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An Overview of Health System in Saudi Arabia

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Abstract: Saudi Arabia established healthcare services in the first quarter of the 20th century. In 1954, the establishment of the Ministry of Health (MOH) was promulgated. All citizens receive free public healthcare services. The MOH is the major provider of health services. MOH provided 60% of healthcare services while other government agencies provided 20%. The private sector provided 20%. The MOH provides its public healthcare services at three levels: primary, secondary and tertiary care. There are some challenges to the delivery of healthcare services in Saudi Arabia such as a rapid increase in the expenditure, the lack of the Saudi health professionals and around 5 million pilgrims visit Saudi Arabia every year.

Key words: MOH, citizens, government, tertiary care, expenditure

INTRODUCTION

Overview of Saudi Arabia: The Kingdom of Saudi Arabia is surrounded by the Red Sea on the West and the Arabic Gulf towards the North-East. It also shares land borders with Iraq, Qatar, Oman, Yemen, Jordan, Kuwait and the United Arab Emirates (Vincent, 2008). It is by far the largest country on the Arabian Peninsula, covering approximately 2,149,690 km^2.

Abdul Al-Aziz Abd al-Rahman Al Saud founded the modern Saudi state in 1902. He struggled for over 30 years to unify the Arabian Peninsula and in 1932, he formed the modern state from the diverse tribes (McHale, 1980).

CULTURAL AND RELIGIOUS PERSPECTIVES IN SAUDI ARABIA

The Kingdom of Saudi Arabia has seen substantial economic and social development within the structure of Islamic beliefs (Littlewood and Yousuf, 2000). Islam is based on the Sunna and the Holy Quran. Islam is the national religion of Saudi Arabia and the lives and culture of its citizens are thus extensively influenced by it. Nonetheless, factors such as the environment, education and economic status also play a part in shaping the culture (Al-Shahri, 2002).

The ethos, food, behavior, social traditions and language of Saudi Arabia are all shaped by Islamic practice. According to Al-Shahri (2002), muslims believe that illness is a recompense for sins committed rather than a punishment from Allah (Arabic name of God). They further believe that death, illness and health all come from Allah (Rassool, 2000). Muslims are also advised to pursue treatment and care during illness however, healthcare providers believe that this may cause problems if muslims do not play an active role in solving their health issues. Islam promotes health and a healthy lifestyle by encouraging regular exercise, moderate eating, no misuse of alcohol, substance or tobacco, breastfeeding and personal cleanliness (Rassool, 2000).

DEMOGRAPHIC AND SOCIO-ECONOMIC FRAMEWORKS

In studying Saudi Arabia's healthcare system, it is important to look at its demographics. This is necessary to achieve a clear understanding of how the administration of Saudi Arabia managers its responsibilities through the allocation of resources to meet the needs of its citizens. An important factor to bear in mind in this regard is the country's population's almost total homogeneity in terms of religion, cultural values and language (Farsy, 1990).

The population of the country has boomed in the course of the last half century. The current annual growth rate of 3.19% (Brown and Busman, 2003) is a result of measures that have led to high fertility rates (4.3 births per woman) and the fact that people now tend to live longer (MOH, 2011). In 2010, the population was estimated to be 27,136,977 with further growth looming such that a

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Table 1: Demographic indicators, 2010

Indicators	Values
Estimated population	27,136,977.00
Crude birth rate/1000 pop.	32.30
Pop. growth rate (%)	3.19
Population under 5 years (%)	11.39
Population under 15 years (%)	31.69
Population 15-64 years (%)	65.48
Population from 65 and above (%)	2.83
Total fertility rate	2.98
Life expectancy at birth	73.70
Male	72.60
Female	74.90

MOH (2011)

Table 2: Economic indicators

Indicators	Values
GDP per capita ($)	15770.0
MOH budget (percentage of governmental budget)	6.5
MOH expenditure per capita ($)	345.0

MOH (2011)

population of 36 million may well become a reality by 2020. Another contributory factor is the increased number of immigrants in Saudi Arabia's demographic profile. In 2004, there were 6,144,236 immigrants, representing about 27% of the total population. About 75% of immigrants were urban residents (MOEP, 2010a) (Table 1).

Oil wealth has laid the foundation for the economy of Saudi Arabia, peaking in the years that followed the 1970s. The kingdom is currently by far the largest producer of oil in the world (Aarts and Nonneman, 2005). Oil accounts for up to 90% of exports and produces 75% of the government's revenue. Moreover, about 45% of the Kingdom's Gross Domestic Product (GDP) is derived from oil with the remainder coming from the private sector (Dincer *et al*., 2004). Plans for further growth of its economy were put into action when the country became a member of the World Trade Organization (WTO) in 2005 and this move allowed venture capitalists to help further grow the economy (Aarts and Nonneman, 2005). With a substantial economy now supporting the country, the possibility of upgrading and expanding its healthcare facilities has become more feasible and sustainable (Table 2).

HISTORICAL OVERVIEW OF SAUDI ARABIA'S HEALTHCARE SYSTEM

In earlier times, before a proper healthcare system was formally introduced, most people in the country treated their illnesses using traditional and ritualistic apothecaries (Saati, 2000). It was not until the first quarter of the 20th century that the country established healthcare services in accordance with a 1926 mandate for the Department of Health (Mufti, 2000). The newly formed department set up medical facilities such as hospitals and clinics in the major cities of the country: Taif, Jeddah, Medina and Makka (Mufti, 2000). A year later, it was re-organized through the Bureau of the Attorney General as the General Directorate for Health and Aid. The Attorney General established a health council (Saati, 2000) whose task was to improve the health standards in an effort to ensure public health was not unduly impacted by infectious diseases during times of pilgrimage (Mufti, 2000). The possibilities of such strategies were constrained by limited finances before 1946 which made the ideal of a Western style healthcare system difficult to achieve. For instance, at that time only 300 beds were available for the entire country (Mufti, 2000). By the 1950s, the cities of Makka, Medina, Jeddah and Taif were upgraded with large hospitals of over 1000 beds and healthcare clinics were also established in Riyadh and Al-Hasa (Khoja, 2001).

The establishment of the Ministry of Health (MOH) was promulgated in 1954 (Niblock, 2006). By the 1970s, booming revenue from oil production and exports were available to finance and support consecutive 5 years national development plans for strategic establishments (Aarts and Nonneman, 2005). These led to great expansion and development in the healthcare service sector, along with human resource development plans aimed at educating and training the local population to become skillful professionals (Saati, 2000). This movement was multi-faceted including promoting scholarships, establishing medical colleges and a Saudi Council for Health Specialties and focusing on the development of physicians and other health professionals (Al-Rabeeah, 2003). As a result, Saudi Arabia is currently ranked 26th in WHO's measurement of healthcare system performance with countries such as Australia and the United States at 32nd and 37th, respectively (World Health Organization, 2000).

SAUDI ARABIA'S HEALTHCARE FRAMEWORK

It is a constitutional responsibility of the Saudi government to provide citizens with healthcare with Article 3 of the Constitution stating, each citizen is under the care of the state for their health and entitlement to healthcare (Mohammadi, 2002). This statute grants free public healthcare service to all citizens, although, in reality there are stark contrasts in the provision of healthcare services across Saudi Arabia, via various public and private sector agencies. The MOH is the major provider of

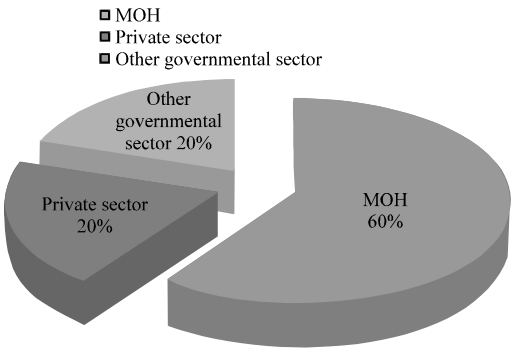

Fig. 1: Beds in various sectors of the Saudi Arabia health system (MOH, 2010)

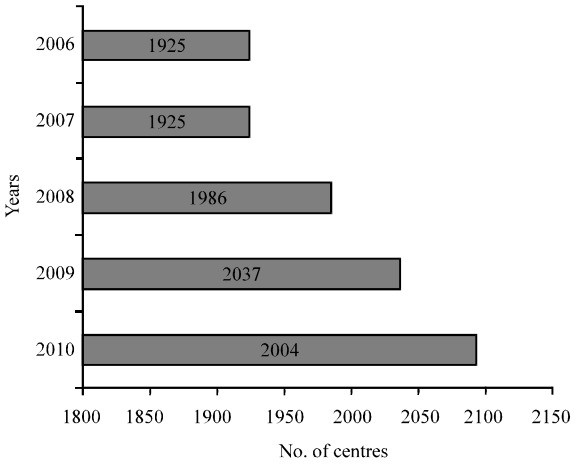

Fig. 2: Trends in No. of health centres (MOH, 2011)

health services, so much of the population receives healthcare through the Ministry of Health which is responsible for providing healthcare services to the citizens of the country. As shown in Fig. 1 in 2010, MOH provided 60% of hospital beds, 47.3% of physicians and 54.6% of nursing staff while other government agencies provided 20% of hospital beds, 22.6% of physicians and 22.9% of nursing staff. The private sector provided 20% of hospital beds, 30.1% of physicians and 22.5% of nursing staff (MOEP, 2010a).

PUBLIC SECTOR HIERARCHY OF HEALTHCARE SERVICES

The MOH provides its public healthcare services at three levels: primary, secondary and tertiary care. The pathway to other healthcare facilities is through the primary healthcare services whereas secondary and tertiary healthcare services are provided in general and specialist hospitals, respectively.

PRIMARY CARE

Saudi Arabia, along with 134 other countries, signed the 1978 Alma-Alta declaration which aimed to achieve the World Health Organization's target of Health for all by 2000. At that time the MOH established health clinics and maternity and childhood health centres in Saudi Arabia, trademarked under a new name, primary healthcare centres. Much of the healthcare was rather basic and focused on encouraging preventative measures, treatment and rehabilitative services including dental care, health education, vaccinations and environmental health (Al-Yousuf *et al*., 2002). Since, its advent, there has been a rapid boom in the number of primary healthcare centres and the associated workforce especially between 2006 and 2010. As shown in Fig. 2 in 2010, the healthcare sector had over 8,356 physicians and 15,696 nurses working in the primary healthcare centres in Saudi Arabia. This meant that the ratio of patients to medical health professions was 10000:4.5 doctor and 10000:8.4 nurses (MOH, 2011). The General Directorate is responsible for managing these primary healthcare centers in the MOH.

SECONDARY CARE

The general hospitals receive patients on the recommendation of the primary healthcare centres and provide further treatment and care. In 2010, there were 193 general hospitals in Saudi Arabia with 21,359 beds, all equipped with advanced medical technology under the administration of skilled staff (MOH, 2011). In 1989, the MOH established a set of policies and procedures to organize the functions of hospitals by establishing an organizational chart that clarified responsibilities and activities of departments, divisions and staff (Mulla, 2001).

TERTIARY CARE

In specific cases where the patients are suffering from advanced stages of illness or disease, tertiary level hospitals are able to provide treatment using state of the art technology. These hospitals receive patients referred by general hospitals (Mulla, 2001). With about 56 specialist hospitals in Saudi Arabia (4 ENT, 4 chest and fever, 20 obstetrics and pediatrics, 17 psychiatric, 2 cardiac and renal and 9 convalescent, rehabilitation and leprosy) the overall healthcare service sector has been consolidated from bottom to the top (MOH, 2011).

HEALTH INSURANCE

Considerable progress has also been achieved towards providing modern healthcare insurance facilities to expatriate residents; most notably through the Cooperative Health Insurance Scheme which was established by the Council of Ministers Resolution No. 71 in 1999. The scheme aimed to provide and regulate healthcare to all expatriate residents with the possibility of extending coverage to citizens by a Council of Ministers resolution. Article 4 provided for the establishment of the Council of Cooperative Health Insurance to oversee implementation through licensing of cooperative health insurance companies, accrediting health institutions that provide health insurance services and issuing the resolutions necessary for implementing the provisions of the scheme (Almalki *et al*., 2011).

The 2008 data show that 1,393 health facilities were accredited to provide healthcare for insured patients, distributed as follows: 139 hospitals, 835 clinics and dispensaries, 215 pharmacies and 204 other facilities. The number of people covered by health insurance under the Cooperative Health Insurance Scheme was 5.27 million, the number of organizations providing health coverage for their employees was 59,541 and the number of insurance companies licensed by the Council to provide health insurance was 29 (MOEP, 2010b).

CHALLENGES TO HEALTHCARE SERVICES IN SAUDI ARABIA

Although, numerous steps have been taken by the MOH to reform the Saudi health care system, there are some challenges to the delivery of healthcare services in Saudi Arabia.

Earlier research has identified a wide range of challenges. One of the most important is that the health system in Saudi Arabia has had a rapid increase in the expenditure (Walston *et al*., 2008). In 2010, the budget of MOH represented 6.5% of government expenditure which was an average expenditure of US$ 345 per capita (MOH, 2011). One of the main reasons for the rising costs has been population growth (which is currently 3.19% annually). Another reason for escalating costs is that the health services are free for all Saudis; this has created long waiting times for health facilities (Jannadi *et al*., 2008).

The lack of the Saudi health professionals (physicians, pharmacists and nurses) is another challenge for the health system in Saudi Arabia (Almalki *et al*., 2011). Most of the workers in the health sector are non-Saudis (Al-Yousuf *et al*., 2002) which has led to high rates of staff turnover and instability (Almalki *et al*., 2011). In 2010, Saudi physicians and nurses represented 21.6 and 48.7% of the total workforce, respectively (MOH, 2011).

Another challenge for the health system in Saudi Arabia is that around 5 million pilgrims visit Saudi Arabia every year (Walston *et al*., 2008) as it has the two holy cities of Islam. A comprehensive plan is required to ensure provision of sufficient housing, transport and health services (Jannadi *et al*., 2008). The pressure is that the MOH provides all the necessary health preventive and curative services to pilgrims, free of charge (Almalki *et al*., 2011). For example, in 2010, MOH had 20 hospitals of which 7 hospitals were seasonal and also there were 150 health centres of which 115 were seasonal and the total number of personnel was 19,650 (MOH, 2011).

CONCLUSION

The Ministry of Health itself has identified many of the issues recorded in the literature. In 2010, MOH (2010) found that its main challenges include: increasing demand for health care services, escalating costs of health care services, changing patterns of disease, geographical isolation of some citizens, rapid technological advances in the medical field, scarcity of highly qualified professionals, high expectations of citizens, dependence on government budgets, Hajj and Umrah, links with other ministries and resistance to change.

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