CHAPTER 2.1

Gulf Cooperation Council Health Care: Challenges and Opportunities

MONA MOURSHED, McKinsey & Company
VIKTOR HEDIGER, McKinsey & Company
TOBY LAMBERT, McKinsey & Company

The coming decade will bring significant new challenges to health care in the Gulf Cooperation Council countries. These challenges will require new strategies on the part of government and private health-care players.

Health-care demand in the Gulf Cooperation Council is undergoing fundamental change

The Gulf Cooperation Council (GCC) countries—Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates—will face an unparalleled and unprecedented rise in demand for health care over the course of the next two decades. We estimate that total health-care spending in the region will reach US$60 billion in 2025, up from US$12 billion today. No other region in the world faces such rapid growth in demand with the simultaneous need to realign its health-care systems to be able to treat the disorders of affluence. Moreover, although GCC health-care systems are far better than they were 20 years ago, many residents remain unsatisfied with the availability and quality of care at government-run hospitals and clinics. Government agencies mostly lack the managerial skills needed to run health-care facilities, and cash incentives alone haven't been enough to attract specialists to treat the rising numbers of people with ailments such as heart disease and cancer.

Government-run hospitals and clinics are ill prepared for a rapidly growing and aging population, nor are they prepared for the rise in chronic diseases such as diabetes, whose prevalence has grown as countries have developed. To augment services and raise standards of care, some GCC governments have already encouraged internationally renowned academic institutions to set up health-care facilities in their countries. Many more private health-care providers are required, however, to meet future demand.

For the most part, GCC governments intend to go on subsidizing robust medical benefits—at least for their own citizens. Governments now shoulder more than 75 percent of this burden, but even those with the deepest pockets may not have enough, in 20 years, to pay for the cost of health care. Most now recognize that they will soon need private-sector help to finance it.

Fundamental changes will be required of payors, providers, and government. Private payors that build volume by competing in more than one GCC state are the most likely to succeed. For private providers, the decision must be whether to enter into government contracts to manage public facilities or to open their own. Finally, big changes to government policy and regulation are needed to ensure that private players can attract patients and succeed. The two most important changes are that governments must reimburse their citizens for private as well as public health care, and that independent regulatory bodies must be established to define and enforce quality standards for public and private providers alike.

Factors driving health-care demand in the Gulf Cooperation Council

GCC governments have made substantial investments in health-care infrastructure during the past 25 years, building hospitals and clinics and promoting a more modern approach to tackling the infectious diseases, such as malaria and measles, that were once rampant in the region. Although differences exist from country to country, the overall improvement has been impressive. Life expectancy rose from 60.5 years in 1978 to 73 years in 2004; in the same period, infant mortality fell from 69 deaths per 1,000 live births to 18.[1]

But GCC health-care systems still struggle today. The primary reason is that governments are not equipped to manage health-care providers and feel little pressure to set quality, service, or financial-performance targets. More troubling is that the GCC faces three drivers that will dramatically increase health-care demand in the region: population growth, aging, and unique health-risk factors:

- **Population growth.** Until 2015, the size of the population will increase at a compound annual growth rate (CAGR) of around 3.0 percent, one of the highest in the world. In the longer term, the growth in population will ease back to 1.8 percent CAGR. As a result, total GCC population in 2025 will be almost twice the size it is today.

- **Aging populations.** Older people generally need to seek more medical care and have more expensive health profiles than younger people. Improvements in life expectancy over the past quarter of a century have left the GCC with an increasing number of elderly people requiring care. Combined with the success achieved in reducing infant mortality rates, this demographic segment will continue to grow in the years ahead. In Saudi Arabia, for example, the number of people over 65 will increase more than sevenfold during the next 25 years.[2]

- **Health-risk factors.** The GCC shows a unique pattern of risk factors. Among GCC nationals, the prevalence of Type 2 diabetes and obesity is unusually high relative to the rest of the world. For example, a joint study between the UAE Ministry of Health and the World Health Organization in 2001 showed that 25 percent of UAE citizens suffer from diabetes (as compared with an average of 5 to 7 percent globally). This figure rises to an unprecedented level of 40 percent for those aged 60 or above. This prevalence has been described as being of crisis proportions. In addition, the obesity rate for GCC nationals stands at 40 percent, one of the highest in the world. The health complications of both diabetes and obesity will correlate with much higher medical costs in the coming years.

Gulf Cooperation Council health-care demand in 2025

Although demand for health care in the GCC is clearly rising, the extent of this increase and the forces that will drive it have been matters of wide debate. To inform the debate, McKinsey & Company constructed a proprietary model of health-care demand covering each of the six GCC countries across 20 specialties and five age brackets (Figure 1). We believe this model to be unique both in terms of the depth of the data used to build it and the comprehensiveness of the health-care profile. Our model projects a substantial increase in health-care costs, as well as in the number of inpatient and outpatient treatments and hospital beds, over the next 20 years. The model takes into account five drivers of changing demand: population growth, the demographic profile, the development of risk factors, treatment patterns, and medical inflation.

The model projects the following by 2025:

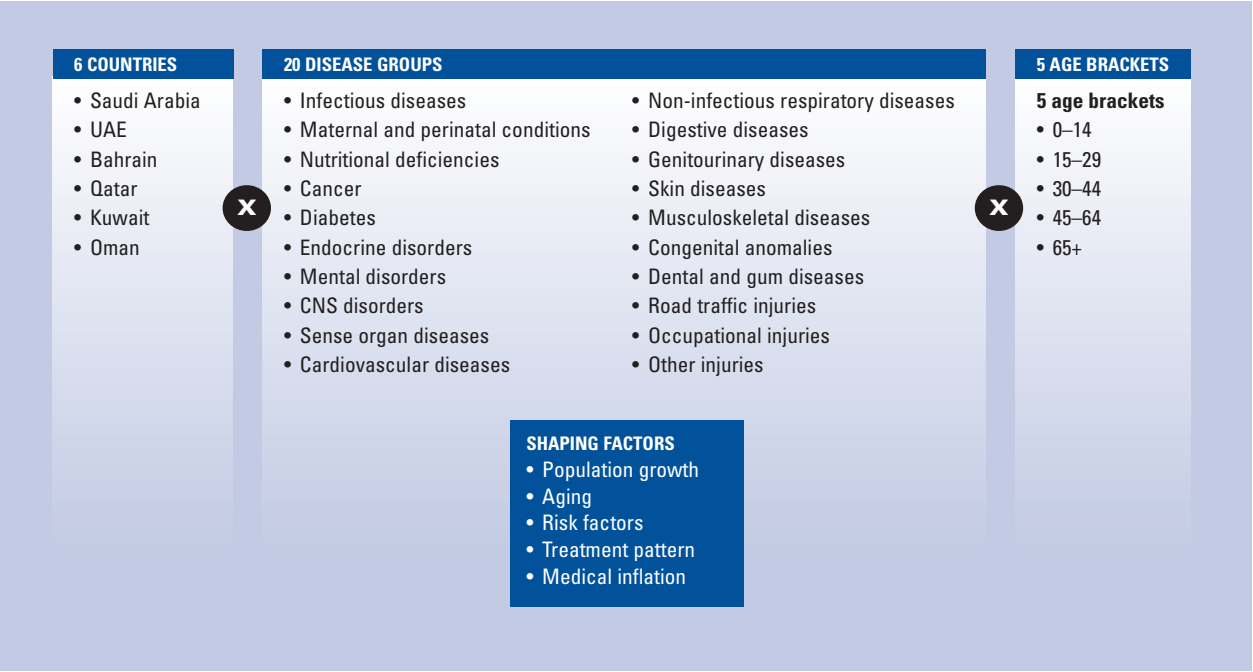
- **Treatment demand.** Over the next 20 years, treatment demand will rise in the GCC by 240 percent (see Figure 2). In particular, cardiovascular disease will experience a steep increase (419 percent), as will diabetes-related ailments (323 percent).

- **Hospital beds.** By 2025, demand for hospital beds in the region will more than double, requiring almost 162,000 beds to meet this demand (see Figure 3). Saudi Arabia and the United Arab Emirates will register the greatest percentage increase in demand for hospital beds.

- **Cost.** Health-care delivery in GCC countries will cost about US$60 billion by 2025, increasing five-fold from today (Figures 4 and 5). Cardiovascular disease will become an enormous cost burden on the GCC. Whereas today it already accounts for 12 percent of total health-care expenditure in GCC countries, this will double by 2025. This means that expenditure for cardiovascular diseases will grow at a rate of almost twice that for health care as a whole.

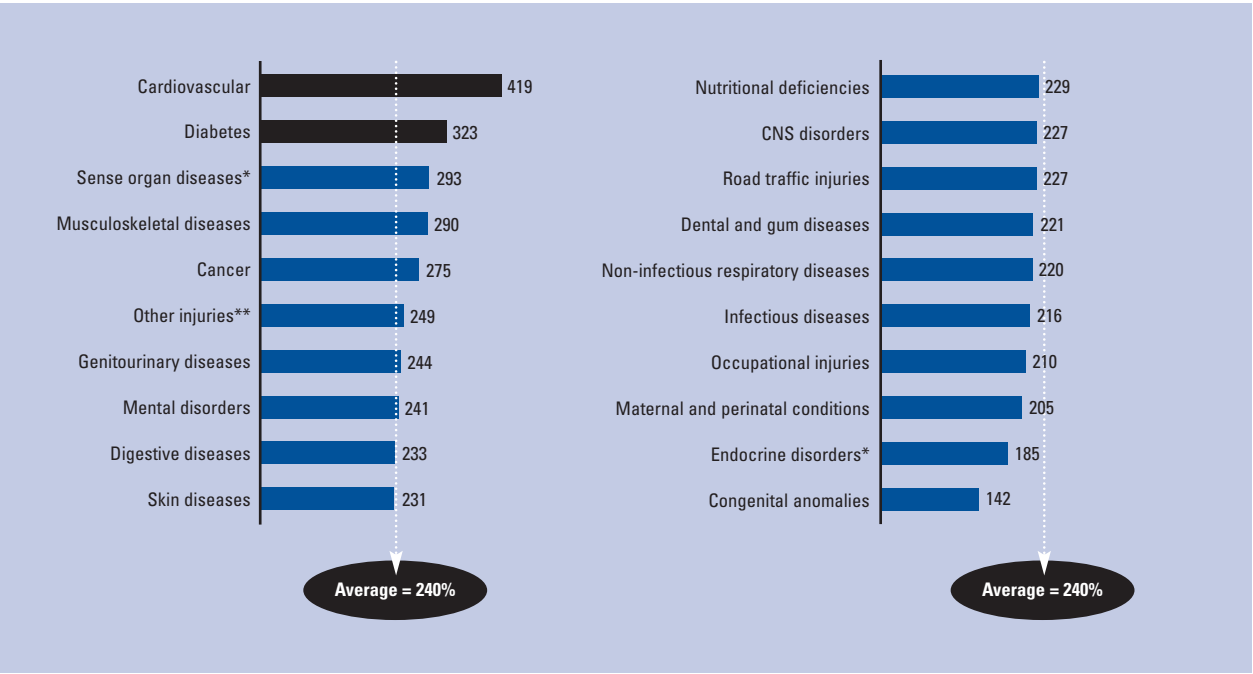
In addition, patient expectations in the GCC are rising in parallel to disease-based demand. The McKinsey survey of GCC patient satisfaction shows that higher expectations do not merely reflect generalized discontent, but rather are the result of direct patient experience. Comparing satisfaction levels for public and private hospitals, our survey data of 600 patients show that public hospitals come under substantially more patient criticism than do private hospitals. Survey respondents reported that public hospitals have limited appointment hours, long waiting times, and unattractive and uncomfortable facilities.

Figure 1: McKinsey's model to estimate disease demand in Gulf Cooperation Council countries



Source: McKinsey & Company.

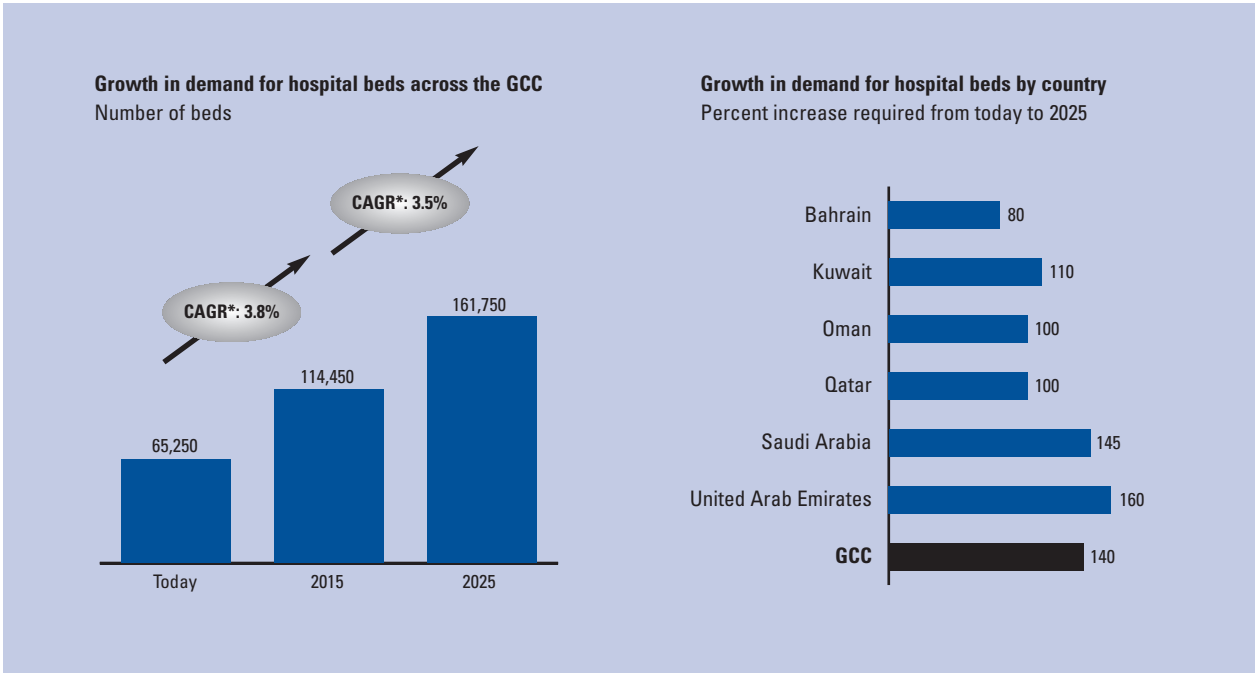
Figure 2: Projected increase in treatment demand in the Gulf Cooperation Council countries by 2025 (percent)



Source: McKinsey & Company.

*Primarily eye
**Primarily household; not occupational or road traffic

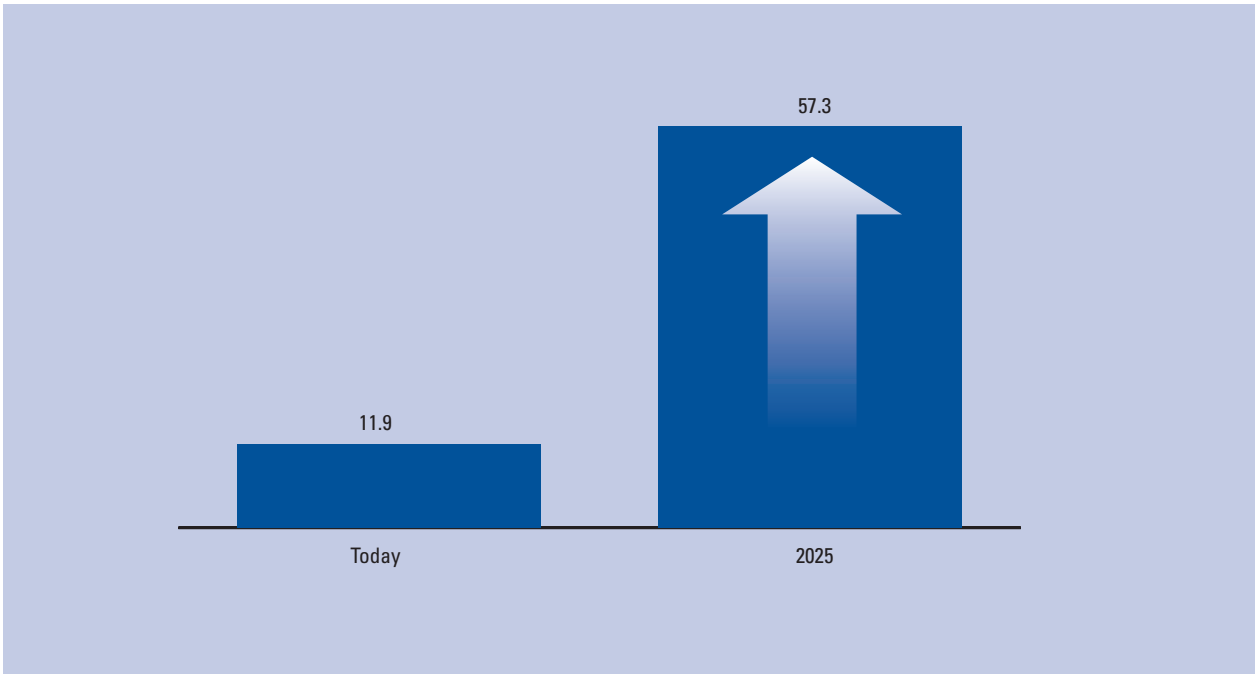
Figure 3: Projected demand for hospital beds in the Gulf Cooperation Council countries by 2025 (percent)



Source: McKinsey & Company.

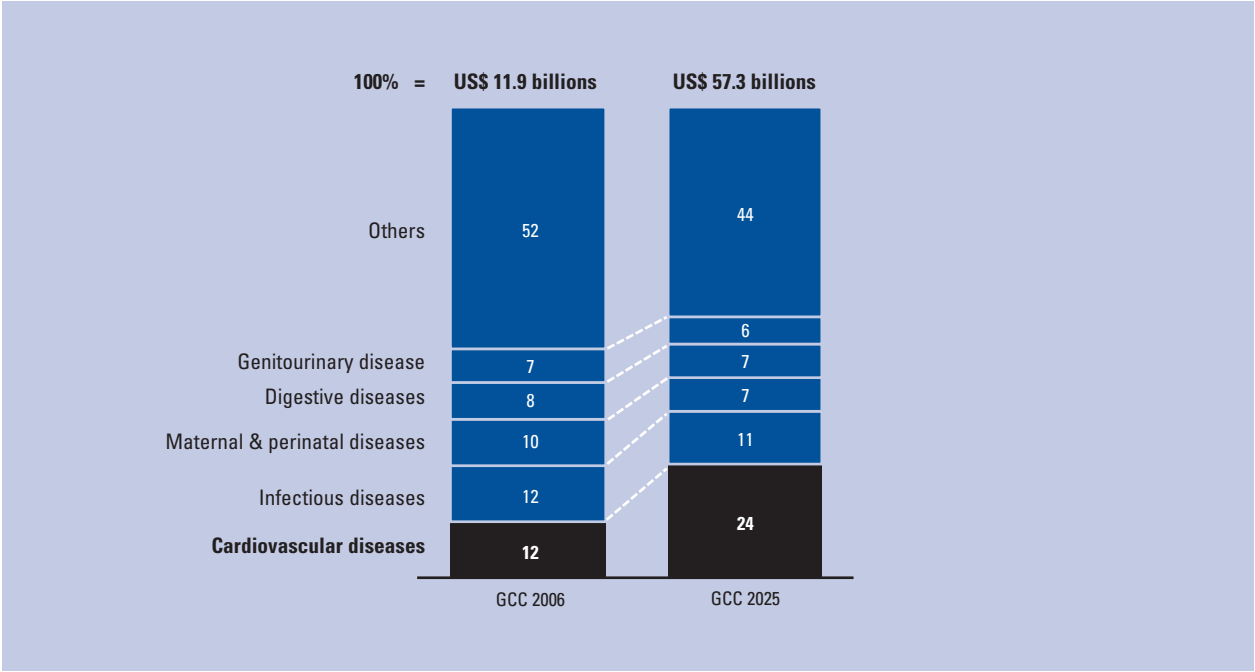
* CAGR is compound annual growth rate.

Figure 4: Projected spending growth in the health-care market in the Gulf Cooperation Council countries by 2025 (US$ billions)



Source: McKinsey & Company.

Figure 5: Projected burden of cardiology in the Gulf Cooperation Council countries by 2025 (percent)



Source: McKinsey & Company.

Note: The public sector currently funds approximately 75 percent of GCC health-care spending.

Implications for government and private health-care players

As GCC policymakers prepare to grapple with the challenges of this substantial rise in overall health-care demand and costs, as well as with the challenges presented by patients seeking better care, they are increasingly turning to private sector for help with both provision and financing.

Finding a private-sector solution requires changing the GCC's unique system of health-care delivery. In 2005, GCC governments spent about US$9 billion running public health-care facilities and reimbursing their citizens for care received abroad. But the private sector receives no more than 25 percent of all health-care spending in the GCC. The main reason is that, while public care is free, patients must pay for private treatment themselves. Generally, public care is free for nationals. Expatriates pay a fraction of what it actually costs the government to provide care. Private facilities not reimbursed or subsidized by the government therefore have fewer patients and lower revenues than they might otherwise. In one Gulf state, McKinsey experience found that private hospitals not affiliated with the government operate at 10 to 40 percent of capacity, since patients tend to pay private providers for diagnoses and then go to a free public hospital for treatment.

Some governments have helped private providers succeed, primarily by engaging them to manage public facilities and then reimbursing them for treating government-funded patients. In the past three years, for instance, generous cash incentives and a guaranteed number of public patients have been offered to top-rated international teaching hospitals, such as Johns Hopkins and the Cleveland Clinic, to get them to manage or open new facilities. The governments' hope is that big, branded players will create competition and raise standards of care throughout the region. Generally, governments try to lure these top hospitals to take over the management of public facilities or to open up shop in the GCC in exchange for cash, including payment for a guaranteed number of public patients.

In reality, the GCC governments need many more private health-care providers, and they cannot solve the problem by rolling out a red carpet for every single one. It is impractical to guarantee volumes of patients for each private provider—such guarantees are costly and reduce the incentive for providers to raise their quality and compete for patients. Since most private providers compete with public facilities to attract patients, governments must create a system in which both public and private health-care providers issue claims and get reimbursed at equal prices for services rendered. To achieve this goal, a vital first step would be for governments to move away from the current practice of writing large checks to public health-care facilities irrespective of patients treated and services rendered.

Most governments acknowledge that such sweeping policy changes are needed, though few have been implemented. GCC policymakers have all hit on the similar solution of seeking to bring the private sector

into health-care delivery in order to manage ever-greater demand and provide a better quality of care in a more efficient manner. Based on our interviews and research, we categorize opportunities for local and international private players into three areas: health-care delivery, health insurance, and support services.

- **Health-care delivery.** The GCC governments increasingly want to focus on policymaking and regulation while gradually minimizing their role in health-care service delivery. As such, they are seeking to encourage private provision in areas that are underserved today, as well as to bring private players to manage public health-care facilities.

  In light of the GCC's unusual risk-factor profile, substantial opportunity exists in primary care to better manage chronic diseases such as diabetes and obesity before they result in cardiovascular complications. Moreover, some GCC countries are actively seeking private-sector involvement in managing public primary-care facilities. In addition, the GCC lacks experienced hospital management. Increasing and improving hospital services to keep pace with the estimated rise in patient demand represents a significant opportunity for experienced private hospital players.

  For providers who wish to move forward on their own, our disease-demand profile for 2025 indicates high demand for oncology and cardiology care that could present significant profit opportunities to private health-care providers willing to make larger capital investments in more sophisticated equipment. For example, although oncology will show the fifth-highest demand increase by 2025, few facilities in the GCC are equipped to care for cancer patients. Opportunities will also present themselves in treatment areas where little infrastructure exists today. Our research shows that physiotherapy, renal dialysis, acute rehabilitation, elderly care, home care, occupational therapy, and speech therapy are among the areas in which capital investment is relatively low and potential returns to private providers are high. Finally, outpatient surgery centers (for example, day-cases) are likely to become an important mechanism for reducing the average length of hospital stay and increasing patient throughput.

- **Health insurance.** The GCC governments currently provide the lion's share of health-care financing today—approximately 75 percent. To lessen the government burden, all GCC countries have recently passed, or are in the process of passing, sweeping health-care insurance legislation. For example, Saudi Arabia and Abu Dhabi have already passed laws requiring employers to purchase private health insurance for their expatriate workers. Though no more than 10 percent of the population of any one GCC country is covered currently, we expect that this will quickly change. Workers covered under these plans can choose care at either public or private institutions—a system that has the benefit of ensuring that public providers must learn to generate claims in order to be reimbursed by the government. Once private health insurance takes hold, we expect that patient volumes for private providers will rapidly increase as patients are allowed to pursue reimbursed care at private institutions.

  The policymakers' objective is to move from a purely public payor system to a mixed public-private payor model. In this regard, all GCC countries face similar needs for international private payors to enter the market to provide health insurance for expatriates today, and ultimately for nationals in the future. Depending on the country, the health insurance opportunity could either be to enter as a stand-alone private player, or to form a joint venture with the government to establish and manage a national payor.

- **Support services.** As governments focus more on policymaking and regulation, they are likely to turn to the private sector for help on several fronts. Such support is necessary for defining the organization functions of the policymaker and regulators and for setting and enforcing minimal regulatory requirements for providers, payors, and medical staff. In particular, we see an opportunity for IT providers to establish systems that report clinical quality and financial data at the procedure, department, and institutional levels, creating transparency for decision makers on current performance and areas for improvement. Little to no experience exists in public health-care institutions with such systems, and so policymakers are seeking the support of either niche international private players or government entities in developed countries that have established similar transparency systems in the past.

The experience of private players in the GCC to date, however, suggests that serious challenges exist to capturing these opportunities, particularly during the transition period (the next five to seven years) of the policy changes taking hold in the health-care sector. The main challenges to private players are fivefold:

1. guaranteeing a threshold patient volume, because of the lack of systematic channels and referral systems in the GCC;

2. hiring, training, and retaining a sufficient caliber of clinical staff, because of the high share of expatriate doctors and nurses in the GCC;

3. agreeing on adequate reimbursement from payors (governments, insurance companies, and individuals), because of the lack of clear pricing systems, free public care for citizens, and complex contracting rules between government and private players;

4. differentiating from competitors in an environment where quality standards are not transparent to patients; and

5. contracting with government to manage public facilities.

Government plays a critical role in facilitating these challenges and facilitating the development of private sector.

1. Patient threshold volume

Patient threshold volume is important for two reasons: first, to ensure viable economics, particularly for interventions requiring high levels of capital equipment (for example, heart surgery). Second, the outcomes of many procedures are correlated to volumes—simply, the more of a particular type of procedure a surgeon carries out, the better the outcomes. At present, many private hospitals in the Gulf simply do not have the volumes to carry out more complicated procedures. This is the result of two factors: a lack of referral networks and crowding out by the public sector.

Primary care throughout the region is almost exclusively the domain of governments. Although the success of systematized health-care delivery in the area of primary care varies from country to country, in no country has a private model of care based on general practice taken off. Thus patients going private do so in order to go directly to a specialist in whichever clinical area they feel necessary. As such, no one physician truly owns the patient relationship. Private providers entering this space will need to catalyze the creation of a high-quality primary-care network in order to capture patients, whether through direct delivery of primary care or by working with existing specialists to create networks. An alternative model would be to follow the model adopted by a few private players in the region to integrate primary care into their hospitals.

Crowding out by the public sector is particularly acute for more specialist procedures, as few are able or willing to pay for such procedures. Those that can currently tend to leave the region for treatment at American, European, or Singaporean centers of excellence. The current trend of government-supported brand name centers of care in the Gulf—such as the Teaching Hospital in Qatar supported by Cornell, or Johns Hopkins' collaboration with the Emirate of Abu Dhabi in cancer at Tawam—will probably make it increasingly difficult for lesser-known private names to distinguish themselves. However, the current trend away from government delivery of services to governmental payment for services will begin to create a more level playing field for private providers alongside existing governmental providers.

2. Clinical staff

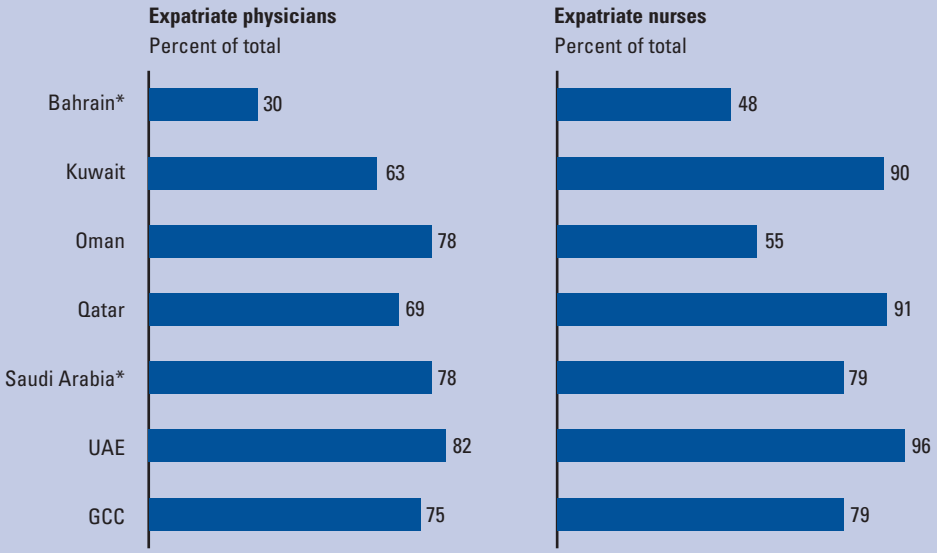
At present, the GCC is unable to produce sufficient numbers of clinical staff to provide health care for its population. As a result, foreign workers can comprise up to 80 percent of physicians in some countries (Figure 6). Existing medical education is now being extended and strengthened by collaboration with European and US medical schools, such as Cornell's undergraduate medical education program in Qatar and the Royal College of Surgeons of Ireland's postgraduate facilities in Bahrain. But the numbers of new medical graduates becoming available in the foreseeable future will not keep pace with the GCC's population increase. Hence reliance on imported physicians and nurses will continue for some time to come.

Such large-scale importation of staff poses two challenges. First, private providers will need to meld together staff from very different cultures, with differing medical practices and approaches to patient care. Second, the GCC is viewed by few of these staff as a permanent home, leading to high turnover rates. Staff from developing countries—for example, the Philippines and India—view the GCC as a stepping stone to more lucrative careers in the West, whereas many staff from the West view a tour of service in the Gulf as an opportunity to save funds before returning home. Meeting these challenges will require creating a strong ethos within the provider to make it capable of absorbing newcomers on a regular basis.

Private providers can help to make nursing and other medical professions more attractive to local students by creating professionally and financially rewarding career paths for clinicians who stay in the region. Better salaries, substantial investments in professional training and development (such as residencies), and more flexible careers made possible by a greater degree of private-sector participation in the health-care system should all help to attract GCC nationals.

For their part, policymakers must find ways to enlist more nationals in the medical profession. GCC governments have had difficulty doing this in the past, particularly in nursing, since many nationals consider it a demeaning profession. However, given the increasing unemployment rates for nationals in the region, it is time to reconsider the attractiveness of the health-care profession to nationals. An estimated 42 percent of the GCC's local population is currently under the age of 15 and will soon be looking for jobs. Although the public sector has historically employed up to 90 percent of the GCC national workforce, its ability to do so moving forward is limited. Given the high demand growth of the health-care sector—and therefore the increasing

Figure 6: Source of human resources in the health-care sector, 2001–02



Source: GCC ministries of health.
* 2003

need for professionals, particularly nurses—policymakers should explore investing in creating vocational training programs for nurses and allied staff and should partner with relevant international training providers.

3. Reimbursement system

As governments fashion their new health-care systems, they will make drastic changes in insurance requirements and eligibility for both nationals and expatriate workers. In the next five to ten years, these governments will likely design basic health benefit packages and provide them free of charge to all nationals. In most GCC countries, the law now requires companies to provide basic health-care benefits (including insurance) for their expatriate workers, who account for 40 to 80 percent of GCC populations (depending on the state). Until recently, expatriates enjoyed virtually free access to public health care, which accounted for as much as 20 percent of its total cost.

Because these expatriates have relatively low incomes and governments strictly regulate premiums to make them affordable, insurers competing for market share will likely lose money on basic benefit packages for this population. Unless private insurers have the exclusive right to sell their benefit packages in certain states or regions of the GCC, they're unlikely to reach the volume necessary to turn a profit.

For nationals and the more affluent expatriates, changed insurance and eligibility requirements should open up more opportunities for international health insurers. To give one example, we expect competition to thrive in the premium-benefit market, which serves nationals and expatriates who want coverage for services excluded from basic packages. Premium policies for dental care or elective plastic surgery or for insurance that covers high-end hotel-style services for the affluent will always be in demand. We estimate that the market penetration of these premium benefit packages, sold at a good profit margin, could reach 4 to 5 percent of the GCC's population.

Further opportunities for international payors will arise from the governments' lack of experience and skills to build and run complex health insurance businesses. Government administrators will need experienced insurers to process and validate claims, to teach providers to issue claims, and to reimburse them. Governments have two choices until they can effectively transfer the necessary skills to local businesses: they can partner with health insurance companies or temporarily outsource some key functions (such as claims processing and management) to international companies that specialize in settling claims. In the Gulf, few people have experience or skills at the point where health care and finance intersect. For governments and the insurance companies they work with, the biggest challenge will therefore be to find qualified professionals to build and run complex health insurance businesses in the region.

To gain the best competitive position, international health insurers and companies that specialize in managing claims must attempt to generate a critical mass of business by striking deals with governments in more than one GCC state. Building more volume by entering several

states and regions of the GCC helps insurers from both a financial and a talent management perspective, since they need to justify their investments and deploy scarce talent. By bringing senior, experienced people into the region and making a commitment to coach, train, and transfer knowledge to locals, the payors can make themselves much more attractive to governments searching for partners.

For many payors, a winning approach might start with offering an experienced expatriate team an opportunity to lead the majority of all claims-management activity. Over 10 or so years, coaching and training programs in which locals shadow the expatriates could make it possible for governments to manage the business themselves. At that point, though locals would staff the administration, the international insurer could continue to own and oversee the claims-management business. Whether or not the insurer did so, these arrangements might be quite lucrative. GCC governments often pay big money to insurers for hiring and training locals. Over this initial training period, insurers could expect to earn profit margins of up to 5 percent or more on basic health benefit plans for nationals—far above what can be expected from competing in open markets.

For governments to encourage the development of such a payor system, they must require all health-care providers, public or private, to gather and report accurate data on their costs and services. Given the current lack of robust data on costs, public health-care systems must embark on long-term efforts to achieve transparency. Governments must also invest substantial sums in IT systems to collect cost data and use these data to inform decisions on reimbursement levels for both public and private providers.

4. Quality standards

Today, GCC patients make their private health-care decisions based on word of mouth, advertising, and the physical external appearance of the institution. Quality standards of providers are neither transparent nor understood by patients, thus high-quality providers can struggle to distinguish themselves in the market. Even worse, patient safety can be compromised by the lack of effective regulation of the health-care sector.

Policymakers will have to undertake comprehensive regulatory reform in order to weed out low-quality providers and protect patients. Currently, to the extent that standards exist, they apply to the private sector only and are not applied to public health-care institutions. Moreover, the content of the standards, and their enforcement, tends to be weak and haphazard.

In order to raise the quality level of the health-care sector and to allow competent private players to thrive, policymakers must create regulatory bodies that will define a set of comprehensive operational quality and facility standards for all public and private providers. This body would be responsible for licensing, inspecting, and enforcing these standards. Because this regulatory body must equally apply and enforce standards to public and private health-care institutions, it should ideally be independent of the ministry of health. In addition, this regulatory body would also be responsible for the licensing and renewal of medical professionals such as doctors, nurses, and allied staff. Although processes do exist today in GCC countries for this function, they tend to suffer from two problems. First, they can be very bureaucratic and take a long time, resulting in providers losing their ability to attract clinical staff from overseas. Second, the criteria for licensure and renewal can be weak when compared with international best practice, resulting in substandard professionals practicing medicine.

In small GCC states, regulatory bodies may also choose to guide the strategic capital investments of providers (regardless of ownership). Because a critical threshold of patient volume is required for specialty services in order to maintain quality, it is important that investment in these specialities is carefully monitored so as to prevent excess supply relative to case volume (and therefore a decline in quality). A regulator has the unique ability to manage capacity in these services by deciding whether to grant a provider a license. Conversely, it can encourage providers to offer services in areas with the greatest unmet needs, such as the management of primary-care facilities and hospitals, long-term care, rehabilitation, and dialysis.

In short, by establishing a strong regulatory body to define and firmly enforce higher-quality standards for health-care providers and medical professionals, policymakers will build the confidence of patients in the quality of health care, no matter who provides it.

5. Contracting with private providers

Hospital and primary-care management skills are in short supply in the GCC. If private institutions have the patience to wade through the bidding process, many can prosper in the Gulf by managing public hospitals and primary-care facilities as well as laboratories and pharmacies. Depending on the deal structure, these private players can earn substantial cash incentives by meeting performance targets for clinical outcomes and care standards.

In one GCC state, the government holds an auction when it wants to contract with the private sector. The process starts with a hospital's current budget, and private companies are invited to bid on how much less funding they could accept while still meeting specified quality and service standards. Another government is currently accepting bids for managing its secondary-care hospitals. That contract would give the winning partner total operational freedom but also full accountability for its performance, as well as a budget that's only 90 percent of the hospitals' current level of government-issued block funding. Given similar constraints, a few private

players have managed public hospitals much more effectively and efficiently than governments do.

For private management of public health-care facilities to become a more widespread reality, governments must improve the way they contract with private players. Too many private players are thwarted in their attempts to take over the management of public facilities, simply because government agencies lack the managerial skills and the data needed to structure deals. Governments regularly send out tenders, but though many providers respond with bids, their questions (for example, about guaranteed patient volumes or prices for services) are seldom answered. Governments may not have considered the goals of an outsourcing effort, and the data may not be available. These unanswered questions have generated a high level of frustration among international health-care providers, and very few contracts have been signed.

Governments will struggle to find the answers to these detailed questions until new reimbursement schemes and more transparent data systems are in place. However, they can immediately increase their chances of attracting more private health-care entities by adopting clear strategies. In short, governments must know exactly what they want from their partners, establish a clear process and timeline, and have competent, well-informed people available to answer questions about the bids.

Conclusion

Health-care demand and spending are rising sharply in the GCC. Policymakers want the private sector to play a bigger role in their health-care systems, in both the provision and the financing of care. To promote the private sector's involvement, GCC governments must make major regulatory and policy changes—above all, using public funds to reimburse nationals for the private health-care services they consume, and defining and enforcing a single set of quality standards for both public and private providers. To have the best chance of success, private providers will need to decide whether to enter into government contracts to manage public facilities or to run their own facilities. The private payors most likely to succeed will build volume by competing in more than one GCC state.

Notes

1 See WHO (2006).

2 McKinsey analysis based on Global Insight data.

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