Grant Thornton

Transforming the Middle East's healthcare model

Healthcare Guide 2009

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Methodology
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Foreword

The Middle East will face an unprecedented surge in demand for healthcare products and services in the next few years. Socio-economic development, characterised by increasing income and access to modern amenities and services, has led to changes in the population's nutritional and lifestyle habits, increasing the prevalence of lifestyle-related medical conditions such as obesity, heart disease and diabetes. Also, as living standards improve, healthcare providers (mainly governments) are faced with heightened expectations for more and better quality services.

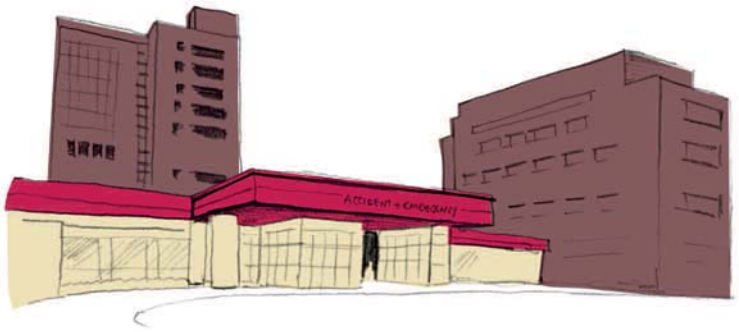
These expectations, together with growing populations and better-informed patients, are driving investment in hospitals and medical facilities, and pushing up demand for healthcare services, innovative drugs and the latest medical technologies. Many countries in the region are setting standards in providing the very best healthcare service not only for the growing local population but also for expatriate workers and patients from across the region seeking the best medical care. Other countries are struggling with over-burdened government-run healthcare systems, and are turning to the private sector for much-needed investment and expertise. Given the current economic situation, there does not appear to be any reduction in the appetite for, nor supply of, capital for healthcare-related projects in the region. It seems that investors are willing to bet that the demographic, economic and social forces driving demand for high quality healthcare in the Middle East are unstoppable.

In fact, the region's healthcare market is expected to continue growing over the next few years, compared to the low growth predicted in the mature markets of the US and Europe. Reduced public investment at home and a hostile environment of healthcare cost containment is making the Middle East more attractive to Western healthcare companies.

These forces, in combination with governments' willingness to partner with the private sector, are in turn creating opportunities for private healthcare providers and insurers, as well as suppliers such as pharmaceutical and medical device manufacturers.

However, making healthcare more about serving the needs of the growing population rather than profit is the key to making the Middle East system sustainable. Zakat, the Islamic principle of charity, is the underlying driving force. As a result, the public and private sectors need to cooperate. Governments are keen to supervise and regulate the healthcare system to make sure private healthcare players fully understand and embrace this unique concept and preserve the culture that exists.

This guide reviews key regional changes affecting the healthcare sector, provides insight into the main Middle Eastern markets, and identifies potential future opportunities for private healthcare players in this region.



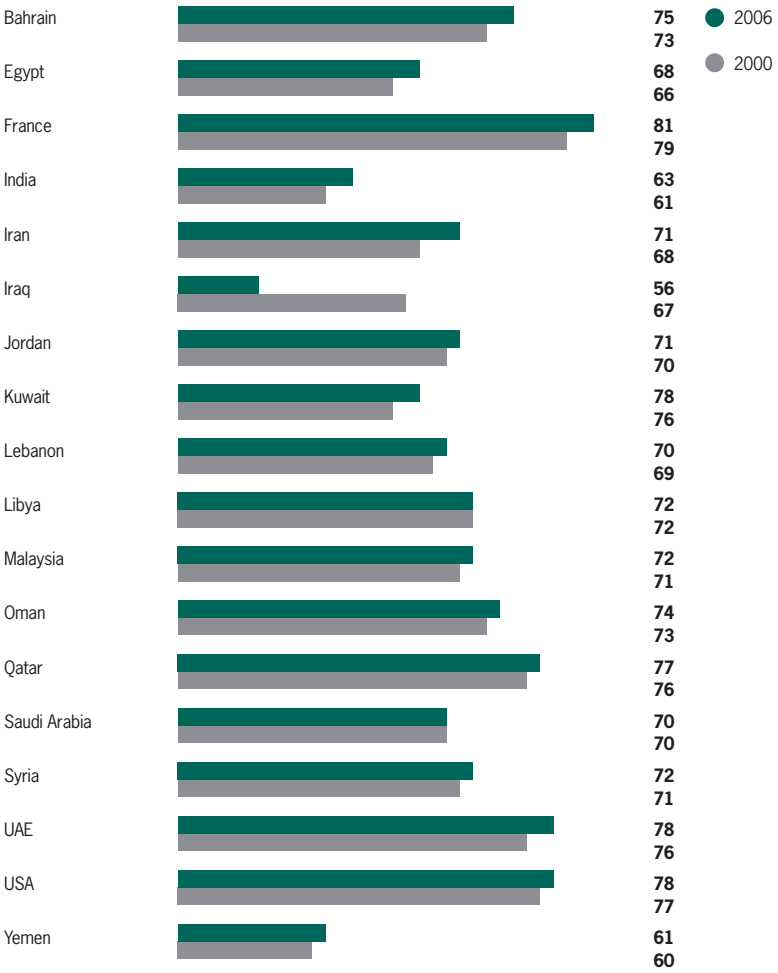
Healthcare today

The issues

Public sector healthcare facilities in the region are finding it increasingly difficult to keep up with the growing demands of their people. In Kuwait, the Ministry of Health admitted that nearly 1.6 million patients had switched from public hospitals to private hospitals in 2007 because of the poor quality at government-run hospitals.

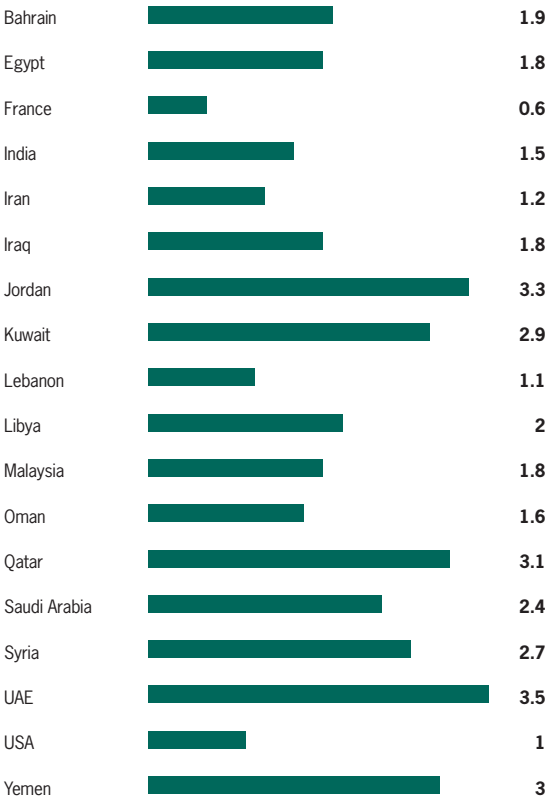
Unsatisfactory healthcare has resulted in residents seeking medical treatment abroad. According to Dubai Health Care City officials, Arabian Gulf citizens spend an estimated US$25 billion a year receiving treatment elsewhere. Meanwhile, patients from the region are the lifeblood of medical tourism markets such as Singapore. With governments struggling to cope with the changing demographics and onset of chronic diseases, it is clear the public sector now needs to take action.

Figure 1: Life expectancy at birth (years) both sexes



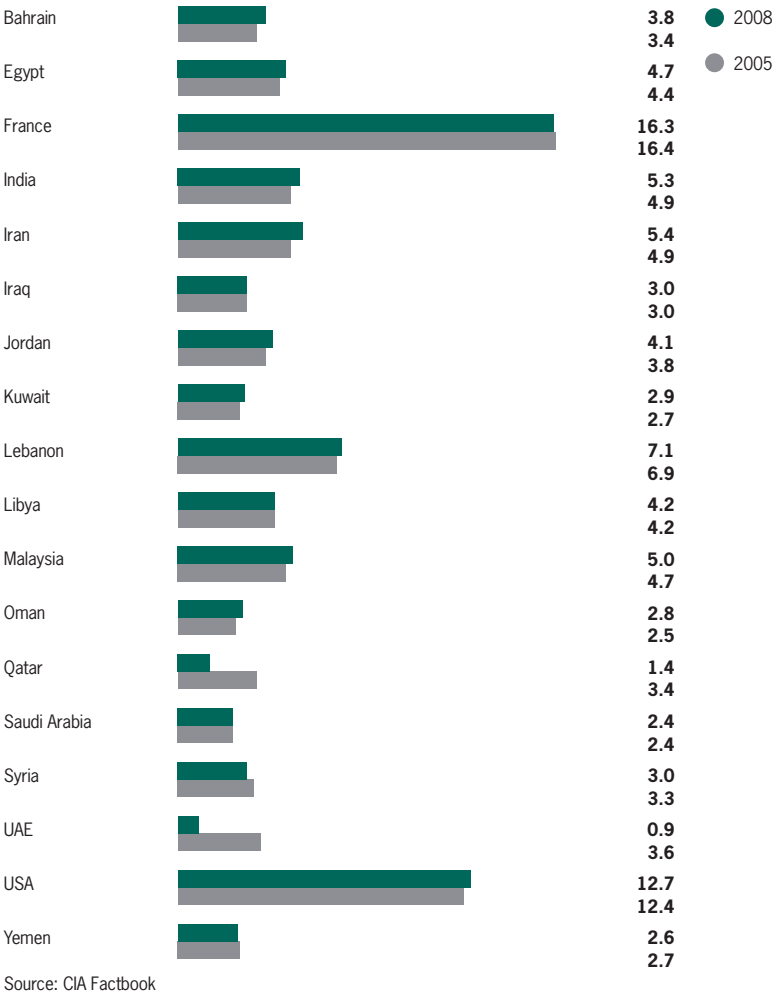
Source: © World Health Organization (WHO)

Figure 2: Population annual growth rate (%) (2006)



Source: © World Health Organization (WHO)

Figure 3: Population over 65 (%)



Source: CIA Factbook

Low levels of national wealth dedicated to healthcare provision is at least partly responsible for the poor quality of healthcare in the Middle East. Although in some countries, notably Jordan and Lebanon, the proportion of gross domestic product (GDP) spent on healthcare is as high as, or higher than, that in more developed economies, in much of the region the figure is very low. Many relatively rich countries such as Saudi Arabia, the UAE and Kuwait spend a surprisingly small proportion of GDP on healthcare. Perhaps even more surprisingly, while this proportion rose in most countries between 2000 and 2006, from 2.3 per cent to 4.3 per cent in Qatar for instance, and 5.6 per cent to 6.3 per cent in Egypt, most of the countries that spend the lowest on healthcare actually saw this proportion fall. Kuwait, for example, spent just 2.2 per cent of GDP on healthcare in 2006, down from 3.1 per cent in 2000.

However, these figures do not reflect absolute reductions in healthcare investment. Healthcare spending has in fact risen in nominal and per capita terms in nearly all the countries of the region. In many countries, however, this increase was combined with high rates of economic growth, such that health spending was unable to keep pace. For instance in Kuwait, per capita health spending actually increased by 52 per cent between 2000 and 2006, from US$523 to US$796, but in the same period fell by 29 per cent as a proportion of GDP.

Figure 4: WHO ranking of world health systems – 190 countries (2000)

Country	Ranking
France	1
Oman	8
Saudi Arabia	26
UAE	27
USA	37
Bahrain	42
Qatar	44
Kuwait	45
Malaysia	49
Egypt	63
Jordan	83
Libya	87
Lebanon	91
Iran	93
Iraq	103
Syria	108
India	112
Yemen	120

Source: © World Health Organization

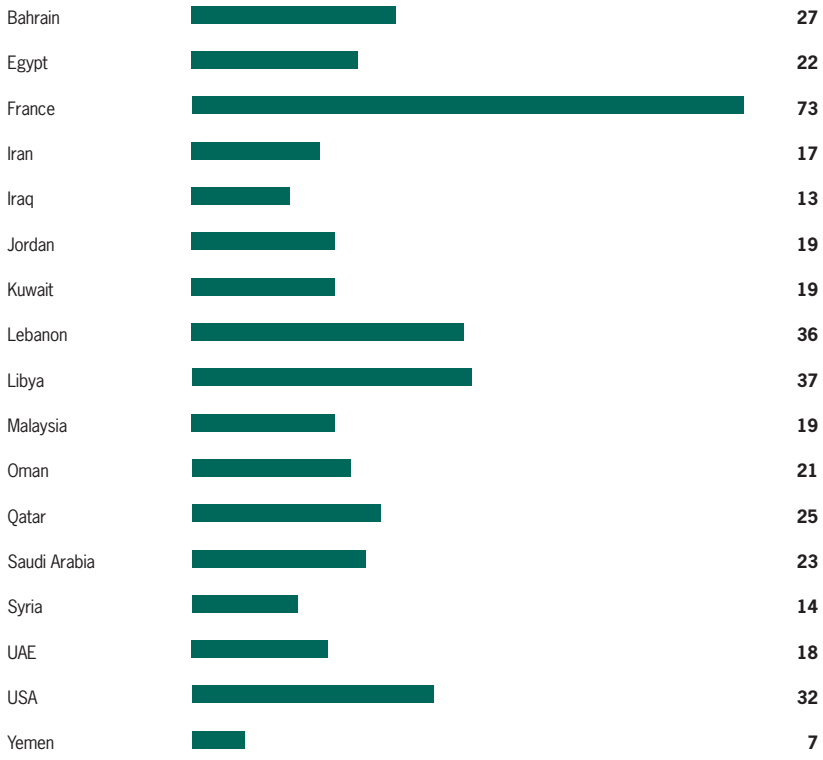
Lack of private sector involvement, shortage of trained medical staff and governments slow to invest the proceeds of economic growth contributed to the slowdown in health spending in some of the wealthier countries. Government led privatisation programmes are now being used to address these issues. For instance, Oman has one of the most efficient health systems in the world, with a government that advises and strongly supports the private sector.

Allocating local medical resources

A combination of the growing population and lack of local medical schools has resulted in severe shortages of trained medical workers in the region. This shortage has become particularly acute in the Gulf Cooperation Council (GCC) countries, as the investment in healthcare cities and other new healthcare facilities increases the demand for medical workers. Historically, the GCC states have responded by recruiting foreign medical staff, mainly from the West, but increasingly from the Indian subcontinent and the Philippines. This trend has led to many expatriate workers in the GCC countries. In some places, it is virtually impossible to find a local medical practitioner – for instance in Qassim province, north of Riyadh, just 2 per cent of practicing physicians are Saudi nationals[1].

Still, the figures vary across the region – Bahrain has a long history of medical training and employs a comparatively high proportion of nationals in healthcare. Bahrain has set up its own medical education infrastructure, including a medical school owned and operated by the Royal College of Surgeons in Ireland. Other Gulf governments are following suit, investing in the development of medical education and training programmes for nationals, and recruiting the services of internationally recognised healthcare brands. Dubai has attracted Harvard Medical School to Dubai Health Care City (DHCC), while Qatar is building a speciality teaching hospital run in association with Weill Cornell Medical College in its US$2.3 billion Sidra Medical and Research Centre in Doha.

Figure 5: Hospital beds (per 10,000 population) (2004-2006)



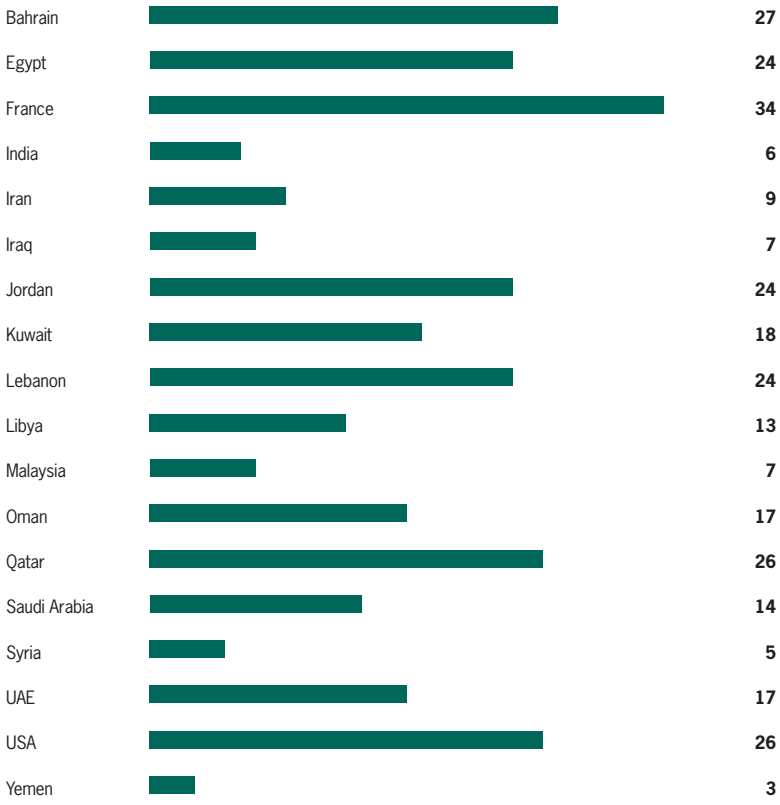
Source: © World Health Organization (WHO)
The data was collected at different points in time

1 Source: www.meed.com, 13 October 2006.

In Saudi Arabia, the government is addressing the shortage of local medical staff. In 2007, it announced plans to recruit 13,000 family doctors by the end of 2010, partly through sending nationals abroad for training while it builds more teaching hospitals, with the help of private investment. It has also announced its intention to increase capacity in the five established medical schools, increase the opportunities for scholarships in various health specialities, and enlarge the base of medical postgraduate studies in the country.

Of course, countries with a relatively high population such as Saudi Arabia have a large base of citizens to train and compete with their foreign counterparts. But in other GCC countries, and in particular the UAE, there is an insufficient local population willing and able to undertake the training required to generate the extra healthcare professionals. These countries will continue to rely on expatriate workers to staff their medical facilities. But this brings its own problems – expats are extremely mobile, and high global demand for healthcare workers raises the risk of them leaving for better opportunities elsewhere. To make a success of the investment being poured into the healthcare cities and elsewhere, governments will need to find ways to retain experienced personnel and reduce staff turnover.

Figure 6: Physicians density (per 10,000 population) (2000-2006)



Source: © World Health Organization (WHO)

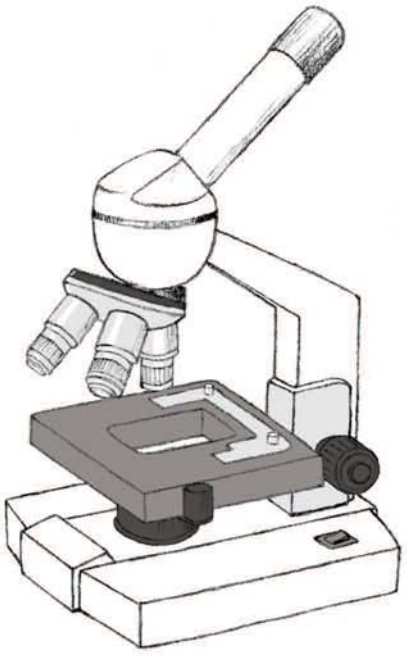
Going private in the Middle East

The World Health Organisation (WHO) statistics on private expenditure on health (see appendix), reflect a mixed picture on the level of private sector involvement in healthcare provision between 2000 - 2006, the latest figures available for the region. The private sector accounted for the highest proportion of overall healthcare expenditure in Egypt, where it produced 59 per cent of spend in 2006. The vast majority of this (95 per cent) was out-of-pocket spending, indicating the low provision of health insurance in Egypt. Lebanon also had a large private health sector in 2006 although Lebanon's share shrank from 70 per cent of the market in 2000 to 53 per cent in 2006.

In Qatar, the government has encouraged the private sector to play a greater role in providing healthcare, with the opening of the first private hospital in 1999. However in recent years the government has been investing its oil wealth in publicly funded and operated healthcare facilities, causing private sector involvement to fall from 31 per cent in 2000 to just 27 per cent in 2006. Meanwhile, in Saudi Arabia and Kuwait, the influence of the private sector remained stable from 2000 to 2005, while in the UAE it grew from 21 per cent of spending in 2000 to 27 per cent in 2006.

However, these figures do not reveal how healthcare is increasingly being financed, managed and delivered in the region. GCC member states, in particular, have been looking to the private sector to take a more active role in the financing and provision of healthcare in the public sector, thus blurring the lines between public and private provision. The governments of these countries are using sovereign wealth funds such as Dubai Holding or Abu Dhabi's Mubadala Development Company to build the much-needed healthcare infrastructure. For example, the new Dubai Healthcare City, a US$3 billion development by Tatweer, a subsidiary of Dubai Holding, is expected to add 17 hospitals, with 2,325 new beds, at the same time as welcoming medical tourists.

Saudi Arabia is also committed to increasing the role of the private sector. In January 2006, expatriate health insurance became mandatory for all firms employing more than 500 foreigners, and in 2008 was extended to all expatriate workers. The scheme is intended to be expanded to encompass all Saudi nationals, but this has proved controversial and will be implemented in stages. From January 2009 affordable health insurance was made available to all Dubai residents. Bahrain is also planning on introducing compulsory health insurance for expatriates, and therefore shift some treatments to the private sector.



Capital investment in new facilities, provision of new medical technologies and expertise are just some of the benefits private healthcare players can bring. Yet, private sector involvement in healthcare needs careful planning. In the past, countries which have part-or fully-privatised their healthcare systems have experienced many difficulties. In Malaysia, for instance, the main thrust of healthcare reform since 1980 has encouraged greater private sector involvement, and this has resulted in an increase in the number and variety of private hospitals and clinics. However, as Malaysia has found, the building of private hospitals and provision of private healthcare services is just the first step.

A way must also be found for patients to pay for the treatment they receive. The Malaysian government has for several decades been contemplating the introduction of a national health insurance scheme to replace tax revenue and out-of-pocket spending as the main source of financing for the healthcare system, but has so far failed to make any progress.

Often, a criticism of private healthcare players involved in former government run healthcare systems is the creation of a "two-tier approach". Those with healthcare insurance, or those who can afford to pay, bypass the public system for higher quality treatment available in private hospitals or clinics. A vivid example: Central and Eastern Europe encouraged private sector participation in healthcare, and now a clear duality of healthcare provision between under-funded public sectors and private sectors exists. The state sectors are characterised by poor infrastructure, low-quality and limited primary and preventive healthcare, disincentives for healthcare staff at all levels, and customer dissatisfaction. In contrast, the private sectors cater almost solely to the wealthy, allowing patients choice of physician, providing services and consultations promptly, using modern medical equipment and, under special arrangements, also enjoying access to public hospitals and clinics.

So to avoid these problems, there has to be a commitment in the way that healthcare is delivered to make sure there is universal equitable access. Investments must improve infrastructure as well as offering high-quality healthcare at an affordable price.

Medical tourism

With rising healthcare costs and hospital waiting times in North America and Europe, the global medical tourism sector has been booming in recent years, especially in Asia, where countries such as India, Thailand and Singapore can offer medical care for a fraction of the price that it would cost in the US. Until recently the Middle East has been a major consumer, rather than a provider, of healthcare services in this context. Now governments in the region, particularly in the UAE and other GCC countries, are hoping to reverse this trend, by building healthcare facilities that will attract patients from elsewhere.

With this aim in mind, the UAE is making rapid progress in building a modern, technologically advanced healthcare infrastructure. And it is ensuring that its facilities are duly recognised as being among the world's best. The leading global healthcare accreditation and certification organisation, Joint Commission International (JCI), whose accreditation has become the international gold standard for the quality and safety of health facilities, has now accredited a total of 16 hospitals in the UAE, all of them (with the exception of the American Hospital Dubai, which was accredited in 2000) in the three years since May 2006[2]. The efforts of other countries in the region are just as impressive. Saudi Arabia now has 20 JCI-accredited institutions, while Jordan and Qatar each have five. These numbers compare very favourably with leading medical tourism destinations such as Singapore, which has 14 JCI-accredited hospitals, and Thailand, which has just four.

Nevertheless, the region is still struggling to establish itself as a safe destination for medical treatment. The UAE's medical reputation was not helped by an incident in May 2008 when an Emirati woman fell into a coma and died after undergoing liposuction at a health clinic in Dubai. Following the tragedy, the Ministry of Health took almost immediate action, closing several clinics and withdrawing licences from some doctors, as part of a move to impose tougher regulations on the industry. But it is telling that so many UAE nationals still travel abroad for medical procedures rather than have them at home, spending some US$2 billion annually in the process. A poll by the website arabianbusiness.com found that 65 per cent of readers said they would not choose a local clinic because of the lack of adequate regulation in the industry[3].

2 Source: www.jointcommissioninternational.org
3 Source: Arabian Business, "Cosmetic Clinics Face Crackdown", August 2008

The UAE also faces challenges in a global market where competitor countries have already established a strong reputation, but are also relatively inexpensive destinations. Thailand received 400,000 medical tourists in 2006, while Singapore, whose health system was ranked sixth in the world by the WHO in 2000, received 410,000 and is aiming to attract one million a year by 2012. India and Malaysia have also carved their own niches in medical tourism. All of these countries have a huge competitive advantage over the UAE in terms of the cost of medical care. For example, the average cost of heart by-pass surgery in the UAE is US$44,000, compared to US$18,500 in Singapore, US$11,000 in Thailand, US$10,000 in India and US$9,000 in Malaysia[4]. Nevertheless, the UAE price tag still compares very favourably with the US$130,000 cost of doing the same procedure in the US, indicating the huge potential that still remains in the medical tourism market.

Importantly, however, while the development of a strong medical tourism sector will bring financial and other benefits to some states in the region, notably the UAE, it will have few, if any, benefits for the vast majority of the population in places like Saudi Arabia, Jordan or Egypt, where facilitating access to basic healthcare services is still the over-riding priority. Naturally, there may be some beneficial spin-offs from medical tourism, such as attracting world-class specialists to the region, but any "trickledown" effects to the general population will be relatively small.

The UAE has the opportunity and the means to become an important medical tourism destination. India is of course better placed and already has advanced facilities to keep its position as market leader. But the increasingly low confidence of developed countries, namely the USA and UK, in their country's healthcare system, is an opportunity for the Emirates. Improving facilities and regulation could attract many medical tourists.

4 Source: Foreign Policy, August 2008.

Working together to shape healthcare

A comprehensive approach

The ultimate aim for any healthcare system is the ability to provide universal access to high quality services at low cost. In theory, this could be achieved by expanding the existing publicly-financed and run health services in the region, but it would put severe strain on public finances.

Instead, Middle Eastern governments are encouraging the private sector to play a more active role to help meet future healthcare demand. Many are adopting a public-private partnership (PPP) model, under which a government project is funded and operated through a partnership between the government and one or more private sector companies. The latter raise the finance for the capital investment, in return for which they receive a contract or lease to design and build the facilities and operate services. Government contributions to PPP may also include the transfer of existing assets such as hospitals to a private operator.

The level of responsibility each government wishes to give to the private sector influences the type of PPP model undertaken. As such, governments must have a clear strategy about the level of involvement with private partners. They should also try to reduce the bureaucracy and red tape that can often constrain the effectiveness of partnerships between public and private sector entities.

For their part, private providers must also have a clear idea of where and how they wish to compete, and which model suits their capabilities and future intentions in the region. And of course all providers, when bidding for projects, will have to work out how to cope with the chronic shortage of qualified medical staff in the region.

Expanding access to healthcare services

Of course, building new hospitals and clinics is of little use if the majority of the population cannot afford to use them, and the end result will be a two-tier system such as that in Malaysia. The payer system must also provide coverage to all citizens. Many governments are introducing health insurance schemes, paid for by payroll taxes or prepaid premiums. Notably, in Saudi Arabia, Abu Dhabi and Dubai, health insurance is a must for expatriate workers. Bahrain is also introducing the same health insurance requirements for expatriates.

The challenge of who pays and how for health insurance schemes, is political, and will differ from country to country. A decision must be made on whether the vulnerable will or will not be exempted from financial contributions, or if a minimum universal package should be developed for all. A standard fee for all can be a difficult sell to citizens used to having access to health services, albeit often of a poor quality, for free. The Saudi scheme is eventually intended to cover all Saudi nationals, but this has proved controversial. However, it can be achieved throughout the region, given the political will, and with the promise that access to healthcare services will not be restricted. These assurances can be reinforced by increasing government investment in providing better basic healthcare services, focusing on public health policy, disease prevention and expanding primary care coverage, while gradually carrying out insurance coverage for specialist secondary and tertiary care.

Countries that have successfully used this model provide more than one package of social health insurance. They offer a basic package that covers the main health problems and offer it at a low cost or for free for the less well off. Meanwhile, extra packages including more services and benefits are available at a premium for those who can afford it.

Apart from the political issues, there are also the practical challenges of introducing private capital and profit-orientated discipline to a former government-run healthcare system. Ideally, there should be a separation between funding and service delivery, and whether the provider is publicly- or privately-run should be irrelevant. In fact, there is no reason why public and private institutions should not compete with each other for reimbursement funds, a solution McKinsey suggested in 2007[5] (for the GCC states).

An improved regulatory framework

Although involving the private sector in healthcare delivery is a great mechanism for gaining access to capital investment and expertise, often bringing an innovative and entrepreneurial approach, it can also introduce complexity as a variety of players with different and often conflicting interests and aims are involved. Without adequate supervision, this may result in less effective delivery of care, perhaps even putting patients at risk. Healthcare systems can only work in an environment policed by credible, independent and efficient institutions which provide transparent rules and foster competition.

This illustrates the need for a robust regulatory system, whose main objective should be the protection of patients. To achieve this, governments should implement and enforce improved standards for all aspects of healthcare, ranging from structural requirements for facilities to standards of care and staff qualifications, and perhaps even to limits on the fees that can be charged for certain procedures. The system could also include incentive payments for those providers who give quality services – measured at a basic level by number of patients treated, or at a more sophisticated level by health outcomes. The system must also have a mechanism for monitoring provider performance and allow the discontinuation of the services of the non-performers. Transparently and effectively enforcing standards and dealing firmly with low-quality providers, as Dubai did with its cosmetic surgery clinics in 2008, will build confidence among patients and help the long-term health of the sector.

Regulation of the insurance sector is also key, since ineffective supervision in a competitive insurance system can lead to adverse risk selection, high marketing expenses, and difficulties for beneficiaries in selection of health plans. Success may require the creation of a public insurance system in parallel with the private one, to cover the higher-risk and lower income sections of the population that might otherwise be unable to get cover in a completely free-market system with only private insurers.

5 Source: McKinsey Quarterly, "Private Solutions for Healthcare in the Gulf", March 2007

67
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The social dimension

Throughout the Middle East, there is a long tradition of voluntary and charitable participation in the financing, organisation and provision of health services, and this cannot be ignored. Many of the region's most prestigious hospitals and health centres owe their existence to such charitable organisations, predating the establishment of health ministries and other state-level institutions. A large number of health facilities, ranging from outpatient clinics to hospitals, are still run by charitable groups, and many more are being built. Egypt's Cairo Children's Cancer Hospital, which opened to patients in 2007, is an example of a medical project funded entirely by charitable donations.

Also many for-profit healthcare players in the region are heavily involved in social and charitable activities. The healthcare sector is uniquely positioned at the heart of business, social and community life, and as such should be an exemplar of responsible business. Many healthcare players underscore their role as good corporate citizens with a number of activities in the fields of education and research, the environment, social needs and culture. A good example is the Saudi-German Hospital Group, which as well as several hospitals in place or in development throughout the region, operates several not-for-profit entities in healthcare, including the Jeddah Chairy Blood Bank and the Health Management Research Institute, a collaboration with the Indian Institute of Health Management Research.

Private sector players can contribute to expanding access to healthcare to diverse areas such as healthcare infrastructure, patient care, finance, and research and development, over and above their combined efforts with government. By helping to build physical and human resources, private players can support disease prevention, diagnosis, treatment and care, and support community-based efforts to train and educate healthcare professionals.

Market insights

Egypt

Egypt's healthcare system is run by many different public and private providers, with private sector facilities concentrated in Cairo and in other large cities. Unlike some of its neighbours, Egypt does not suffer from medical staff shortages.

Currently around half the population is covered by basic government health insurance, with the rest being either enrolled in private insurance schemes or uninsured. Although basic primary healthcare services are offered free of charge and hospital services in public hospitals are free for the uninsured, the geographical coverage and the quality of care received is not consistent. So, citizens increasingly seek outpatient care in expensive private facilities, which are perceived as providing better services.

"Given the size of its population, Egypt could easily become the largest healthcare market in the Middle East. But achieving this potential will depend largely on the implementation of the government reforms."

Amr Fathalla
Grant Thornton Consultants, Egypt

However, this would not be the case, if a reasonably-priced universal insurance was available. In 1997, the government responded by rolling out a reform programme to offer all citizens universal coverage of basic healthcare services by 2010. The reform package also focused on the decentralisation and privatisation of large parts of the healthcare sector. As with most plans, the programme has been difficult to carry out, meeting opposition from both providers and beneficiaries.

Economic growth rates together with an ageing and growing population, which is expected to reach 83 million by 2013, are driving healthcare reforms. Given the size of its population, Egypt could easily become the largest healthcare market in the Middle East. But achieving this potential will depend on government reforms. A change of attitude by the public is also needed towards paying for health services, (which will come if services are improved). An ideal scenario would involve both the private and public sector. Privatisation could help deliver high quality facilities and run services, and this would be paid for by social insurance.

United Arab Emirates

The rapid population growth being experienced by the UAE, driven mainly by the influx of expatriate workers, has placed huge pressure on its healthcare infrastructure. This is changing fast, however, helped by government initiatives, including the privatisation of publicly-owned healthcare facilities and the introduction of compulsory private health insurance. There are now some 65 hospitals in the UAE, up from just seven in the 1970s. This phenomenal growth was originally driven by the public sector, with most hospitals being financed and run by a variety of government institutions, including the federal Ministry of Health. In recent years, the private sector has taken up the running with around half the hospitals in the UAE, including the dozen or so hospitals in DHCC (a number that is due to grow to 17 by 2010). According to a report by the Dubai Chamber of Commerce and Industry, the number of hospital beds in Dubai is expected to nearly double from 2,934 in 2007 to 5,415 in 2010, with most of this increase in capacity being provided by the private sector.

To pay for this massive expansion in healthcare provision, the UAE federal government is introducing a comprehensive health insurance scheme that is intended to provide full health coverage for nationals by 2009, and phased-in coverage over several years for expatriates. The scheme has already started in Abu Dhabi, where all large employers must enrol their expatriate workers into a scheme known as DAMAN, which is run in partnership with the German insurer, Munich Re. The scheme applies only to expats; UAE nationals enjoy free healthcare under the thiqa health insurance scheme, enrolment is free of charge for Abu Dhabi citizens. DAMAN has already led to increased demand for health services and products.

The partnership with Munich Re is typical of the approach being adopted in the UAE, which has become a regional leader in healthcare reform through its willingness to use international expertise. This approach is exemplified by Dubai Healthcare City (DHCC) and DuBiotech, which have been established as 'free zones', actively encouraging international companies to introduce the latest approaches to the delivery of health services, as well as making investments in medical education and research and development (R&D). DHCC has attracted many international healthcare brands, including Harvard Medical School, the Mayo Clinic and Great Ormond Street Hospital, as well as leading pharmaceutical and medical technology suppliers such as Johnson and Johnson, Novartis and Novo Nordisk. Of course, DHCC is also part of Dubai's vision to not only provide better healthcare for nationals and residents, but also to promote medical tourism. As part of this vision, DOHMS has initiated laws making it mandatory for all healthcare facilities in Dubai to attain international accreditation by 2010 or face closure.

Meanwhile DuBiotech, which is being built at a cost of US$400 million, is intended to establish a viable local research base to complement the cutting-edge healthcare provision at DHCC. Companies locating in the DuBiotech Park receive 100 per cent exemption on corporate and personal tax guaranteed for 50 years, 100 per cent ownership of their business, 100 per cent repatriation of capital and profits, no currency restrictions, support services, simplified incorporation, and a fast-track visa-application process. DuBiotech has already attracted over 40 companies active in R&D, scientific discovery, clinical testing, manufacturing, sales and distribution, as well as business support and legal services, and venture capital firms, among others.

Despite the current economic climate, which has affected the UAE as much as the rest of the world, there seems little doubt that the advances that have been made in the country's healthcare sector in recent years will continue, albeit at a slower pace. These advances will increasingly be driven not only by the huge investments in healthcare provision being made by both public and private sector entities, but eventually also by the innovation that should result from the 'cluster' effect created by schemes such as DHCC and DuBiotech if they continue to attract the world's top healthcare institutions, companies and people.

"Despite the current economic climate, which has affected the UAE as much as the rest of the world, there seems little doubt that the advances that have been made in the country's healthcare sector in recent years will continue, albeit at a slower pace."

Hisham Farouk
Grant Thornton, UAE

Saudi Arabia

Saudi Arabia is by far the largest healthcare market in the Middle East, with a total healthcare spend valued at over US$15 billion per annum[6]. Some three quarters of this currently comes from government spending, a proportion that is generally recognised as being unsustainable, with demand growing and government revenues constrained by falling oil revenues (an estimated 75 per cent of government revenues are from sales of natural resources, and none of these revenues are specifically earmarked for the health sector). This will mean a much greater role for the private sector in healthcare, which has been identified as one of the key sectors to be targeted in the government's privatisation programme.

In fact, the government may already be planning to privatise the country's 218 state-owned hospitals, according to an interview given in 2008 by the head of the Saudi Arabian General Investment Authority (SAGIA), Manar al-Moneef. Under the plan, which was first unveiled in 2002, the hospitals would either be sold outright or leased out under a management contract. A further 2,000 hospitals and clinics that are planned or under construction will be established under a fund to be set up and monitored, but not controlled by, the Ministry of Health, as part of a gradual shift by the Ministry to become a regulator rather than provider of healthcare services. This will provide opportunities for private providers, but the potential for involvement of foreign firms is less certain.

Saudi Arabia is another participant in the vogue for 'healthcare cities' in the Gulf region. The Kingdom has already established the 1400-bed King Fahd Medical City (KFMC), which it claims is the largest medical complex in the Middle East, in Riyadh. In late 2008, the Ministry of Health revealed its latest plans for a healthcare city it claims will be even bigger. The King Abdullah Medical City (KAMC) will house three 500-bed hospitals, with the first due to open to patients in the second half of 2009. However, unlike similar developments in Dubai and Abu Dhabi there are, as yet, no big international names involved, and no plans to promote the developments for medical tourism. Saudi Arabia does already have a unique medical tourism offering, being the gateway to the holy sites of Mecca and Medina. During the Hajj, many pilgrims combine the trip with treatment in the clinics of Jeddah, and over this period the city's dental, medical and cosmetic surgery clinics experience a huge surge.

6 Source: Economist Intelligence Unit, 19 January 2009

Demand for healthcare services will be driven by the rapidly expanding and ageing local population, which is predicted to grow from just under 25 million today to nearly 29 million in 2013, with the number of over-60s increasing from about a million today to 2.5 million in 2020. And as the population grows bigger, it will become more susceptible to chronic lifestyle diseases. Already some 20 per cent of Saudi nationals over the age of 20 suffer from type-2 diabetes, due to poor diet and sedentary lifestyles. According to the WHO there will be 2.5 million diabetes sufferers in Saudi Arabia by 2030, a much greater absolute number than anywhere else in the region. With these trends driving growth, the Economist Intelligence Unit (EIU) predicts that overall health spending in Saudi Arabia will double to US$30.2billion in 2012.

"Saudi Arabia already has a well-established local private hospital management sector, with some 100 facilities accounting for about a fifth of hospital bed numbers and currently run by operators such as the Saudi German Hospital Group, Kingdom Holding and the Saad Group.The loosening of laws on foreign ownership, which now allow for 100 per cent foreign equity investment in local companies, should offer lucrative opportunities."

Akram F El Husseini
Aldar Audit Bureau, Saudi Arabia

Future opportunities

By 2025 the need for hospital beds will more than double to about 165,000, and "treatment demand" will rise 240 per cent, predicts McKinsey. Healthcare costs will rise fivefold to US$60bn. In fact, a potent combination of high population growth, rapid economic growth and openness to global capital, expertise and innovation will make the Middle East a major growth centre for the healthcare market over the next few years.

The UAE will continue to be the main focus for foreign investment in hospitals and medical facilities, insurance and consultancy services, as PPPs are formed to deliver leading healthcare services demanded by locals and expatriate workers alike. Private healthcare providers will have to decide whether to enter into these government contracts, with all the complexity and bureaucracy that may entail, or to build and operate their own facilities. There may also be the opportunity to achieve economies of scale by operating in other GCC countries, such as Bahrain, Qatar and Kuwait.

Outside of these countries, change will occur, but at a slower pace. Larger countries such as Egypt and Saudi Arabia will find the introduction of mandatory health insurance and privatisation more difficult to achieve, and so opportunities there will be less appealing. Against that, the relatively large size of those markets means that any breakthroughs could result in huge gains for those able to exploit them.

Some of the biggest opportunities are likely to be found in healthcare infrastructure projects, which have already attracted companies such as General Electric (GE) and Siemens, both of which have large infrastructure businesses as well as being major suppliers of healthcare IT and diagnostic imaging technologies. GE has already opened their new headquarters in Dubai Internet City, as well as a production facility in Saudi Arabia, manufacturing diagnostic imaging systems.

Initiatives such as the creation of 'free zones' for foreign companies, including 100 per cent ownership and tax benefits, are expected to attract more companies to the region, increasing foreign direct investment (FDI) in general and investment in biotechnology research in particular, and eventually fuelling growth in the market for biotechnology products. Leading international biotech companies, including Amgen and Genzyme, have already set up operations in DuBiotech, and smaller players seem certain to join them. Whether this will be enough to create 'critical mass' and establish a cluster to rival those around Boston, Massachusetts, or Research Triangle Park in North Carolina, remains to be seen – there is a lot of global competition for biotech talent and funds. Nevertheless, the ambition and drive to succeed is certainly there, and Dubai has an admirably positive 'build it and they will come' attitude, which has already worked in sectors such as property and financial services.

More opportunities will arise in health insurance, which until now has been a relatively underdeveloped sector in the region. This will change rapidly as the shift to privately-funded healthcare takes shape, particularly in the GCC countries, but also potentially in Egypt and others. The lack of government experience in running large and complex health insurance schemes will provide openings for international insurance players, either by partnering with governments to create and run a scheme from the start, or by providing services on an outsourced basis. Certain key functions such as claims processing and management will be able to tap into a strong international outsourcing industry of specialist companies, but others will have to be provided on the ground, often for regulatory reasons. In Abu Dhabi, for instance, all insurance companies and intermediaries that wish to sell health insurance are required to have established a place of business in Abu Dhabi. This may present something of a barrier to insurance groups that wish to set up critical mass across the region and want economies of scale by deploying scarce talent and expertise in one location. However, it should also be seen as an opportunity to train locals in key locations, and so create goodwill with governments.

In addition to the market for healthcare products and healthcare-related services, there will be a growing market for regulatory consultancy services as the region's governments struggle to adapt international best practices to local organisational, legislative and legal frameworks. Privatisation will mean that the role of each country's Ministry of Health gradually shifts from that of healthcare provider to that of regulator, requiring a significant shift in mindset and reassignment of resources. And in the UAE in particular, the Ministry of Health will have to get to grips with the development of stringent regulatory standards for medical and life sciences research that are aligned with international practice but also adapted to local cultural and moral codes.

Despite the challenges ahead, Middle Eastern countries now have the opportunity to capitalise on emerging trends such as medical tourism. However, the healthcare sector must be regulated and further investment will be necessary to take advantage.

Appendix
Economics overview

Gross Domestic Product per head, current prices (US$ millions)

Location	2008	2009	2010	2011	2012
Bahrain	27,247.8	22,808.8	24,548.7	26,138.0	27,783.6
Egypt	2,160.9	2,456.8	2,610.9	2,860.3	3,130.1
France	46,015.9	39,922.3	40,169.5	41,317.3	42,784.7
India	1,016.2	982.0	1,007.9	1,066.1	1,145.8
Iran	4,732.0	4,629.0	4,965.8	5,240.2	5,454.8
Iraq	2,989.1	2,194.8	2,512.6	2,799.3	3,054.9
Jordan	3,421.4	3,616.0	3,807.9	3,982.7	4,176.2
Kuwait	45,920.3	30,040.6	33,606.5	35,951.1	37,499.5
Lebanon	7,616.6	8,131.7	8,517.9	9,004.9	9,462.8
Libya	16,114.7	9,936.8	11,462.3	12,891.3	14,378.3
Malaysia	8,140.7	7,653.8	7,817.1	8,197.7	8,716.6
Oman	18,987.8	15,402.4	17,366.0	19,160.8	20,833.5
Qatar	93,204.1	81,860.6	98,567.7	104,599.1	102,524.5
Saudi Arabia	19,345.3	14,655.5	16,203.7	17,481.7	18,559.6
Syria	2,756.6	2,590.4	2,802.0	3,017.9	3,225.3
UAE	54,606.5	43,856.7	46,600.8	49,194.3	52,375.3
USA	46,859.1	45,550.3	45,253.9	46,662.9	48,590.7
Yemen	1,181.6	1,211.4	1,433.7	1,625.5	1,812.9

Gross Domestic Product, annual growth (%)

Location	2008	2009	2010	2011	2012
Bahrain	6.1	2.6	3.5	3.9	4.9
Egypt	7.2	3.6	3.0	5.0	6.0
France	0.7	-3.0	0.4	1.7	2.0
India	7.3	4.5	5.6	6.9	7.6
Iran	4.5	3.2	3.0	2.6	2.2
Iraq	9.8	6.9	6.7	6.3	6.2
Jordan	6.0	3.0	4.0	4.5	5.0
Kuwait	6.3	-1.1	2.4	4.3	4.8
Lebanon	8.5	3.0	4.0	4.0	4.5
Libya	6.7	1.1	2.8	7.3	8.7
Malaysia	4.6	-3.5	1.3	4.1	5.5
Oman	6.2	3.0	3.8	6.0	6.3
Qatar	16.4	18.0	16.4	8.9	3.4
Saudi Arabia	4.6	-0.9	2.9	4.4	4.9
Syria	5.2	3.0	2.8	4.6	4.5
UAE	7.4	-0.6	1.6	3.3	4.6
USA	1.1	-2.8	-0.0	3.5	3.6
Yemen	3.9	7.7	4.7	4.0	4.5

Source: IMF Economic Outlook Database (estimates), April 2009

Gross Domestic Product, current prices (US$ billions)

Location	2008	2009	2010	2011	2012
Bahrain	21.2	18.1	19.9	21.6	23.4
Egypt	162.2	188.1	203.8	227.8	254.3
France	2,865.7	2,499.2	2,527.6	2,611.7	2,716.9
India	1,209.7	1,185.7	1,234.0	1,323.2	1,441.1
Iran	344.8	343.0	374.2	401.5	425.0
Iraq	90.9	68.6	80.5	91.9	102.8
Jordan	20.0	21.7	23.3	25.0	26.8
Kuwait	158.9	106.2	121.2	133.5	143.5
Lebanon	28.9	31.3	33.2	35.6	37.9
Libya	100.1	62.9	74.0	84.9	96.6
Malaysia	222.2	212.5	220.7	235.4	254.5
Oman	52.6	43.1	49.0	54.6	59.9
Qatar	102.3	99.7	133.3	157.0	170.8
Saudi Arabia	481.6	374.0	423.8	468.7	512.5
Syria	54.8	52.8	58.5	64.5	70.6
UAE	260.1	215.2	235.5	256.9	280.8
USA	14,264.6	14,002.7	14,050.8	14,633.1	15,390.0
Yemen	27.2	28.7	35.0	40.8	46.9

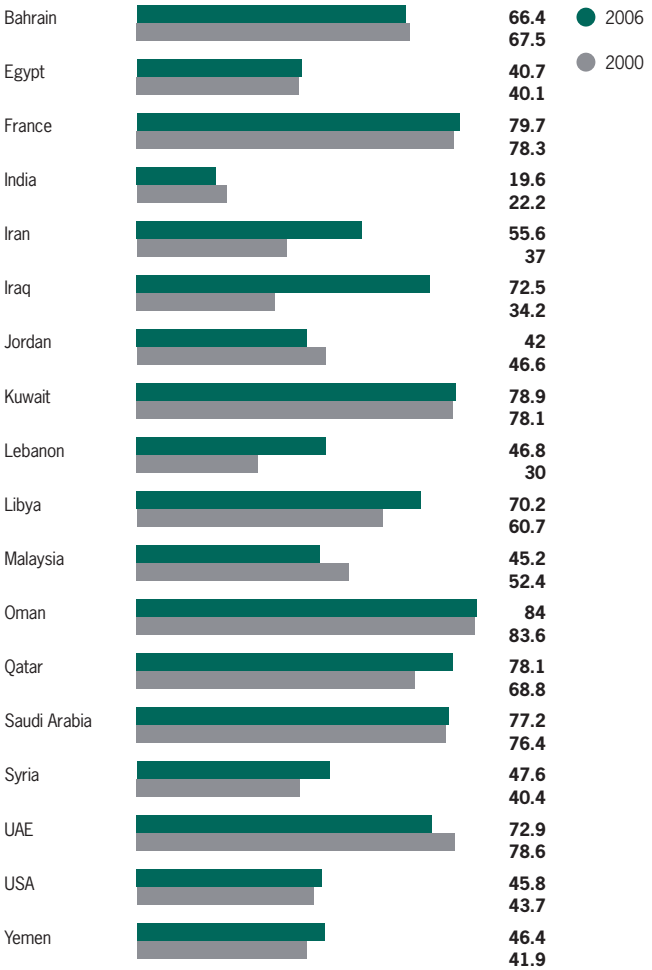
Population (millions)

Location	2008	2009	2010	2011	2012
Bahrain	0.8	0.85	0.8	0.8	0.8
Egypt	75.0	76.5	78.1	79.6	81.2
France	62.3	62.6	62.9	63.2	63.5
India	1,190.5	1,207.5	1,224.4	1,241.2	1,257.8
Iran	72.9	74.1	75.4	76.6	77.9
Iraq	30.4	31.2	32.0	32.8	33.6
Jordan	5.9	6.0	6.1	6.3	6.4
Kuwait	3.4	3.5	3.6	3.7	3.8
Lebanon	3.8	3.8	3.9	4.0	4.0
Libya	6.2	6.3	6.5	6.6	6.7
Malaysia	27.3	27.8	28.2	28.7	29.2
Oman	2.8	2.8	2.8	2.9	2.9
Qatar	1.1	1.2	1.4	1.5	1.7
Saudi Arabia	24.9	25.5	26.2	26.8	27.6
Syria	19.9	20.4	20.9	21.4	21.9
UAE	4.8	4.9	5.1	5.2	5.4
USA	304.4	307.4	310.5	313.6	316.7
Yemen	23.0	23.7	24.4	25.1	25.9

Source: IMF Economic Outlook Database (estimates), April 2009

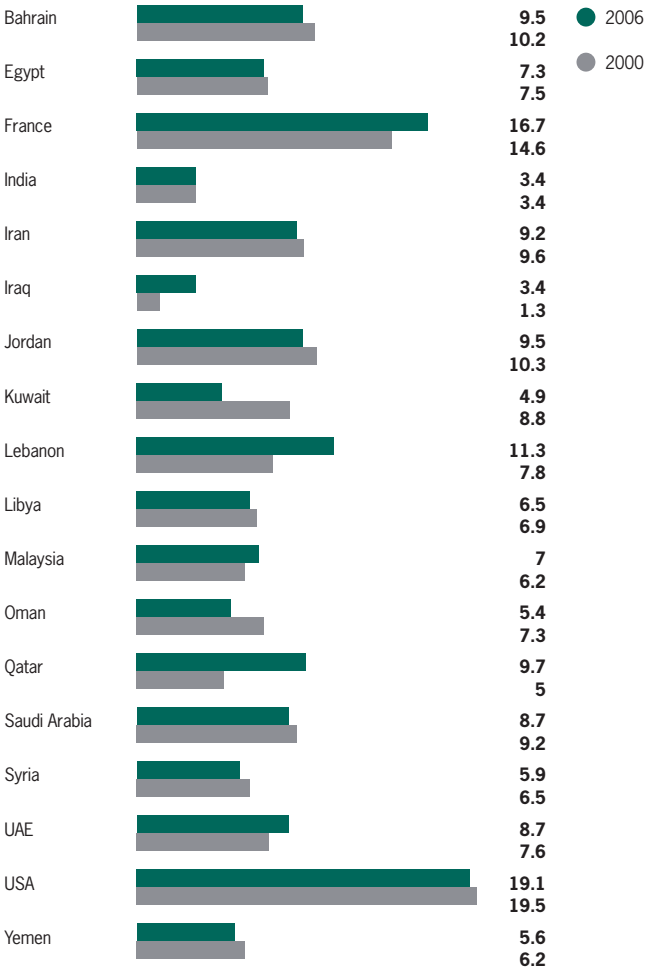
Going private in the Middle East

Figure 7: General government expenditure on health as percentage of total expenditure on health (%)



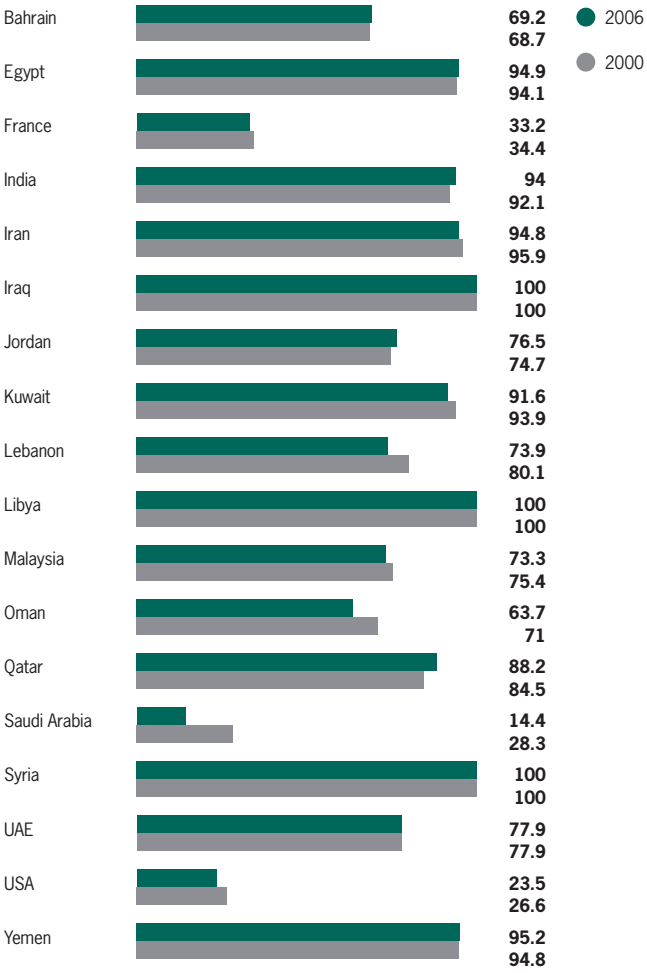
Source: © World Health Organization (WHO)

Figure 8: General government expenditure on health as percentage of total government expenditure (%)



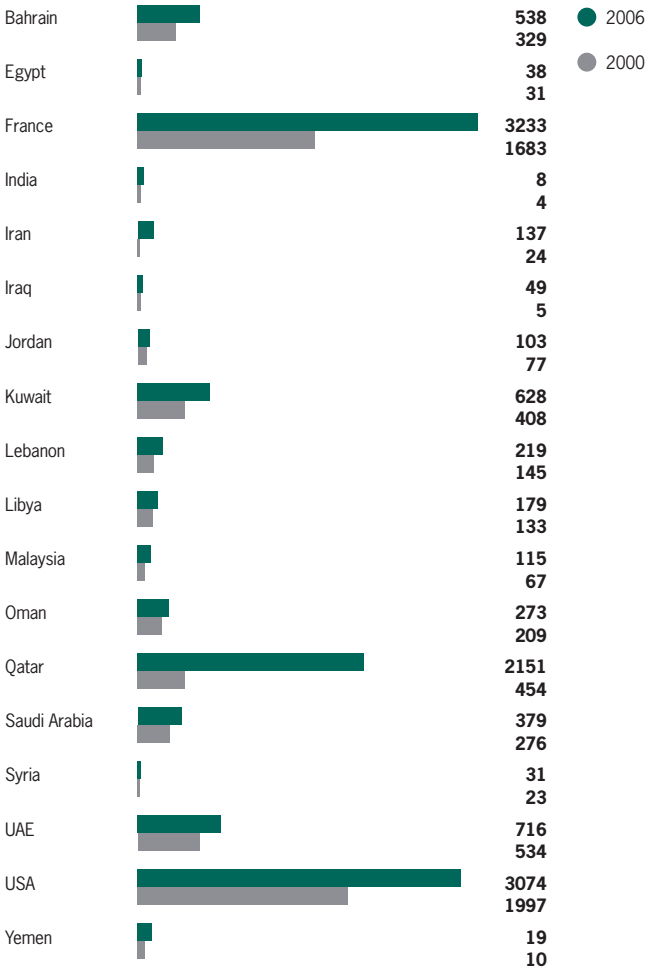
Source: © World Health Organization (WHO)

Figure 9: Out-of-pocket expenditure as percentage of private expenditure on health (%)



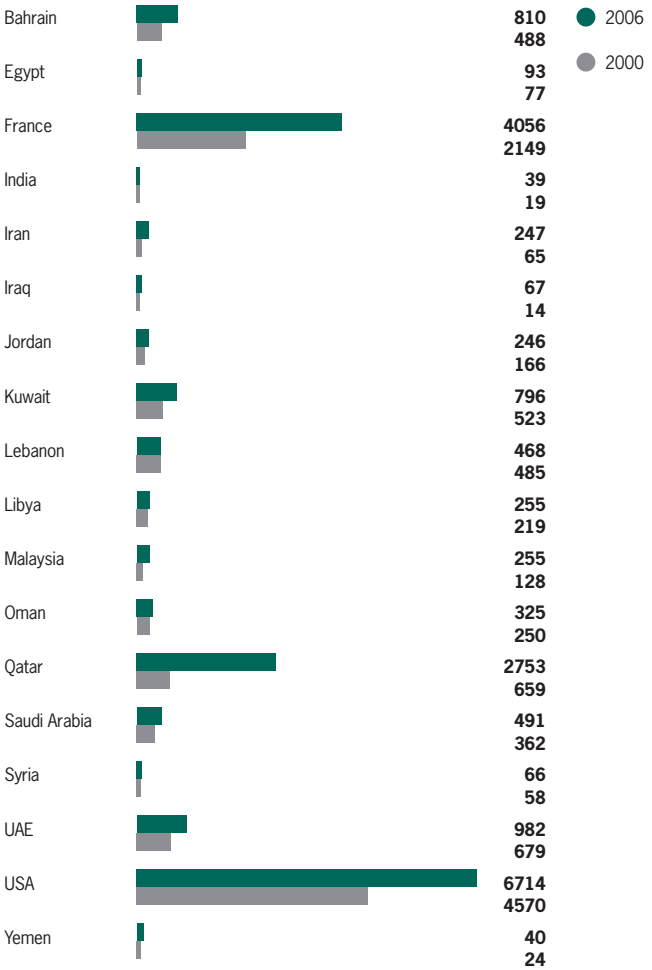
Source: © World Health Organization (WHO)

Figure 10: Per capita government expenditure on health at average exchange rate (US$)



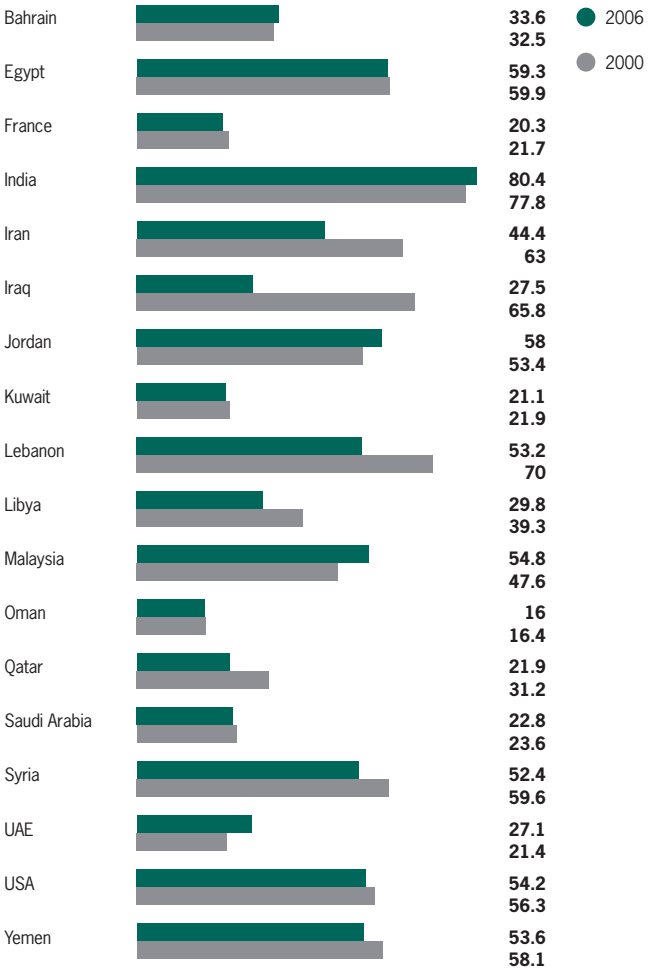
Source: © World Health Organization (WHO)

Figure 11: Per capita total expenditure on health at average exchange rate (US$)



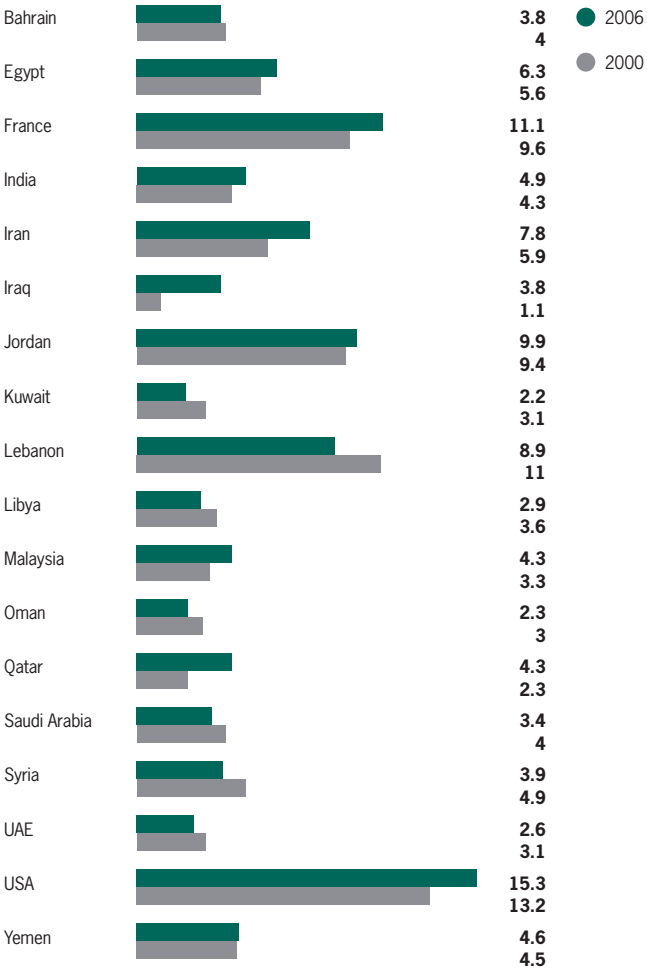
Source: © World Health Organization (WHO)

Figure 12: Private expenditure on health as percentage of total expenditure on health (%)



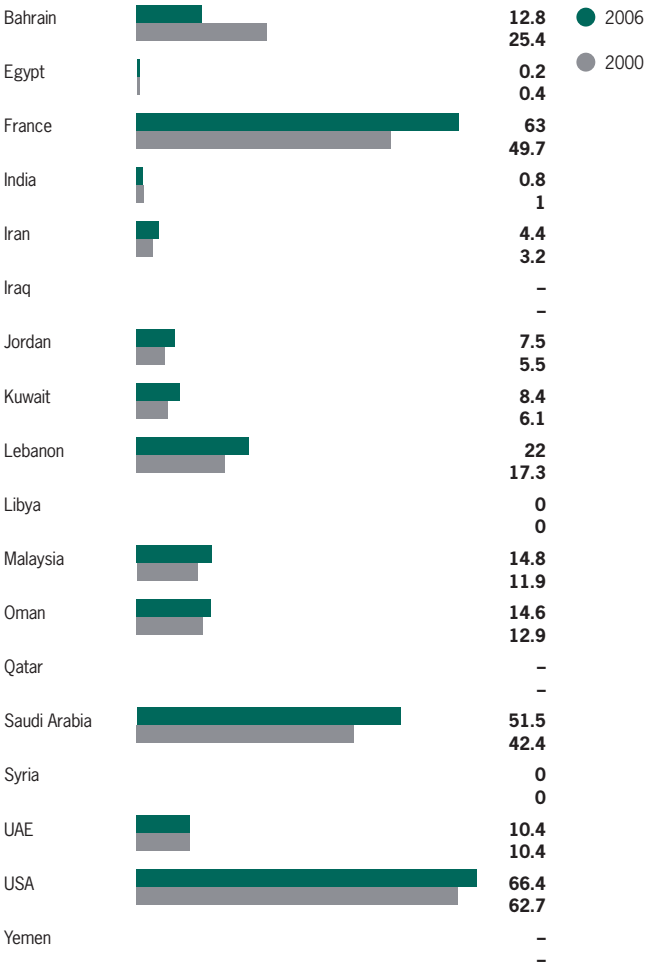
Source: © World Health Organization (WHO)

Figure 13: Total expenditure on health as percentage of gross domestic product (%)



Source: © World Health Organization (WHO)

Figure 14: Private prepaid plans as percentage of private expenditure on health (%)



Source: © World Health Organization (WHO)

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