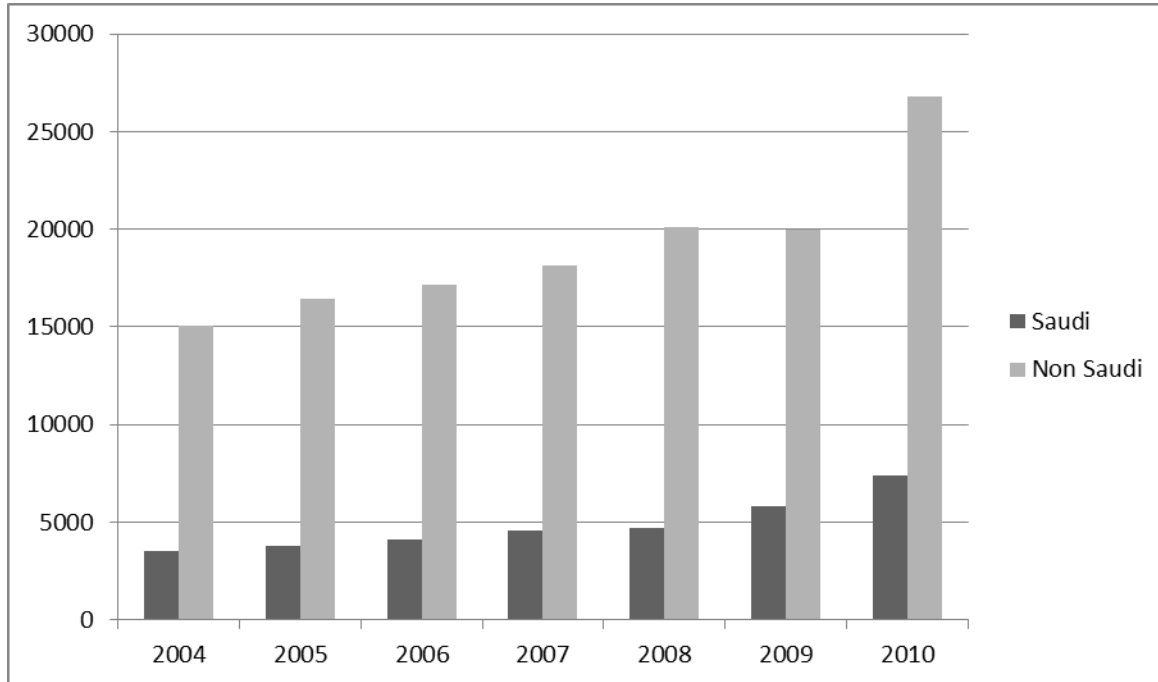
Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

Table 7: Health Resources Indicators - Year 2006-2011

Indicators (Rates per 10,000 Pop.)	2006	2007	2008	2009	2010	2011
Physicians	20.4	21	21.5	21.8	24.3	24.4
Dentists	2.33	2.5	2.8	2.9	3.4	3.5
Pharmacists	3.61	6.21	6.4	5.9	5.5	5.1
Nurses	35.4	38.7	40.8	43.7	48	47.4
Allied Health Personnel	19	20	20.8	23.5	25	27.8
Hospital beds, KSA	23	22.1	21.72	22.04	NA	20.7
Health Care Centers	0.81	0.79	0.8	0.8	0.8	0.74
Beds in Govt. hospital	17.8	17.45	17.14	17.38	16.7	16
Beds in Private hospital	5.3	4.65	4.58	4.66	4.72	4.7

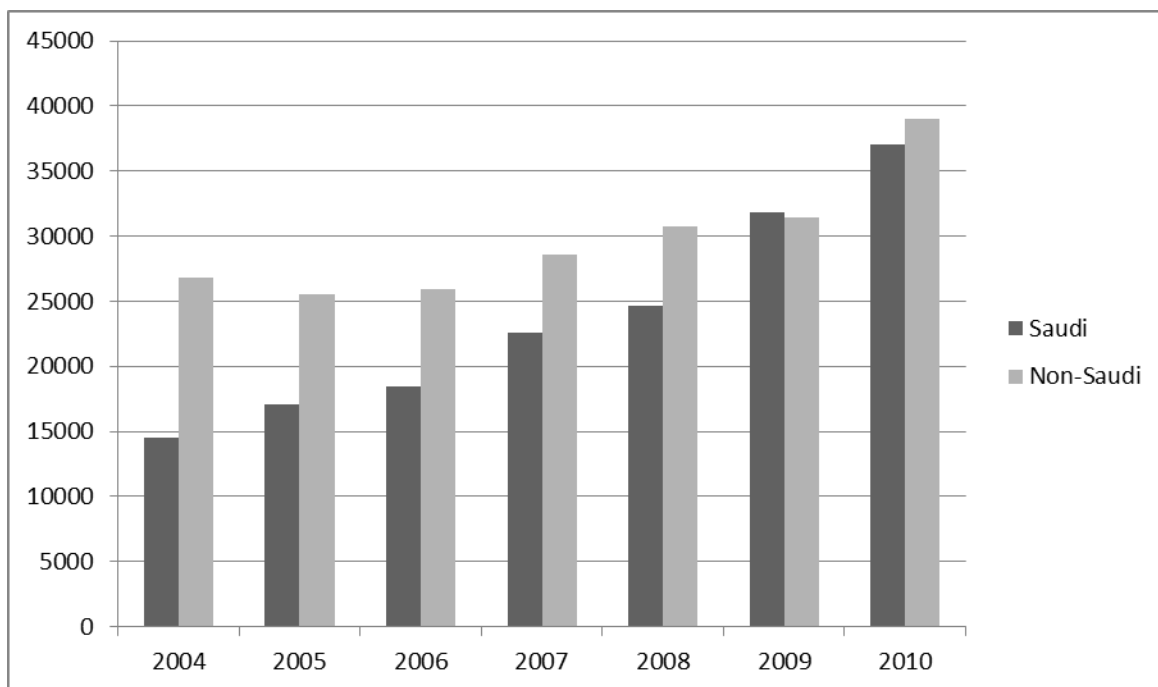
Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

Figure 1: MoH Physicians by Nationality (2004-2010)



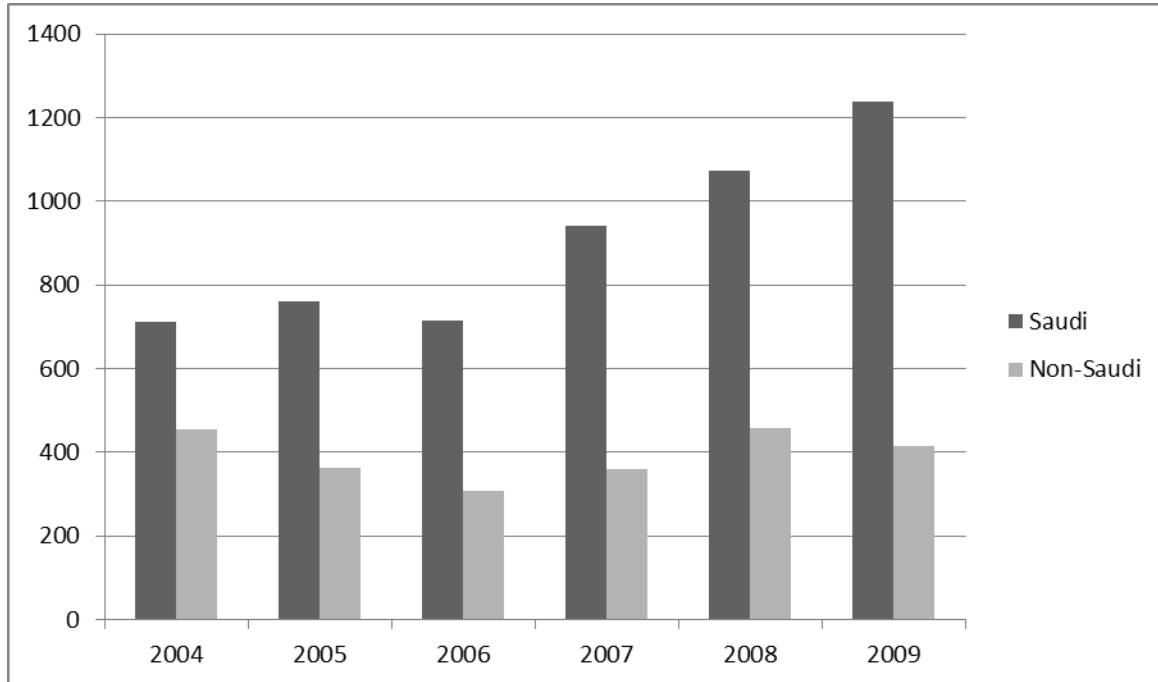
Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

Figure 2: MoH Nurses by Nationality (2004-2010)



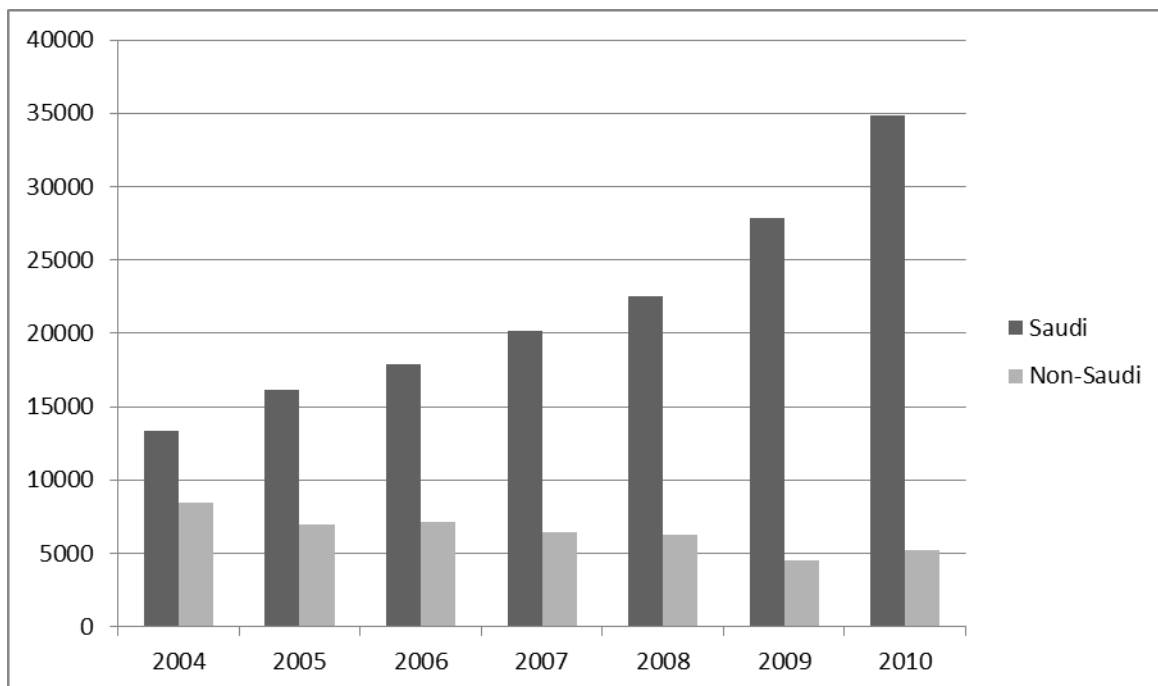
Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

Figure 3: MoH Pharmacists by Nationality (2004-2009)



Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

Figure 4: MoH Allied Health Personnel by Nationality (2004-2010)



Source: *Health Statistical Yearbook*, Ministry of Health, Riyadh, Saudi Arabia

7. Healthcare workforce in Saudi Arabia

The issue of talent and the large dependence on foreign work force is also a significant challenge. For many foreign medical staff, especially nurses, Saudi Arabia is not regarded as a permanent home, and is often a stepping stone for experience, opening doors to more lucrative opportunities in the West. The turnover rate is high with industry sources claiming the stay per nurse as short as two years. The country's dependence on expatriates to fill physicians' posts will continue for long time. Similar shortage is also envisaged among Saudi nurses and other health personnel, indicating an urgent need to accelerate the training of the Saudi work force in all health fields. With the escalation of training costs in the health field all over the world, the involvement of the private sector in training, in conjunction with the privatization of the country's health system, could be part of the solution. It should be noted that the development and training of health manpower in the country should concentrate not only on the number of health workers trained but also on the assurance of the quality and the performance of those trained. This, undoubtedly, will mean the adoption of better quality assurance programs in all health facilities to maximize the utilization of Saudi manpower and develop medical curricula in medical institutes to meet the required training standards. In view of the rapid population growth in the country, the shortage of qualified and experienced Saudi medical personnel pose a challenge to the smooth running of the health system. The provision of free health care to the entire population is enshrined in the constitution of Saudi Arabia. Previous development plans had repeatedly emphasized the right of all Saudi citizens to a healthy life, and the need to develop and organize the health system to achieve this. Development plans of the country clearly details this and specifies the steps needed for the development of health manpower in terms of both quantity and quality, the assurance of both curative and preventive services to all Saudis, the development of primary health care services as a solid basis of the health delivery system to the entire population, particularly to mothers and children, and the control of all endemic diseases and their possible eradication.

8. Conclusion

GCC population in the age group of 65 and above is expected to surge from 1.2 million in 2015 to 14.2 million in 2050, driving demand for healthcare services. Older people generally need to seek more medical care and have more expensive health profiles than younger people. Improvements in life expectancy over the past quarter of a century have left the GCC with an increasing number of elderly people requiring care. Combined with the success achieved in reducing infant mortality rates, this demographic segment will continue to grow in the years ahead. Although demand for health care in the GCC is clearly rising, the extent of this increase and the forces that will drive it have been matters of wide debate. The number of overweight

and obese adults in the developing world has quadrupled from 250 million in 1980 to 1 billion in 2008. The growing incidences of non-communicable diseases such as diabetes and heart disorders due to obesity is expected to take a global economic toll of US\$ 47 trillion over the next two decades, due to lower labor productivity and higher medical costs. Other challenges that remain for GCC governments include increasing private sector participation to finance healthcare expenditure, increasing the quality of healthcare, insufficient medical practitioners and a lack of stringent guidelines on quality standards.

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