In-Focus Report

Saudi Healthcare Sector Review: Rising Opportunities for Private Hospitals

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Executive Summary

- The Saudi Healthcare industry is forecasted to expand steadily over the coming five years as population growth rates remain high, the ageing segment widens, and the Kingdom's predisposition to chronic lifestyle diseases persists.
- The Ministry of Health continues to incur the bulk of expenses for the market, with growing private sector penetration. Revenues in the latter amounted to SR22 billion by the end of 2009.
- The public sector's share in health expenditure is forecasted to decline to 74% by 2015, from its current share of 77%.
- Total bed capacity is estimated to reach 79,222 by 2015, raising the Kingdom's hospital bed-to-population ratio to a feasible 2.50.
- Outpatient visits and inpatient admissions are expected to reach 159 million visits and 4 million admissions, respectively, by 2015.
- The critical success factors of private healthcare providers are sustainable growth in key financial indicators, incentivizing and retaining skilled medical manpower, and aligning the management style of the hospital with the dynamics of the healthcare industry.
- Bank's appetite towards funding long-term projects of private medical operators is rather positive. Long-term loans may extend up to six years.
- However, financing risks banks face include asset-liability mismatch, operational risks associated with contractors, and the inability to foreclose on a hospital in case of default.
- Challenges the sector is likely to meet in the future are the rising costs of services and equipment, limited supply of financial and human resources, and high barriers to entry, given the capital-intensive nature of the industry.
- The size of the Kingdom's healthcare GDP is expected to expand by 55% over the forecast period, amounting to SR96 billion in 2015.
- Total private investment in bed capacity is expected to reach SR9.6 billion through the period 2009-2015.

Introduction

The Kingdom of Saudi Arabia has the largest healthcare market in the GCC, boasting the region's most technologically advanced infrastructure, state-of-the-art facilities and medical equipment. While the Saudi Ministry of Health (MoH) continues to be the main financier for this sector, public funds alone will be insufficient to meet the increasing health care needs of the Kingdom's rising population.

Healthcare in the Kingdom is segmented structurally and provided for by the MoH, Other Public Sector (OPS)–which includes the Ministry of Defense, National Guard, Ministry of Interior, medical colleges, and Saudi Aramco –as well as the private sector. By the end of 2009, there were 408 operating hospitals, and 2,037 Primary Healthcare Centers (PHC). Both outpatient visits and inpatient admissions amounted to 131 million and 3 million, in 2009, respectively.

Demand for healthcare services will continue to rise over the upcoming five years, backed by rapid population growth, a larger ageing segment, and the prevalence of long-term non-communicable diseases. While the government has taken great steps to enhance public healthcare delivery systems, it has fallen short on its stipulated targets outlined in the Kingdom's successive development plans.

Consequently, several initiatives have been undertaken to encourage private sector participation, such as the facilitation of financing vis-à-vis lending institutions. Opportunities for private players lie in the three tiers of medical care: primary, secondary and tertiary. However, with government efforts divided between providing healthcare services for all three tiers, greater revenue drivers for the private sector will still be in secondary and tertiary care. Additionally, the anticipated all comprehensive health insurance scheme will act as a catalyst in propelling private sector participation forward.

This report will examine the trends and developments of the Saudi healthcare sector, highlight its current situation, and forecast its emerging opportunities and challenges through 2015.

Market Determinants

(A) Population Growth and Ageing Segment

Population growth is the main driver of healthcare demand in the Kingdom. The most recent census taken in mid 2010 established that the Kingdom's population stood at 27.1 million, having grown at an inter-census Compounded Annual Growth Rate (CAGR) of 3.15% since 2004. The Kingdom will continue to witness a high rate of population growth across all age groups, due in part to those entering marriageable age (20-29 years). In addition, the number of Saudis past retirement age (60+ years) will also grow, as Saudis live longer lives.

In 2008, Saudis had a life expectancy of 73 years at birth. This represented an overall increase of 9%, and 3%, from 1988 and 1998, respectively. Additionally, according to the World Health Organization (WHO), in 2008, 76% of Saudi males and 84% of Saudi females had a survival rate to age 65, further indicative of a growing elderly society on an improved healthcare system.

(B) Lifestyle Diseases

Non-communicable diseases (NCDs)–known as lifestyle diseases–are increasing at an alarming rate in Saudi Arabia as a result of increasing prosperity and the socio-economic transformation. The epidemiological profile of the Kingdom includes high incidences of obesity, hypertension and diabetes mellitus, particularly Type-2. The latter has been the leading cause of cardiovascular disease, kidney failures and amputations. The complications caused by these diseases will increase long-term costs, further burdening an already over-stretched healthcare system.

According to the outcome of a survey released by the Saudi Diabetes & Endocrine Association (SDEA) in 2010, over 70% of the Saudi population is alarmingly obese. The WHO determined that both men's and women's estimated mean Body Mass Index (BMI) in the Kingdom scored 26.6 kg/m^2 and 28 kg/m^2, respectively in 2010. A BMI score above 25 kg/m^2 is indicative of an overweight populace and that above 30 kg/m^2 denotes obesity.

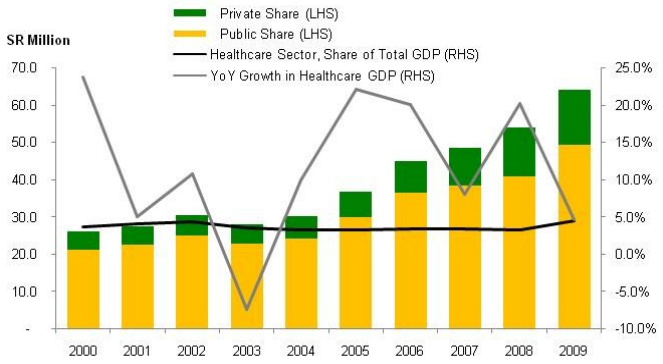
In 2009, 6.2% of total visits to MoH health centers were related to diabetes. Of this segment, 45% of visits came from patients in the 45–60 age group, with patients from ages 15+ accounting for 96% of these visits. Saudis accounted for 97% of these total visits. This figure omits all other diabetes related complications such as cardiovascular diseases. Additionally, emergency cases related to diabetes were equivalent to 484,239 or 3% of the total of emergency cases reported in 2009 at MoH hospitals. Of significance, again, is that 93% of these diabetes emergency cases were reported by Saudi nationals. Although these measures are restricted to MoH hospitals, which cater mainly to Saudi nationals, they still serve to highlight this inherent national problem. The economic burden associated with the disabilities and loss of life caused by diabetes will escalate, should the lifestyle not adjust.

Market Size

(A) Healthcare Sector Share of GDP

According to The World Bank, healthcare represented 3.3% of Saudi Arabia's nominal GDP in 2008—an equivalent of SR58.9 billion—with the share of public health of GDP constituting 2.3%, and that of private health, at 1%. From 2000-2009, the Kingdom's nominal GDP grew at a CAGR of 7.9%. By 2009, it is estimated that the public health sector's share was still hovering high at 77%, with private health participation accounting for 23%. Per capita healthcare GDP amounted to approximately SR2,506 in that year, (Figure 1).

Figure 1: Saudi Healthcare GDP

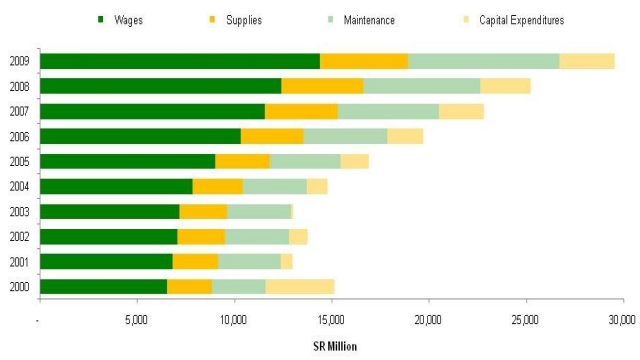


Source: World Development Indicators 2010, NCB Estimates

(B) Government Expenditure

The 2009 MoH annual report reflected a 9% increase in capital expenditures, amounting to SR2.8 billion, which is in line with the government's continuous initiative and 2010 budgeted plan to increase the number of primary health care centers and hospitals in the Kingdom. Also, wages in 2009 continued to account for almost 50% of the MoH's total appropriation, at SR14.4 billion, more than doubling over the 2000-2009 period, (Figure 2).

Figure 2: MoH Expenditure Allocation



Source: MoH Annual Reports 2000-2009

The 2011 state budget, announced in December 2010, stated that the Health and Social Affairs component of expenditure will increase to 11.8% of the total budget, rising by 12.3% from last year. In studying previous MoH annual reports, health alone used to account for up to 80% of the total Health and Social Affairs budget. However, in 2009, it had decreased to approximately 56%. As social awareness programs increase and preventative care initiatives begin, this trend will most likely continue, (Table 1). Additional health projects were also financed from previous year budget surpluses, especially that of 2004–2006. By 2009, this translated into a total of SR5.9 billion, which was distributed across the Kingdom for an additional 1,499 projects.

Table 1: Health, % of Total Budget

	2007	2008	2009	2010
Total Budget (SR bn)	380	410	475	540
Health & Social Budget (SR bn)	31.0	44.4	52.3	61.2
MoH Budget (% of Total Budget)	6.0%	5.6%	6.2%	N/A
MoH Budget (SR bn)	22.8	25.2	29.5	N/A
Health (% of Total Health & Social Budget)	73.6%	56.8%	56.4%	N/A

Source: MoF Annual Budgets 2007-2010, MoH Annual Reports 2007-2009

(C) Other Public Sector Expenditure

To estimate OPS expenditure in 2009, the average operating expenditure of a MoH's bed for the same year, equivalent to SR887,060, was used as a proxy after adjusting it to approximately SR1.1 million per bed. This is to reflect the better level and more expensive care generally offered within the OPS sector. Consequently, the OPS expenditure for 2009, based on 10,822 beds, is estimated to have reached almost SR12 billion.

(D) Private Sector Revenues

The revenues generated by private hospital operators were estimated at SR22.1 billion and SR25.4 billion in 2009 and 2010, respectively. This was based on (1) private inpatient visits equivalent to 869,682 in 2009, with an average SR8,000 incurred cost per stay, and (2) private outpatient visits equivalent to 39,740,680 in 2009, with an average outpatient incurred spending of SR380 per visit. For 2010, both the inpatient and outpatient visits are estimated to have increased by 5% and 8%, respectively, along with an expected increase in outpatient average cost to SR420 per visit (Table 2).

Table 2: Private Healthcare Sector Market

	2009	2010
Inpatient Market, SR mn	6,957	7,271
Inpatient Visits per Year	869,682	908,924
Avg. Revenue per Length of Stay, SR	8,000	8,000
Outpatient Market, SR mn	15,101	18,094
Outpatient Visits per Year	39,740,680	43,081,651
Avg. Revenue per Visit, SR	380	420
Private Sector Revenues, SR mn	22,059	25,366

Source: MoH Annual Report 2009, NCB Estimates

Health Insurance

In an effort to encourage further private healthcare participation, in January 2006, the Kingdom introduced mandatory medical insurance coverage for non-Saudis legally residing and working in the Kingdom. While this mandate currently applies only to expatriates and private sector employees, it will ultimately apply to all Saudi national employees as well.

The Saudi Stock Exchange (Tadawul) lists 31 insurance companies, 25 of which provide health insurance. By end 2010, the market capitalization was SR22.1 billion. According to SAMA, health insurance, including both compulsory and non-compulsory lines, accounted for 49.9% of the gross written premiums (GWPs) by end of 2009, amounting to SR7.3 billion. This represented a CAGR of 49% over the three year period 2006–2009, since mandatory health insurance was introduced. Health insurance accounted for the SR2.49 billion of the reported SR3.69 billion increase in GWPs in 2009.

According to industry sources, approximately 7 million people carried insurance policies at the end of 2009, paying an average annual premium of SR1,042 per person. In that year, only 1,736 private operators had contracts with insurance companies. It is predicted that this number will rise, as more people become insured.

It is important to highlight, however, that as health insurance takes over as the primary method of payment for patients, communication gaps between health providers and insurance companies will continue to rise. This may result in transactional delays, further burdening an already long collection period and creating a credit risk for medical providers. The current lack of a centralized database of insurance card users, which tracks access to various medical resources, may translate into a rejection of claims by some insurance companies. Coupled with a built-in rejection quota, this may affect the quality of medical service provision and reflect negligence on health providers.

Furthermore, as the insurance market grows, it may decrease profit margins for medical care providers, especially private clinics, who will be forced to comply with the growing number of colluding insurance companies. Another existing concern is the oligopolistic nature of the Saudi insurance market, resulting in companies resisting to increase prices, while simultaneously imposing the discounts on medical providers.

Healthcare Sector Capacity

(A) Primary Healthcare Centers

The MoH is in the process of reforming healthcare provisions. One initiative is to increase the number of PHCs and establish them as the single point of access for all patients. This will create efficiency in the system by decreasing delays in public hospitals. After a patient has been screened at the initial level, his/her case will be systematically referred to hospitals as necessary. Over the past nine years, PHCs grew by approximately 14%, amounting to 2,037 centers.

With the total number of physicians in the PHCs reaching 6,853, the national average of physicians per PHC in 2009 was 3.36 physicians. When analyzed with total patient visits to PHCs across the Kingdom, each physician conducts 7,964 visits in a year, resulting in 28 patient visits per physician on a daily basis. If each patient's visit lasts 15 minutes on average, then within an eight hour working day, a physician can only meet with a maximum of 26 patients, and therefore does not have the capacity to meet with the additional 2 patients per day. Consequently, this pressure needs to be relieved through an addition in the number of PHCs or in the number of physicians. The table below represents the regional breakdown, with burdened health areas identified, (Table 3).

Table 3: Region-wide Distribution of PHCs

Region	2009 PHCs	Phys/ Region	# Saudis	Phys/ PHC	Annual Visits/ Phys
Riyadh	377	966	201	2.56	10,554
Makkah	76	483	185	6.36	7,271
Jeddah	80	553	384	6.91	4,151
Ta'if	105	347	27	3.30	7,512
Madinah	134	526	93	3.93	8,478
Qaseem	152	534	34	3.51	6,884
Eastern	126	482	276	3.83	6,013
Al-Ahsa	68	208	56	3.06	14,565
Hafr-Al-Baten	34	80	3	2.35	16,368
Aseer	227	595	85	2.62	6,973
Bishah	72	110	0	1.53	11,427
Tabouk	67	223	6	3.33	7,328
Ha'il	93	221	9	2.38	8,387
Northern	41	167	3	4.07	7,278
Jazan	149	387	35	2.60	12,043
Najran	62	335	10	5.40	5,056
Al-Bahah	91	309	20	3.40	5,712
Al-Jouf	33	155	6	4.70	5,649
Qurayyat	20	57	5	2.85	6,064
Qunfudah	30	115	3	3.83	9,944
	2,037	**6,853**	**1,441**	**3.36**	**7,964**

Source: MoH Annual Report 2009, NCB Estimates

(B) Secondary and Tertiary Care

As the incidences of NCDs increase, the Saudi population, leveraged by increased prosperity, will demand greater secondary and tertiary care. Demand growth in this segment will act as an incentive for private investors to establish multi-disciplinary hospitals and specialized centers for complex diseases. Such investment will increase competitiveness and improve the quality of services. Private hospitals are generally preferred due to (1)

excess queues at public facilities, (2) capacity saturation within public care (overburdened emergency rooms and hospital beds), (3) lack of specialized treatment and facilities in rural areas, and (4) higher efficiency in private care. Limited opening hours of governmental hospitals has also been cited as a reason for referrals to private hospitals. These factors have placed added pressure on the healthcare market and can be met by more private investment.

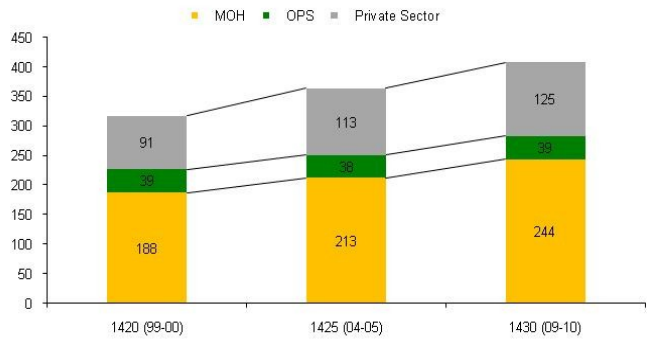
(C) Hospital Services Market

Hospitals in the Kingdom are the backbone of the health sector offering primary, secondary and tertiary care. Every year, the government's budget conveys the increment of the number of hospitals planned, and several are currently underway.

(C-1) Operational Hospitals and Beds Capacity

Capacity is measured by operational hospitals and the respective number of beds. According to the MoH, by end 2009, there were 244 MoH hospitals, 39 OPS hospitals, and 125 private hospitals for a total of 408 hospitals. Total installed hospital bed capacity in the Kingdom amounted to 55,932 beds, (Figure 3). However, the Kingdom's 8th Development Plan (2005–2009) targeted 39,764 MoH beds by end 2009, and only 33,277 were achieved. The shortage of 6,487 beds is likely to have increased pressure on current and upcoming public hospital expansion plans.

Figure 3: Operational Hospitals by Category

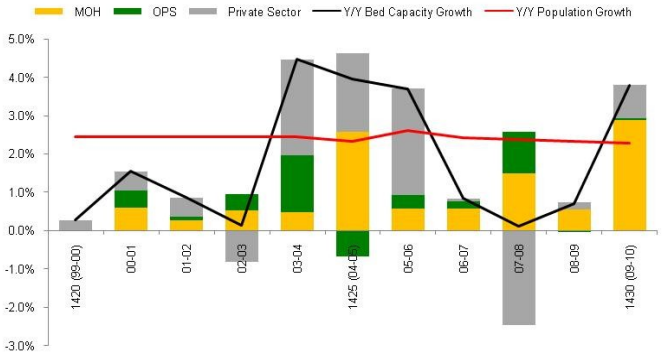


Source: MoH Annual Reports 2000-2009

The OPS operate health facilities for the primary benefit of their employees. There has been no change in the number of hospitals operated by the OPS in the past three years. While their bed capacity initially increased to 10,828 in 2007, this number had declined to 10,806 by end 2008 to rise marginally again by end 2009 to 10,822 beds, (Figure 4).

In general, private sector participation has continued to increase in providing both hospitals and beds. Since 1999, private hospitals grew by 37%, illustrating that the private sector has shown faster growth over the past decade, accounting for 31% of total hospital capacity. Accordingly, beds in the private hospitals reached 11,833 in 2009.

Figure 4: Y/Y Hospital Bed Capacity Expansion

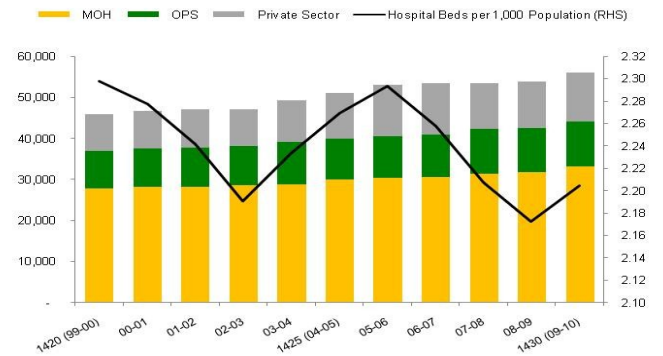


Source: MoH Annual Reports 2000-2009

(C-2) Utilization Indicators

Despite the overall increase in number of hospital beds, the Kingdom has witnessed a deterioration in its hospital beds-to-population ratio. The hospital beds-to-population ratio is expressed as the number of available hospital beds for every 1,000 population. Over the past ten years, the hospital beds-to-population ratio declined 4.5% from 2.30 to 2.20 by end 2009. This can be attributed to a rapidly rising population of 2.4% CAGR since 1999, versus only a 2.0% CAGR in number of beds for the same period, (Figure 5).

Figure 5: Hospital Beds Capacity



Source: MoH Annual Reports 2000-2009, NCB Estimates

By the end of 2009, total physicians per 10,000 population was 21.6, while physicians per hospital bed reached 0.51, rising by 31% during the previous seven years. In all hospitals, Saudi nationals accounted for 32% of the physician workforce. Total nurses per 10,000 population stood at 43.7, with Saudi nationals in all hospitals representing only 33% of the total. The MoH set its target ratios at 0.75 Physicians, 1.5 Nurses and 0.8 Allied Health

Personnel, per hospital bed, by 2014. Both the physician and allied health personnel per hospital bed appear to be unachievable in the short-term, provided they only grow in seven years at CAGRs of 3.9% and 5%, respectively, whereas the nurse per hospital bed target ratio may be achieved, (Table 4).

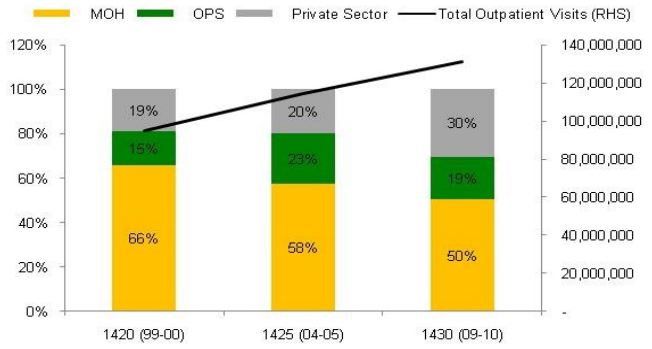
Table 4: Medical Personnel per Hospital Bed & MoH Targets

Medical Personnel	2009	7 YR CAGR	MoH Target (2014)	2014F
Physician per Bed	1	3.9%	0.75	0.62
Nurse per Bed	1.19	4.6%	1.5	1.49
Allied Health Personnel per Bed	0.59	5.0%	0.80	0.75

Source: Ministry of Planning: 9th Development Plan, NCB Estimates

Outpatient visits became five times greater than the population, reaching 131 million visits in 2009. The existing congestion in the system can be assessed by the number of visits per physician and the frequency of visits per person, Over the past ten years, visits per physician across the Kingdom fell by 21%, reaching 2,389 visits by the end of 2009. The average number of visits per person, over the same period however, increased from 4.7 to 5.2 visits. This indicates a lack of improvement in morbidity attributed to the increased occurrence of non-communicable diseases, (Figure 6).

Figure 6: Outpatient Visits by Category



Source: MoH Annual Reports 2000-2009

The Kingdom's overall inpatient admission to total population rate rose to 12% by 2009, increasing from 10.4% in 1999. Total admissions in the same year were roughly 3 million, reflecting a staggering 46% increase over the last decade, with inpatient admissions in private sector hospitals growing by 56%. Currently, the Kingdom's Average Length of Stay (ALOS) is 6.5 days, marking a decline of 16% over the last decade, on the back of rising healthcare costs. Stays in public facilities are generally longer than those in private ones due to higher costs attributed to private care. In 2009, MoH hospitals showed that the average length of stay was 7.1 days, whereas the private hospitals' average length of stay was comparatively shorter at 4.8 days.

Occupancy rates are often calculated annually to determine the utilization of specific beds in a health facility to assess efficiency. The industry benchmark sets the overall optimum rate at 85% to accommodate for unforeseen emergencies throughout the year. Based on MoH statistics, occupancy rates are split into three categories. In 2009, occupancy rates in "General hospitals", "Psychiatry, Chest and Fever hospitals", and "OBS/GYN hospitals" reached 60.8%, 82.4% and 68%, respectively. However, the three categories omit occupancy rates in Eye/ ENT, and Convalescence and Leprosy and Rehabilitation facilities. Additionally, the second category was upwardly biased as Psychiatric patients generally have different medical profiles–often requiring longer stays–than Chest and Fever patients.

The Sector Outlook

(A) Health Expenditure

In the Kingdom's latest five year Development Plan (2009–2014), social development and healthcare is poised to command a 19% share of total budgeted expenditure, equivalent to SR273.9 billion. Financial allocation for the healthcare segment alone commands 89% of this total, corresponding to SR242.7 billion. Additionally, approved MoH health projects for 2011 include Kingdom-wide developments of more than 3,500 beds in hospitals of various disciplines.

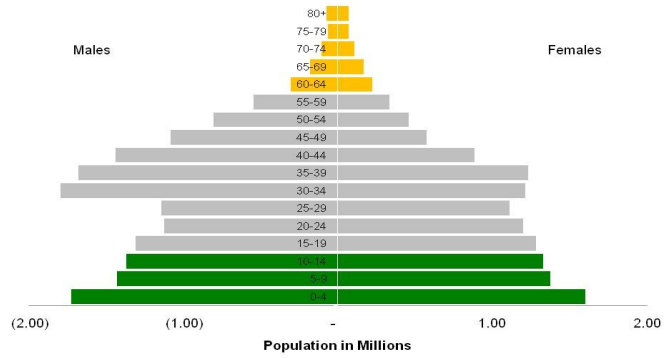
Health is one of the key sectors identified in the government's privatization program. Therefore, as the MoH focuses on restructuring its activities as a regulator of private services and gradually moves away as a main provider, more private players are expected to emerge. We foresee the public sector share in health expenditure to decline to 74% in 2015, from its current share of 77% of total health expenditure.

(B) Population

By 2015, the Kingdom's population will reach an estimated 31.69 million. The growth rate for Saudi nationals will continue to rise, while the proportion of expatriates will increase at a decelerating rate, thereby slightly decreasing relative to previous influxes spurred by economic booms. The significance of this demographic shift is that Saudis have developed a predisposition to lifestyle diseases that will translate into an expensive medical profile requiring complex treatments over the long-term. This will increase demand for enhancing medical facilities, (Figure 7, Figure 8).

The number of Saudis past the retirement age of 60+ years will grow by 27% by 2015. We estimate that this age group (60+) will account for approximately 4.7% of the total population in 2015–or 1,367,303 individuals–an increase from the current 4.4%. This will lead to an in-

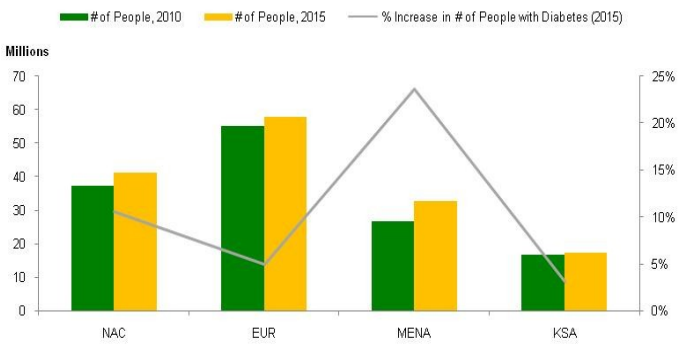
Figure 7: Saudi Population Pyramid (2015)



Source: NCB Estimates

crease in demand for high-cost medical care necessary to treat more serious diseases, typically faced by older patients. The United Nations (UN) estimates that Saudi life expectancy will increase to 73.8 years by 2015, provided demographic trends remain the same. Based on our population projections, outpatient visits and inpatient admissions are expected to reach 159 million visits and 4 million admissions, respectively, by 2015.

Figure 8: Diabetes Prevalence



Source: International Diabetes Federation

The Business Monitor International's Burden of Disease Database examines the total number of disability-adjusted life years (DALYs) lost to disease and injury annually. It indicates that by 2015, approximately 3.4 million DALYs will be lost to NCDs in the Kingdom. Thus, in the short-term, increased incidences of NCDs will increase per capita healthcare costs, causing health insurance claims to rise for these patients. This will boost the nation's aggregate expenditure on healthcare. If not accounted for, this may create a challenge for insurance companies, especially newly listed ones, due to higher claims, causing barriers to entry.

(C) Hospital Bed Demand Projections

The 9th Development Plan (2010–2014) as set forth by the Ministry of Planning (MoP) targets a hospital beds-to-population ratio of 3.50 beds per 1000 population by 2014. To achieve this ratio by 2014, it will require the healthcare industry to add 41,603 beds between the public and private sectors, to reach a total of 97,535 beds, from the current level of 55,932 beds. On average, a hospital in 2009 had 137 beds. However, across the categories of MoH, OPS and Private hospitals, the average was 136 beds, 278 beds and 95 beds, respectively.

By 2014, the 9th Development Plan aims for 56,379 beds in MoH hospitals from the current level of 33,277 beds. If we assume a SR1 million investment is required per bed, this will mean a public outlay of SR23.1 billion will need to be extended between 2010 and 2014 to meet the Development Plan target. If we then take each MoH hospital to accommodate 150 beds, the government would need to build a further 154 hospitals between 2010 and 2014 to achieve this number, (Table 5).

Table 5: MoH Targets (2014)

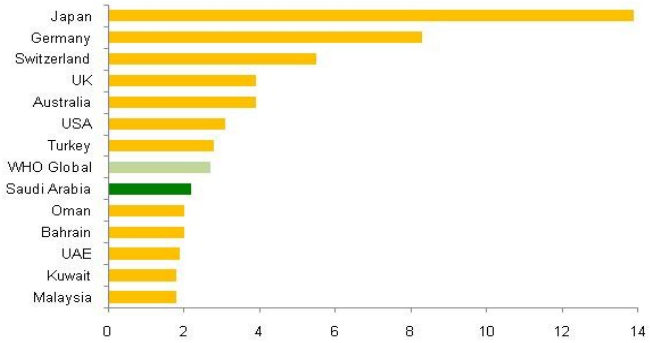
Type of Beds	2009	MoH Target (2014)	Increm. Beds	SR bn Invest.	Increm. Hosp.
MoH Beds	33,277	56,379	23,102	23.10	154
OPS Beds	10,822	20,296	9,474	9.47	32
Private Sector Beds	11,833	20,860	9,027	9.03	90
TOTAL	55,932	97,535	41,603	42	276

Note: Avg. # of Beds in hospitals taken as 150 for MoH, 300 for OPS, and 100 for Private Sector

Source: Ministry of Planning: 9th Development Plan, NCB Estimates

Assuming total bed targets are accomplished and total population reaches 30.72 million in 2014, this will result in a ratio of 3.20 beds per 1000 population, still falling short of the 3.50 MoH target, which is believed to be an ambitious target. Judging on past performance, and after comparing ratios in neighboring countries, we consider that aiming for 2.50 hospital beds per 1000 population might be a more attainable target, (Figure 9).

Figure 9: Hospital Beds-to-Population Ratio for Selected Countries (2000-2009)

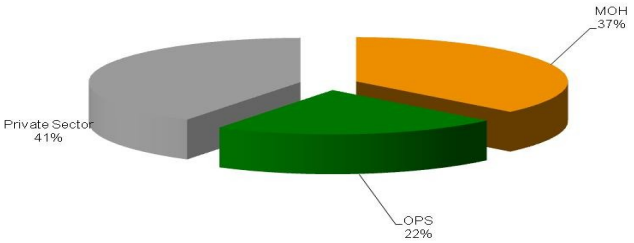


Source: World Health Statistics 2010

This proposed realistic target will bring total supply to 79,222 beds by 2015, an increment of 33% or 23,290 beds over the forecast period. The private sector is fore-

casted to contribute 41% of the total installed beds, equivalent to 9,557 beds, with an annual outlay of SR1.6 billion, (Figure 10). This estimate does not account for other forms of investment within healthcare; such as the replacement of decommissioned facilities and/ or the renovation of existing ones.

Figure 10: Incremental Bed Capacity Forecast by Category (2015)



Source: NCB Estimates

On an aggregate basis, accounting for all types of healthcares providers, average bed operating expenditure amounted to SR1,110,208 in 2009. Using the seven year average healthcare inflation rate of 1.5%, operating expenditure per bed is estimated to reach SR1.2 million by 2015. Based on the projected bed capacity of 79,222, therefore, the healthcare GDP (market size) is expected to grow by 55% over the forecast period, to amount to SR96 billion in 2015, (Table 6).

Table 6: Healthcare GDP (2008-2015)

	2008	2009	2010F	2011F	2012F	2013F	2014F	2015F
Average Bed Operating Exp. (SR mn)	1.09	1.11	1.13	1.14	1.16	1.18	1.20	1.21
Total # of Beds (000s)	53.9	55.9	61.1	64.4	67.9	71.5	75.3	79.2
Healthcare Market (SR bn)	58.9	62.1	68.8	73.6	78.8	84.2	90.0	96.2

Source: NCB Estimates

Funding

There are currently several lending institutions that cater to the health sector. According to SAMA's 46th Annual Report, domestic soft loans issued by the MoF for health projects increased by 3.8% to SR2.3 billion in 2009. This translated into 3 additional loans being approved at SR84 million each in that year. In 2008, the Saudi Credit & Savings Bank provided 29 loans to the medical sector, for a total of SR89 million. Recently, the cap on loans to private hospitals was increased to SR200 million.

In determining the financing extended by banks in the Kingdom, we examined the nature of the loans common to private hospital operators. They are: (1) Short-term loans/ overdraft facilities used to fund day-to-day operations of the hospital and/or bridge the funding gap of receivables, (2) Trade facilities such as Lines of Credit (LCs) and/or LC refinance used to facilitate importation of hospital machinery, equipment, pharmaceuticals and medical supplies, and (3) Medium to long-term loans used to fund expansion of hospital facilities, and may extend up to five or six years. Based on market insights, the range of debt to equity ratio in private hospitals extends from 30%-60%.

Among the key challenges facing commercial banks in financing hospital expansion is the asset-liability mismatch. This is a supply side risk, which is particularly due to the maturity mismatch of the bank's short-term liabilities, current deposits, against the long-term assets with private healthcare operators. Additionally, operational risks may affect banks, especially if contractors lack adequate professional and technical resources to complete the construction work, and then borrowers fail to meet payback payments on time. Another key risk, however, is that healthcare facilities cannot be foreclosed on because of default on payments, due to the nature of the services they provide to the community.

Alternatively, private companies can opt for a public offering to raise money for funding expansions or new business opportunities. Al Mouwasat Medical Services, a medical player in the field of operating hospitals and dispensaries, offered 30% of its total shares in mid 2009. A total of 7.5 million shares were issued at a price of SAR44, for a total issue size of SAR330 million.

(A) Success Factors of Private Providers

According to industry insights, several success factors of private hospitals emerged when assessing their long-term growth potential. Primarily, key financial indicators should be considered, including growth of revenues per patient, and growth in net income. Second, visiting specialty physicians from abroad is one method that can be adopted by specialized medical centers looking to cater to a niche in the market, providing them with a competitive advantage. Third, strategic alliances between private hospitals–which provide the medical personnel and operating theatres–and medical equipment companies, has proven to alleviate the cost of expensive machinery while capitalizing on latest technology.

Another success factor is the implementation of a profit sharing scheme aimed at incentivizing medical manpower and retaining highly skilled professionals. In addition, a hospital's contractual arrangements to provide medical services to employees of large companies, such as Saudi Aramco, secures a stable flow of revenues. This, however, entails obtaining global accreditations, like that of Joint Commission International that ensures the quality of services provided.

With insurance mainly driving the direction of private medical operators, the location of a private hospital/ clinic is a significant factor, since the area they set up in plays a critical role in allowing the business to grow. Finally, the management style of a hospital is imperative in its success. Physicians better understand the dynamics of the sector and are historically proven as the best operators of hospitals.

Healthcare Challenges

The Saudi healthcare industry faces several challenges. As the economy develops, evolving patient expectations and rising patient awareness will create upward pressure on healthcare expenditure vis-à-vis the availability of more advanced and expensive care. This can be seen in the rising Cost of Living Index for Medical Care. Over the period 2000-2009, it had increased to 113.2, a rise of approximately 11.9% since 2000.

The sector has a high entry barrier, characterized as very capital intensive with financial and human resources creating the largest hindrances. It is also highly regulated, with corporate players regarding the sector as fairly complex. Generally, the private model adopted in the Kingdom is one where a physician develops his medical profession, growing it into a single hospital, which organically evolves with minimal direction. When this hospital is passed on to the second generation, challenges may arise.

The issue of talent and the large dependence on foreign workforce 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.

Conclusion

Over the next five years, the Kingdom will continue to face pressures on its healthcare delivery system. With a high population growth rate, longer life expectancy, and an increase in the incidence of NCDs, the health market will rely on private sector participation to shoulder increasing demand.

With saturated capacity, long queues, and limited opening hours at public hospitals, the efficiency and higher quality in private care by comparison have propelled private investment in the sector. By 2015, we anticipate that the growth in compulsory private insurance will also increase demand on private investment in the healthcare sector.

Going forward, the rising demand for hospitals and beds will require the Kingdom to invest an estimated total of SR23.3 billion between 2010 and 2015. An increment of 23,290 beds in both the public and private sectors will put the Kingdom at a feasible ratio of 2.5 hospital beds per 1,000 population, just below the current global average ratio of 2.7. The private sector's investment share will amount to a total of SR9.6 billion by 2015, equivalent to an annual outlay of approximately SR1.6 billion.

The success factors for private operators, beyond growth in key financial indicators, include the ability to sustain highly skilled medical manpower through profit sharing schemes, contractual relationships with large companies, and alliances with institutions or medical equipment providers that can offer private hospitals access to the latest machinery.

Challenges facing the sector include the highly capital-intensive nature of the industry acting as a barrier to entry, the lack of domestic talent and large reliance on foreign labor, and the rising cost of medical care restricting margins. Other risks constricting project funding from banks include asset-liability mismatch, operational inadequacies of contractors, and the inability to foreclose on hospitals in the event of defaults.

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