



HEALTH SYSTEMS OF THE WORLD – SAUDI ARABIA PROFILING A CONSULTANT’S VIEW OF THE HEALTH CARE SYSTEM OF SAUDI ARABIA

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ABSTRACT

- In early 2000 the World Health Organization’s global evaluation of health care rated Saudi Arabia as 26th in the world and the United States as 37th in health care.
 - For a youthful kingdom this surprising position may be unjustified and perhaps short lived.
 - Significant overall population health shifts are rapidly occurring in Saudi Arabia.
 - The new kingdom’s lifestyle coupled with a rising level of comfort and aging population as well as disdain toward exercise is sure to exacerbate the present national health care demands.
 - A 20 percent increase in population by 2016 is certain to tax the already challenged health care system.
- The apparent overburdened health care system of Saudi Arabia appears quite similar to the health care system of the United States, but it is the result of distinctly different factors.
 - Health care in the kingdom is a national entitlement not a procured protection.
 - Saudi Arabia’s cutting-edge facilities are equipped with state-of-the-art equipment, and these are staffed with well-trained professionals acquired through aggressive recruitment and education techniques.
- The apparent success of the Saudi program can be attributed to one primary advantage :the royal checkbook.
 - Because of the seemingly endless flow of royal cash, little desire or effort has been dedicated toward efficiency, self-sufficiency, or both.
 - This Arabic health system’s “gift horse” also may be the root cause of its lame inefficiencies.
- Recognition of these shortcomings has caused Saudi government officials to initiate privatization of the national health care system.
 - However, historic behaviors and tribal customs of the Arabic population, derived from its nomadic days, allow little room for change.
 - Paternalistic commitments of the tribal communities often satisfy the tribe while unjustly burdening the employing health care provider.
 - Apparent inefficiencies result, but these sometimes are clouded in the myriad manipulated outcomes data and skewed

- budget reporting.
- Quality of life for Saudis is frequently sacrificed via a false attempt to enhance outcomes data.
- (DRG) classification measures should be implemented and accurately reported in order to best assess current state of the system.
- Long-term strategic plans are in place in order to best evaluate measure and implement change in the attempt to redirect a runaway health care system.
- Privatization and the accompanying competition will drive reform gradually, but at what cost to the existing system and the citizens that rely on this health care?
- Active monitoring and corrective legislation is required to stimulate the process.
- Oil revenue has served to create a strong foundation for a globally recognized health care system in a relatively young nation, but it will take more than money to continue both its survival as well as to improve its delivery *or global ranking.

HEALTH SYSTEMS OF THE WORLD - SAUDI ARABIA

IN EARLY 2000, THE World Health Organization performed a global evaluation of the state of various available health care systems available. This was the first time the organization attempted so broad an assessment. The results placed the health care system in Saudi Arabia (26) notably ahead of health care in the United States (37). Obviously, many factors play into such a rating for subject countries, but, for a nation, which was founded in 1932, such impressive results for Saudi Arabia are astounding for a Kingdom of only 77 years. The Kingdom’s government sincerely pledged to improve the health care facilities for its people and willingly committed the resources to the noble effort. But money alone is not equal to quality care, as has been proven regularly in the United States. Through focused drive, concerted effort, and strategic initiatives Saudi Arabia has advanced its level of health care to be a world leader, one that should be studied and perhaps envied.

The criteria for health care that is used by the World Health Organization (WHO) included five indicators:

Overall level of population health; health inequalities (or disparities) within the population; overall level of health system responsiveness (a combination of patient satisfaction and how well the system acts); distribution of responsiveness within the population (how well people of varying economic status find that they are served by the health system); and the distribution of the health system’s financial burden within the population (who pays the cost). (Press Release WHO/44, 2000, p. 3)



These measurable criteria provided the basis for critical comparison of the various subject countries for the World Health Organization; it represents the informal structure of this document in reference to health care in Saudi Arabia.

The overall level of population health in Saudi Arabia is changing as rapidly as the health care system that supports it. As a result of the significant growth in their socioeconomic status, the population has been dramatically influenced by the recent success. Obesity in middle-aged people has surfaced as a “growing problem,” and with it comes the ever-so-familiar accompanying risks of diabetes mellitus and coronary heart disease. The results of the Community-based National Epidemiological Household Survey conducted during 1990-1993, which used 10,651 subjects comprised of 50.8 percent males with a mean age of 35.8 years, indicated a 31.2 percent prevalence for being overweight (33.1% male and 29.4% female). When judging obesity, the Saudi study designated 22.1 percent of the sample set as obese, which was made up of 33.1 percent of the males and 29.4 percent of the females. Their dietary habits, which include high carbohydrate intake (via bread, dates, sugar and potatoes), are recognized as one of the leading factors in understanding the trend. The extreme environmental temperatures and complacent life styles of the population have a negative effect on the potential benefits of exercise. Recent surveys indicate that less than 5 percent of the people in Saudi Arabia perform any kind of physical exercise. This laxity is naturally more prevalent in the elder segment. These negligent life choices, coupled with the genetic predisposition for diabetes mellitus, puts Saudi Arabia in a state of concern having recently earned the distinction of a high prevalence country for such disease among the other nations of the world studied by the WHO.

It is therefore recognized that the lifestyle of the people in this new kingdom's, with a rising level of comfort and success, will further exacerbate the increased need for health care services. In addition to the increased obesity and the onset of diabetes, it is fully anticipated that the markedly aging population is destined to fall victim to cancer and cardiovascular disease, further increasing demand on this kingdom's presently taxed health care system. It is said that:

Saudis will become older. The percentage of population over 60 is rising, and is expected to more than double by 2020. By 2020, the number of old people is expected to grow from approximately 1 million (4 % of the population) to roughly 2.5 million (7 % of the population). (Booz Allen Hamilton, 2007, p. 2).

But the increased proportion of elderly is not the only reason for concern. Saudi Arabia's entire population is expected to grow considerably. A 20 percent increase is anticipated by 2016, raising the

present population from 23 million to 30 million. The reciprocal demand (during this timeframe) for hospital beds is expected to rise from the present status of 51,000 to one of 70,000, increasing the need for physicians from 40,000 to 50,000 and hospitals from 364 to 502.

To anyone in the United States, these pending challenges may sound all too familiar; too many patients, too few beds; too many bad habits, abounding bad health, limited resources, and limited access to health care. There certainly are a host of broad similarities when comparing Saudi Arabia to the United States. But this view of the health care in Saudi Arabia provides a foundational depiction only, which is now accompanied by the deeper analysis accomplished through a two-week study of this fascinating and influential country. Having the opportunity to engage behind the scenes with one of the kingdom's premier tertiary care providers allowed for a rare revelation of the integral workings of an intricate and incongruent system in distinct contrast to health care in America. Equally challenged and criticized perhaps, but for polar opposite reasons and idiosyncrasies that can surprise even the brightest of thought leaders. The visit reveals the many challenges the Kingdom faces in sustaining or improving its WHO ranking.

Health care in Saudi Arabia is a universal entitlement that, on the surface, appears to be one of the best systems a person could hope for. Cutting-edge facilities with state-of-the-art medical equipment dot the otherwise arid landscape and provide what should be ample amenities for the current population. Aggressive educational programs are instituted to attract, educate, and retain Saudi nationals as specialists, physicians, and nurses empowered to provide the long-term expertise and compassion required to effectively care for needy families in this population. Supplemental recruitment efforts are being used constantly in order to fill additional short-term obligations (e.g., health care workers) necessitated by so vast a network of care. In addition to filling the present void in specialists, physicians, and nurses, the constant recruitment of Western leaders (i.e., managers, researchers, and doctors) serves to provide the contemporary medical knowledge to the sometimes less-than-leading-edge novice staff of such a rapidly growing movement.

Based on the relatively young nature of the kingdom these gallant efforts are reaping considerable benefits. It is demonstrably apparent that the foundation of a great system has been firmly laid, most remarkably at the sole financial obligation of the “royal checkbook,” to the generous tune of 16.4 billion (equivalent U.S. dollars) from 1985 to 1990. Like their counterparts in the Arabian Gulf, the facility that I highlight, as well as facilities similar to the tertiary care campus that I visited, is financed by the ruling family. Such ruling families are very generous in their funding



of both facilities and equipment, as is well demonstrated by the continuing development of high-end academic medical centers in the United Arab Emirates, Qatar, and Bahrain. Yet the of funding facilities and technology is rarely met with the same level of commitment and continuous improvement in operations and human capital. As an example, the claims collection rate for the 700-bed tertiary care facility is just 4 percent. This is quite a contrast to the financially challenged domestic counterparts in the America and may account for a major portion of the Saudi leading advantage in the WHO survey. Because it has 100 percent governmental subsidy, the Saudi health system is blessed; there are no economic burdens to trickle down to the patient, which clearly produces a distinct advantage compared to the health care problem in the United States. And yet interestingly, this endless cash stream and the method of allocation does not reward attention to improving daily health management.. The Arabian “gift horse,” in this case, has a surfeit of inefficiencies in tow.

In stark contrast, the American health care system, burdened with its inflationary costs and limited financial resources, struggles to reinvent itself regularly and compete for funding, be it from the government, insurance companies, or private citizens. This perpetual reevaluation of the domestic system is based on the resounding challenges of access, quality of care, and efficiency of care. Here at home, one can read no paper, listen to no talk show or open no newspaper without being bombarded by the pursuit for the perfect solution that ultimately provides this “trifecta” of health care. But as in the quest for the Holy Grail it proves to be elusive. Thought leaders, physicians, scholars, politicians, and common folk in America continuously peruse the fathoms of uncharted health care waters while methodically re-churning the familiar in the futile search of the wave of curative change. And although it is blatantly apparent that such a “prize” remains elusive, we have (as a result of tsuch concerted efforts) stumbled upon a beneficial byproduct: “accountability.” With the focused attention of so many people, the microscopic analyzation of our current system has allowed little room for error and even less room for extravagancies. Conversely, this may in fact be the “evil curse of the royal checkbook,” in reference toSaudi Arabia. It is ironic that what has catapulted this country to its level of world recognition may now be its arch nemesis: an abundance of capital.

Where recent years of focused concentration on managed care has provided a structure of efficiency and commitment to competence in the United States, the opposite appears to be true in Saudi Arabia. i am not saying there is no framework of financial management or fiscal responsibility in this Arabi nation; I am stating that it is simply not as a high of priority for them as being a “world leader” when judged by the global market. Where revenues and regulation take control in our land of the “being”

well, this crosscheck methodology remains nonexistent in the land of the “oil” well. With the Saudi’s current reservoirs of liquid cash, accountability is not a primary focus, and as a result, inefficiencies continue to inconspicuously snowball. Throwing capital at the rapidly growing health care enterprise is providing world-class capabilities with world-class insatiability, leading to spiraling demise.

Recognizing the need for competition, and the intrinsic value that it renders in regards to tightening inefficient operations, the Saudi government has been authoring regulatory language, inviting privatization of the current health care system.

‘Saudi Arabia’s healthcare system is ripe for investment opportunities,’ said Ziad Fares of Booz Allen Hamilton. The growing affluence of Saudi Arabia and the GCC region as a whole will mean that the healthcare systems of these nations will need both money and expertise from outside sources in order to cope with an aging, yet well-to-do population. (Booz Allen Hamilton, 2007, p. 1)

The Ministry of Health, armed with its soft regulatory structure, will remain the sole administrator of the network of care. Fortified simply with the best of intent, it will invite the inflow of private capital and monitor the direction of the future market shift. Destined to change the fabric of the nation’s health system, the transition is welcomed by some while feared by others. This infusion of private capital will generate welcomed health care alternatives for many Saudi nationals while additionally serving to produce dreaded competition for the oftentimes fat and happy present state. Although Western influence in medicine has always been a desired amenity in the kingdom, the introduction of a well-equipped neighbor has put the “fear of the Lord” in many and is sure to have positive incremental results in eliminating waste and increasing efficiency. But fear or no fear, to meet the needs of the nation while assuring continuation of the current economic growth, decisive measures must be made.

At present, the Saudi Arabian government funds most of the demand for healthcare capital and operating expenditures. However, analysts believe that government alone will be unable to continue to meet this demand. They have concluded that the only way to ensure that Saudi nationals’ health needs will be met without adversely affecting economic progress is to increase private sector participation in the health care system. The Saudi government has recognized this situation, and has identified healthcare as one of the key sectors targeted in its wide-ranging privatization program. (Booz Allen Hamilton, 2007, p. 1)

This may be a bit more difficult than it sounds upon closer examination. In fact, it is anticipated that dramatic changes in the



health care management of the Saudi health care system will not be rapidly evident as a result of privatization, because the slightest breath of change may very well be met with staunch opposition. This protective mannerism is a result of the cultural dichotomies and historical behaviors of its people. It appears there is good reason for this obstinate behavior at the leadership level, as it can be traced to years and even generations back. The managerial hierarchy in Saudi Arabia, and more specifically its citizens, is a result of how these “nomadic” people coped in the scorching barren deserts of a virtual wasteland. Regional tribes were formed throughout the vast desert wilds as a matter of survival, each protectively equipped with a respective leadership and chain of command seated prominently within the tribal unit. The Anayzah, Bani Kahlid, Harb, Al Murrah, Mutayr, Qahtan, Shammar, and Utaiba were just a few of the Bedouin tribes that roamed the harsh environment. And, although considerable dunes of sand have shifted as a result of the winds of time, these tribes remain does their powerful influence and the intense reluctance of their members to change.

Discretely positioned in the modern fabric of today’s society, they assemble at unceremonious meetings held periodically at various members’ homes. The informal gatherings provide a forum of discussion on various topics that revolve around looking out for the fellow tribesman. As an example of their mission and reach, members discuss current affairs in the world as well as in the neighborhood. On a small scale, if one member fails to repay a loan to another member, and it appears that person may be unable to do so in the near future, a plate is passed with the implied obligation that all members must contribute. This will satisfy the debt and render the person who owes the debt whole, thus alleviating any conflict. The historic and impenetrable commitment serves to protect and provide for the chosen affiliate, by way of a sacrifice by others. On a larger scale, members of the tribe pledge positions of authority and/or employment for those who belong to the collective tribe. This paternalistic behavior provides employment for the tightly knit membership, but at times it places novice personnel, unjustifiably, in crucial roles of authority. In this regard, these strongly recommended appointments undeniably serve the tribe, but at times they fail to serve the employer. However, because of the protected status of the appointment, little if anything can be done. As a result of the significant influence, there is an implicit understanding that Saudi Arabian nationals are virtually impossible to remove from any level of employment, regardless of their actions or ineffectiveness, which broadcasts a blatant lack of accountability and furthers abuse.

This ancestral comradeship remarkably has endured the test of time and has seeded itself in all aspects of contemporary life throughout the kingdom. The health care system has most defi-

nately received an ample dose of this sometimes curative, but most times fatal potion. Political influence runs rampant in the hallways of hospitals as well as the conference rooms of research and education centers. Hidden agendas often override strategic plans and well-thought-out decisions are frequently aborted due to ulterior motives, further disrupting congruent leadership and likewise continual planning. This Saudi phenomenon is so prevalent that it respectfully bears its own moniker namely, “Wasta.” No one denies the existence of this destructive influence, and yet no one fully acknowledges its impact. Even though smiles abound when discussing the positive potential of vitamin “W,” when poised in the right direction; absolutely no one appreciates the ill effects of misdirected Wasta or the hinderance it may render on their own projected venue.

Although “trumping” occurs regularly at all levels of health care, no where is Wasta more tunefully orchestrated than when particular departments are vying for annual budgets and/or royal disbursements. With total disregard toward the facility as a whole, or the strategic plan for the organization, the opposite camps enter their respective corners. The financial gloves come off and the various cost centers compete openly for their share of the pecuniary pie. And at most times, when the final bell rings, the “Wasta Welterweights” have been effectively knocked out, while the cunningly connected revel in their good fortune, oblivious to the positive or negative effects the decision represents to the organization as a whole. To some people in the United States this may sound frighteningly familiar, and there is no argument from this author that these behaviors exist in our domestic counterparts. However, the stark contrast between the two subject systems is the frequency that Wasta wins in the kingdom and to the amount of the stakes at hand. Equally unnerving is the blatant admission of the influential behavior and the inability to openly criticize or overrule the destructive behavior. Increased transparency and accountability would serve to reduce, and optimistically eliminate, the paternalistic actions of misguided administration and self-oriented leaders in the hopes of a consolidated effort to consider the facility first and then the patients.

Regardless of the internal rivalries and miscued management, Riyadh has been fortunate to have a premier tertiary care facility for the past 30 years. In spite of the multifaceted executive compass, the health care giant rambles on. Deep within the silos of each departmental unit are surprisingly motivated and committed individuals. These departments, whether they are radiology, cardiology, research, central sterile, food service, or laundry, operate successfully with a focus toward patient care and improved outcomes. These units appear to function effectively, albeit independently, despite being handcuffed with, at times, indecisive leadership, zero accountability, organization-wide factions and



growing human resource retention deficiencies. These precarious units of health care have been likened to “pearls in the mud.” All beautiful formations of a precious nature, individual in their own right with an utmost value to the organization, but all indefinitely suspended in the quagmire of desperation and exasperation. They are committed to improvement, hungry for change, and dedicated to shine, if only granted the rare opportunity.

Inefficiencies are abominably apparent in the current state health care system in Saudi Arabia, all of which need immediate assessment, recommendation, and rectification. As an example of such reckless expenditures, the average length of stay in the Saudi tertiary facility presently under review is officially 11.2 days. Unofficial estimates, that are suggested to be the more accurate, are posted at 14 days. These statistics, compared to the U.S. national average of just over 5 days, indicate an excessive leniency toward oversight and a grossly inefficient follow-up process.

Many factors play into the kingdom’s statistics. Patients oftentimes travel many miles to enter a referral facility for care. Upon arrival, the physicians order a comprehensive barrage of tests regardless of the patient’s chart or history. Because cost is not a factor, the physician, for sake of convenience, orders the gamut (and if this overuse of the system is not caught by the radiologist, it may in fact overexpose the patient to radiation or redundant discomfort). Even though the facility boasts an enormous radiology department, complete with state-of-the-art equipment, bottlenecks arise from the regular practice of overprescribing. In this case, the patient will rest comfortably in a hospital bed waiting for his/her diagnostic time in radiology. Further complicating the patient’s wait time is the fact that the distances involved from home to the hospital and the tribal culture usually results in a large entourage of family members that accompany the patient; these patient relatives occasionally overflow an area or occupy peripheral beds and amenities, amplifying deficiencies in patient care. As a result, family housing has been developed around the facility campus to provide for the large family support groups, but once again this has taken place at an increased financial burden for the struggling health care system of Saudi Arabia.

After completion of the applicable diagnostics, the staff radiologists must read and relay the outcomes of the testing to the physician. It is only at this point that the patient can be rightfully scheduled for surgery, if so required. With eighteen state-of-the-art operating theatres, ample facility space is available if staffing meets the need. Surgeries are often cancelled at the last minute because of a staffing deficiency or the failure in the delivery of complete lab work. Communication gaps throughout the facility exacerbate inefficient flow in and out of the operat-

ing rooms. These cascading complications leave the extremely expensive theatres empty and the a patient in bed with the clock running, while the disgruntled family is camped in the periphery; all adding to the total cost.

Postoperative recuperation provides the next apparent extravagance in the length of stay statistical review. In this kingdom, if the patient does not feel up to leaving the facility, he or she simply refuses to leave and merely stays in bed, one might say in royal fashion. If the respective family believes the patient would be better left in the hospital to convalesce longer, the length of stay increases accordingly, and so does the cost of care. No one forces anyone out, regardless of level of clout or influence. With no motivation to leave and little concern for cost, the beds are consumed indiscriminately, further restricting the required patient flow necessary to serve the ever-growing and ever-aging Saudi population. Recent strategic planning has addressed the crisis by proposing additional beds in new wings instead of proper reallocation of existing resources through improvements of efficiency and calculated discharge procedures. With the present munificent allocation of 700 beds and 700 physicians it appears rather evident that “more is not the cure.”

Along with the high bed-to-physician ratio, facility administrators have come to realize that two beds in a single room are not practical because of the privacy needs of women and the potential for family overflow; thus, most rooms contain only one bed. This further negates efficiency when observing square-foot-to-bed ratios and puts an additional burden on the operating costs of the facility. Although efficiency improvements may appear justified, this current wave of change appears opposite the intended direction required to compete with the soon-to-arrive private providers. The current misdirected effort positioned toward increasing bed counts and procedures, which appears to be gaining momentum, allows this Titanic of health care to motor expeditiously deeper into the icy waters of blind competition. Until the present leadership accepts the bitter pill of change, the current bed race will result in nothing more than impressive statistics and diminishing returns.

An additional pessimistic indicator is the dismal statistic that only 6 percent of the annual treatment flow is considered new patients. This further emphasizes the overload of recurrent care for regular customers and highlights the apparent abuse of an all-too-welcoming health care system. Patients do not hesitate to return once introduced to the level of care provided and the hospitality afforded them, even when their follow-up care does not justify using such a high-level facility. Once invited into the “club,” members seldom wish to leave and, as the membership base ages, demand is sure to increase.



In addition, there is concern that perhaps the positive outcome statistics of the well-renowned provider are somewhat skewed as indicated by such a high level of returning patients. Regretfully, as a result of the self-funding status of operation for the tertiary provider, accurate data are suspect on all accounts. This prevents concise analysis of such measures and provides an avenue of escape for many naysayers. Because billing claims are erratically generated, reimbursement remains optional and therefore the credibility of data becomes a regular defense for those on the losing side of a given argument. Although the data is used for the purpose of financial application with the Ministry of Health, it is quickly discounted when it serves to discredit a person's position or benefit.

For the betterment of the organization, a comprehensive claim classification system must be implemented and closely monitored to provide accurate, measurable, and timely data. Similar to the "Diagnosis-Related Group" (DRG) recognized in the United States, adoption of equivalent classification measures would provide the ability for reimbursement procedures as well as allow for precise statistical data collection. Attention to this implementation will serve to provide for the anticipated privatization movement as well as allow for the production and assembly of concise data to facilitate enhanced strategic planning and measurable procedural outcomes.

Through recent interviews with prominent staff within the facility, a legitimate level of concern has been voiced about the realistic outcomes of the growing transplant market. From the inaugural kidney transplant conducted in 1981, the facility boasted a remarkable 390 transplants in 2005, and it appears there are no signs of slowing down with this procedure. With the great rush to increase procedural quantity, the disturbing consideration becomes whether it is realized at the cost of quality. Not so much quality of the actual procedure, but the quality of life post procedure. Present outcomes shortsightedly measure death on the table as the only means of failure and not necessarily life on a dialysis machine or life in a nursing home. A greater focus on quality of life post procedure and accurate measurable data should serve to alleviate this shortsightedness and further help the facility to comprehensively serve its patients.

Deeper analysis of the provider and, more specifically, the facilities management facet, further illustrate the need for an organization-wide strategic plan. Existing procedural development calls for committee approved plans for sizable equipment purchases or significant calculated growth. Appropriately seated on the respective committees are representatives from various facets of the organization. For example, in the case of a radiology expansion, the committee may consist of the chief of radiology,

associate radiologists, facility planning representatives, mechanical engineers, space planners and finance representatives. Their collective approval would allow the process to continue to the Chief Executive Director (CED) for final review. This appears to be a dutiful and productive course of business, except that after thorough and productive review the decision may be easily overturned at the executive level because of an ulterior motive or as a result of a rivalry for allocated funds. In addition, the facility now has over 300 committees performing similar functions and has allowed a process that is frequently been referred to as, "paralysis by analysis."

This intensely bureaucratic approval process has led to snail-paced decisions with escargot-level consequences. Imperative issues are held indefinitely, while countless committees are formed, informed, and empowered to render vital recommendations. But not long after the last tray of delicately layered confectionaries are consumed or shortly before the last pot of Arabic coffee has stopped steaming, someone is whispering somewhere (outside of earshot of the committee) attempting to unravel what recent successes may have occurred behind closed conference-room doors. Committed individuals dedicate countless hours toward committee functions and yet reap minimal benefit from the perpetual exercise. Futile attempts at collective decision making by these dedicated individuals render nominal results and provide miniscule self-satisfaction other than having "a voice heard in a forum of peers." When discussing the beneficial accomplishments, available from the host of committees within the organization, a lead engineer in the planning department stated with a smile as broad as his scope of duties, "A camel is simply a horse by committee!"

It is painfully evident that this framework of governance includes many faces; many voices; many opinions; many agendas; many influences; many factors; many distractions; many delays; many directions; many committees; many camels and quite simply not enough horses. Just as the camel readies itself for the desert crossing by storing up to eighty pounds of fat in its conspicuous hump, so too does the current Saudi Arabian health care system, just as conspicuously and just as generously. With too little muscle and too much fat, its apparent day in the desert has just begun to heat up. With the onset of competition destined to besiege the Saudi's present-day health care system, it is clearly anticipated that the kingdom is destined for fat reduction that would rival the best that Dan Marino, Don Shula, and the entire Nutri-Systems family has to offer. With or without the acknowledgment of executive leadership, change is on the way. Swifter than a team of Arabian stallions and stronger than the influence of the grandest of Wasta, competition will level the landscape and flatten the weak if it is not anticipated. Therefore it is imperative for the existing providers that have served their young nation well, to prudently analyze their exist-



ing and future competition as well as any threats or opportunities that appear inevitable while planning accordingly. This market analysis should be done professionally as well as independently to allow for unbiased results and recommendations. As a result of such an exercise it most likely will become obvious that a narrowed focus may be in order. Rather than trying to compete on a broad spectrum of fronts, a specific concentration in targeted health care strengths may be more manageable and may prove beneficial for the years to come.

Certain facilities, such as our subject provider, have become recognized for research, cardiology, oncology, and pediatric medicine. Therefore, after a thorough external analysis, appropriate internal assessments should be made, again by outside consultants, to independently identify both strengths and weaknesses. This phase is critical to obtain an autonomous prospective of what most administrators and physicians who are involved are simply too close to observe. Each department is naturally protective of what has been developed over the years, but some departments clearly outshine others. For example the research department is instrumental in the country as a result of the closely scrutinized interbreeding necessity of so close a population. As a result of the deficiency of random shuffling of critical genes, genetic disorders are prevalent in the Saudi populace. Recently developed and strongly encouraged genetic analyzation has been able to test pre-marital couples regarding genetic concerns and has also allowed the delivery of healthy children in high-risk instances through in-vitro fertilization. Although this procedure provides no cure for the thousands of genetically ill children who are already born, it does curtail the likely onset of more of this type of problem.

For children that have been born with a genetic disorder, routine health care functions become complicated. As an example, certain strains of cystic fibrosis in pediatric patients were showing false negatives when lab tests were sent to prominent U.S. facilities, because of the genetic disposition of the population. Saudi researchers identified the root cause of the misdiagnoses and have published significant findings on the subject as a result of the urgent needs of the people. Revised testing procedures now supply accurate results, allowing for early detection and improved quality of care. As a result of keen insight and focused investment, the Saudi Arabian investigators were able to identify a domestic need, establish a protocol of research, and deliver a curative measure. No better use of Saudi funds can be found and yet they too become caught in the quagmire of murky leadership and shortsighted development.

Thorough review of all available systemic assets must be performed and ample discussion should ensue between respective departments for purposes of additional discovery only. After

careful consideration of all input data, final strategic plans should be established and introduced to the organization. Meetings of department heads should be arranged to further promote the direction as well as attempt to facilitate buy-in. Implementation methodologies should be discussed at all levels to allow for the universal acceptance and progressive transfer of goals. The greatest strategic plan is of little value to the association when pigeonholed on the bookshelves of management.

This analysis focused from a broad national level to a provider stage as an example of reality in the Saudi health care arena. This facility in review is not only reflective of the nation, but it is also the very first tertiary hospital in the nation and likewise provides care for the royal family in all cases. This privilege provides preferential treatment regarding receipt of financial endowments and status, but comes at a considerable cost. For example, wings of the hospital sit vacant in anticipation of VIP requirements. A mobile blood bank sixteen-wheeler sits waiting for critical use by the family as well. The reallocation of a portable MRI trailer has graciously been donated by the Prince to be used by the facility as a supplemental diagnostic depth, but prior to the re-dedication it sat rusting in a parking lot.

As another extraordinary measure of ineffectiveness, an intensive care unit is presently being constructed in a local palace to care for an injured member of the royal family to make visitation more convenient for the other family members. Along with the financial commitment to construct such a satellite, the ICU will have to be staffed by the finest of caregivers, further challenging the staffing deficiency in the existing hospital. Not exactly the best use of resources as viewed by the Western world, but required nonetheless. Just as difficult to comprehend, if a member of the royal family is admitted in the central facility, it is the obligation of the CED to leave his post as the leader of the hospital and sit alongside the ailing individual out of respect. This unanticipated disconnection in leadership leaves the organization vulnerable and at a progressive standstill, which shall prove challenging in the race for privatization. Such obligations are inherent and, although questionable by Western standards, are deemed justified by Saudi governance. Although it is not likely that any of these instances of "ill-use" will change in the near future, they do indicate a tendency toward glut and are reflective of the system in general.

Regardless of the royal challenges that accompany such esteem, the prominence of this organization is illustrated by the significant stature its leadership holds at the national level. The CED and 27 direct reports are all held in high regard at the Ministry of Health. In fact, the present Director assumed the lead role in the Ministry prior to acceptance of the CED position. Expertise and seniority are respected attributes within the kingdom. Knowledge



sharing is encouraged at all levels and in an unusual method of forced cross-pollination, the Ministry of Health mandates that board members serve on each other's hospital board of directors. This obviously assists in providing a broad perspective of medical experience, but it is counterproductive in other aspects of competitive analysis and counteractive strategic planning. This atypical mandate may have to be reevaluated as privatization roots deeper in the kingdom's health care market.

In summary, the health system of Saudi Arabia mirrors the Western world in many ways and, when perusing the criteria of the World Health Organization survey, it often exceeds what it mirrors. The overall health of the Saudi population is markedly better, but with 43 percent of the population of the kingdom under 15 years of age, that may be understandable. The universal accessibility of the government funded health care system provides an undisputable advantage for a Saudi, but, with the privatization shift and the potential for change regarding universal coverage, this distinct advantage may decrease. It is always easier to accept less when it is free, as in the case of the kingdom's health care, and nowhere will you find a more critical consumer than one in the United States, where escalating expectations on all accounts are seldom met. The unilateral accessibility and consistent level of care to all patients provides a distinct advantage to the Arabic nation; but the differentiation will begin when private facilities offer more services to those willing to pay. Finally, the financial burden to the citizens is nonexistent in the kingdom; but the rapidly growing and aging population may soon tax even the most generous benefactor.

Saudi Arabia, in a relatively short period of time, has developed a leading healthcare system worthy of its global status and due recognition. And just as in any rapidly growing nation, changes are inevitable and challenges are on the horizon. This analysis of the national tendencies, as well as the situation at the provider level, has illustrated the strengths and the weaknesses of so unique a delivery system of care. History, culture, pride, and oil have contributed to the distinct formation of the present state and the same causative factors will carry it "well" into the future. The willing migration toward privatization will provide ample self-correcting measures and will breathe new life into a complacent institution. Active monitoring and corrective legislation will assist in prodding and pulling the virile stallion from the sleepy camel. In final retrospect "money alone can not buy quality of care"; but it can easily get you 9/10ths of the way there!

REFERENCES

1. Booz Allen Hamilton (2007, February 18) The New Saudi Arabia Healthcare Market, Retrieved from the World Wide Web on October 14, 2007, http://www.boozallen.com/capabilities/industries/industries_article/33599338
2. Collymore, Y. (2003, May) Saudi Arabia Faces Population Pressures, Retrieved from the World Wide Web on November 20, 2007, <http://www.prb.org/Articles/2003/SaudiArabia-FacesPopulationPressures.aspx>
3. Map of Saudi Arabia provided by: <http://googlemap.com> 2008 Google Map Data @2008 LeadDog Consulting, Tele Atlas, Europa Technologies
4. The American Heritage® Dictionary of the English Language, (2007) (4th ed.). New York: Houghton Mifflin.
5. World Health Organization Press Release (2000, June 21) World Health Organization Assesses the World's Health Systems, WHO/44 Press Release, 3
6. Wikipedia, (2007) Saudi Arabia. Retrieved October 24, 2007 from http://en.wikipedia.org/wiki/Saudi_Arabia
7. U.S. Library of Congress, (2003 - 2007). Bedouin tribes and merchant families. Retrieved November 11, 2007 from <http://countrystudies.us/saudi-arabia/55.htm>
8. U.S. Library of Congress, (2003 - 2007). Health in Saudi Arabia. Retrieved on November 11, 2007 from <http://countrystudies.us/saudi-arabia/32.htm>