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An Overview of Health Care System in Saudi Arabia

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Abstract

Healthcare services had been one of the great priorities of the Saudi Arabian government. In its attempt to improve health services, the Saudi government has invested heavily in the health care sector. By responding to the demands of its citizens the Saudi health system introduced various changes over the years to implement achievement. This leads to improvement of Saudi population health in the recent decades. Still, issues like the available electronic health strategies underutilization, limited financial resources, national health information system shortage, free services that triggered high demand, Saudi health professionals shortage, health care facilities with poor accessibility, multiple roles of the health ministry, changing patterns of disease and a national crisis management policy absence, handicap the good system of health care. The total quality management (TQM) implementation is the driving force of the health service, and its delivery is considered one of the system's serious challenges. This continuous process of all facilities in the healthcare of Saudi Arabia, demanded funds allocated to the Ministry of Health (MOH) by the Ministry of Finance (MOF) for better departmental equipment, management specialists and quality-training programs. The health care system in Saudi Arabia is reviewed through its current structure and past developments. Future challenges and possibilities to face and reform them were pointed out.

Key words: *Healthcare system, Saudi Arabia, total quality management, MOH.*

1. INTRODUCTION

The formation of the Ministry of Health in the year 1951, following the foundation (by a royal decree by King Abdul Aziz) of the Public Health Department in 1925 (Yusuf, 2014) coincided with the establishment of hospitals (Al-Rabeeah, 2003). Providing approximately 58% of health care in Saudi Arabia, MOH is the principal provider of health care, alongside some other governmental agencies. As Al-Farsy (1990) states, the Saudi policy is to provide free health services to all citizens of Saudi Arabia. The other main government agencies acting as health providers are the Ministry of Defence, Ministry of the Interior, Ministry of Higher Education, the National Guard, and KFSH (King Faisal specialist hospital) and research center. Government agencies provide free health care services for their own staff; so for example, the Ministry of Defence has hospitals providing treatment free of charge to its employees (Mufti, 2000). Al-Farsy (1990) found that such hospitals will also accept patients referred by other hospitals.

Despite the above efforts, the Saudi government's reform of the health system has not been entirely successful. The current system still faces problems, such as difficulties accessing its services, long waiting lists, medical malpractice, patient dissatisfaction and so on (Mufti, 2000; Al-Asheikh 2000; Al-Yousuf et al., 2002; Al-Rabeeah, 2003; Al-Ahmadi and Roland, 2005).

Until the 1980s, in line with the expectations of population, health services in Saudi Arabia were largely curative, emphasizing the provision of treatment for existing health problems (Al-Yousufet al., 2002; Health system profile, 2011). The curative care model, however, can be costly to health providers, when many diseases can be prevented or minimized through developing a preventive strategy. A variety of preventive measures were run by the MOH through former health offices and to some extent through maternal and child health care centers. A number of disease control activities were performed by vertical programmed, e.g. malaria, tuberculosis and leishmaniasis control (Al-Yousufet al., 2002; Health system profile, 2011).

In accordance with the Alma-Ata declaration at the WHO General Assembly in 1978 (Al-Ahmadi and Roland, 2005), the Saudi MOH decided to activate and develop the preventive health services by adopting the PHC approach as one of its key health strategies. Consequently, in 1980, a ministerial decree was issued to establish PHC centers. The first step was to establish suitable premises throughout the country. Existing facilities located in adjacent areas were integrated into single units. These included former health offices, maternal and child health centers and dispensaries. The health posts in small and rural districts were upgraded to PHC centers (Al-Yousufet al., 2002;Health system profile, 2011). The health centers aimed to focus on the 8 elements of the PHC approach: educating the population concerning prevailing health problems and the methods of preventing and controlling them; provision of adequate supply of safe water and basic sanitation; promotion of food supply and proper nutrition; provision of comprehensive maternal and child health care; immunization of children against major communicable diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs (Al-Mazrou et al., 1990; Al-Mazrou and Salem, 2004).

Focusing on a PHC strategy and applying a logical referral system has helped to reduce the number of visits to outpatient clinics (Al-Yousufet al., 2002). About 82% of client visits to MOH facilities during 2009 were to PHC centres comprising more than 54 million PHC clients (Health statistical year book.4, 2009). The creation of individual and family health records inside each PHC centre has reduced duplication of consultations. The use of the essential drugs list and documentation of prescriptions in patient health files has not only reduced the costs of medications, but also improved prescribing practices.

2. SAUDI ARABIAN SOCIO-ECONOMIC AND DEMOGRAPHIC PATTERNS

Saudi Arabia is of 2.0 million square kilometers area, the largest country in the Middle East (Table 1).In the last five decades its nation has undergone a transformation that categorized it in the Middle East as one of the most urbanized societies that developed from a relatively small rural population (Khaliq, 2012).

The basic dimensions of measuring and evaluating Saudi financial resources to meet the citizen's expectations of excellent healthcare and well being, are to know and specify the demographic and socio-economic parameters. These levels and boundaries are essential to understand responsibilities, predict and plan for achieving the fundamentals of healthcare system foundation and the challenges that face it (Al-Farsy, 1990). (Albejaidi, 2010)

Table 1. Demographic, economic and health related data for Saudi Arabia and five other countries in the region[a](Khaliq, 2012)

	Saudi Arabia	Kuwait	Egypt	Jordan	Libya	Oman
Area in square kilometres	2.0 m	17,818	1.0 m	91,880	1.76 m	309,500
Total population in millions	25.4	2.4	82.0	5.3	5.3	2.5
Population growth rate	2.2%	3.3%	2.0%	2.5%	1.8%	2.2%
Population under 15 years of age	35%	23.7%	37.4%	37.1%	32.0%	38.9%
Adult literacy rate	88%	90.9%	69.4%	90.9%	86%	78%
GDP per capita (current $)	$18,603	$15,984	$1,036	$2,103	$5,128	$12,239
Expenditure on health as % of GDP	3.3%	3.8%	3.7%	10.4%	3.3%	2.8%
Health expenditure per capita	$621	$552	$192	$188	$222	$340
Out-of-pocket spending as % of total health expenditure	–	–	61%	9%	23%	9.1%
% of population with access to safe drinking water	97%	100%	91.3%	95.1%	98.45	75%
Life expectance at birth (in years)	73.4	78.7	70.1	71.4	69.0	74.3
Infant mortality per 1000 live births	17.4	9.4	20.5	22	24	10.3
Maternal mortality 100,000 births	14	9.1	63	40	51	15.4
Total fertility rate per woman	3.0	2.2	2.97	3.7	2.96	3.1
% of one-year-old children vaccinated for measles	83%	–	96%	95%	96%	98%
Married women using some form of contraception	–	–	59.2%	56%	53.7%	–
No. of hospital beds per 1000 population	2.2	2.0	2.0	1.8	3.7	1.8
No. of physicians per 1000 population	2.1	1.9	0.6	2.3	1.2	1.6
No. of nurses and midwives per 1000 population	4.1	4	1.3	3.0	4.8	3.7

GDP = gross domestic product.
[a]The data reported in this table cover years 2003–2009 and are not for the same year in each of the columns or the rows. These data are reported only to provide a comparative context for Saudi Arabia.

The population of Saudi Arabia was 27.1 million in 2010 according to the official census done in that year, with an annual population growth rate of 3.2%, since 2004 (Key indicators.3, 2011; CDSI, 2016). Of this total population, 68.9% were Saudi citizens with 50.2% males and 49.8% females and an annual fertility rate of 3.04(Almalki et al., 2011, Key indicators.3, 2011; CDSI, 2016)..

The urbanized residence centers comprise more than 85%, and Riyadh, the capital city, and its adjacent areas citizens exceeded a count of 6.2 million people in 2009 (United Nations Development Program [UNDP] 2010; United Nations Children's Fund [UNICEF] 2011; World Bank 2010; World Health Organization [WHO] 2010a; World Health Organization [WHO] 2010b; World Health Organization [WHO] 2011; Khaliq, 2012).

Young Saudis were represented by 67.1% whose age was less than 30, 37.2% less than 15 and only 5.2% were above 60 years of age. Saudi population will be 39.8 million at the year 2025 and 54.7 at 2050, as had been stated by the United Nations. This high growth expectancy is attributed to the high birth rate and life expectancy with reduced child mortality (Yusuf, 2014). This high rate of population growth would have its demanding feedback on healthcare services and facilities (Almalki et al., 2011). Whilst Saudi Arabia became

the first country that produces and exports oil, it is now one of the richest with the highest rates of growth in the Middle East countries. This in addition to the vast expansion in economy and industry bases bringing about a huge increase in capital income (Almalki et al., 2011; Yusuf, 2014)

The Saudi community has been positively affected in their income (General statistics12., 2007; Human11., 2009; Human10., 2010; Saudi Arabia. Data13., 2011; Almalki et al., 2011), and the country was highly ranked in the Human Development Index (0.75), becoming the 55th. in 194 which lead to better services that included healthcare (Human10., 2010; Almalki et al., 2011; Khaliq, 2012).

This lead to an approximately 80% of the Saudi health services to be governmentally funded and free of charge, not only to Saudis but also to expatriates working in the public sector **(**Al-Otaibi, 2010). The majority of other social services are also either completely free or are highly subsidised, including education, utilities and so on. Such has been the level of service that Saudis now consider free services not so much a privilege as a right, and as such they demand that the government provides the very best level of health care free of charge. This indicates that most Saudis are very conscious of their country's vast wealth. As Mufti (2000) notes, prior to the discovery of oil and the enormous rise in wealth that it brought with it, health resources were at the other extreme, being particularly deficient and offering minimal access to the type of care one would expect from a modern health system. **(**Al-Otaibi, 2010).

3. BACKGROUND AND CURRENT HEALTHCARE SYSTEM AND STRUCTURES IN SAUDI ARABIA

3.1 Healthcare System Background

Healthcare system was not standardized before oil was discovered, but, with the advent of the year 1926, a 'Health Department' was established according to the decree by King Abdulaziz Al-Saud (1880-1953), the Saudi Arabian leader (Mufti, 2000; Yusuf, 2014). That was the first and earliest sign of modernized and organized healthcare system existence in the Kingdom (Albejaidi, 2010). This was followed with an attachment between the Bureau of the Attorney General and the newly formed General Directorate for Health and Aid (GDHA), (Mufti, 2000; Albejaidi, 2010).

This health department being established in Mecca in 1925, a number of hospitals and dispensaries were formed to take the responsibility of providing free healthcare for the Saudi nation and the annually coming pilgrims (Almalki et al., 2011). Still, at that period, incidents of epidemics during hajj were high (Alharthi et al., 1999; Almalki et al., 2011). This was followed by another royal decree in the year 1950 that gave the advanced step of Ministry of Health (MOH) formation. After two decades, a 5-year National Development Plan was initiated by the government to reform the healthcare system and all other nation sectors (Al-Mazrou et al., 1995; Mufti, 2000; Al-Mazrou and Salem, 2004; Almalki et al., 2011). Complete transformation of the healthcare system was evident during that period, which brought into effect the foundation of primary healthcare, hospitals, research facilities and the entire essential infrastructure. These services were augmented with the intervention of expatriate medical personnel services that lead to the expansion of health facilities in addition to the development of human resources by offering Saudis with scholarship opportunities in the medical field that was met by the generous heavy investment by the government ((Altuwaijri; 2008, 2010Jannadi et al, 2008; ; Albejaidi, 2010; Yusuf, 2014).

The public sector with its rich oil-revenue resources and central planning was the financial provider for the Saudi health system; whilst a precursor for the private sector has come to existence (Al-Yousuf et al. 2002). 19 health regions were newly divided to represent the regions geographically with a Regional Directorate of Health each, for administrative aims and reasons (Al-Yousuf et al. 2002; Khaliq, 2012). These regions were offered some operational autonomy that was considerable in transacting the plans, implementation and regulation of health services directed by the MOH, in addition to controlling services price, medical devices and pharmaceutical products, including the private sector (Al-Yousuf et al. 2002; Walston et al. 2008).

Another proposed development for the Saudi health system is 'Saudization', by which foreign health professionals (physicians and other categories) in Saudi Arabia would be replaced by Saudi nationals (Gallagher, 2002). This proposal should be seen as an extension of the existing policy. The huge expansion of facilities and services by health care providers puts great pressure on health planners to deal with the extreme shortage of health workers by recruiting foreign labour from around the world. The health planners recognized some time ago that a nation reliant on skilled immigrants for such a vital activity as health care is highly exposed to outside influence. Many of the non-Saudi health professionals have different cultural values,

which causes some difficulty when they have to deal with patients, as does the language barrier. Therefore, the government initiated Saudization to overcome the shortage of health professionals, aiming to replace foreign national by Saudis who are familiar with the language and culture of Saudi society. This reform step is a good long-term investment because the turnover among foreign workers is very high compared with the domestic labour force (Mufti, 2000).

As result of Saudi government effort to improve health care services, the number of primary health care centres, including dispensaries and clinics, rose from 599 in 1971 to 1848 in 2005, while the number of physicians and dentists (combined) rose in the same period from 1,316 to 40,265, with 21.3% of them (8558 physicians) being Saudi. For nurses during the same period, the corresponding figures are 3,355 and 78,587, with 18,805 (24%) being Saudi. There were 75 hospitals in 1971 and 364 in 2005; and for hospital beds the corresponding figures are 9,837 and 51,130 (MOH, 2007). These figures make it clear that the health care system has undergone a rapid expansion in physical facilities and professional personnel, delivering a correspondingly greater volume of benefits and assistance to the public. This is a form of change that should be regarded as positive in its impact upon the population (Gallagher, 2002). Between the year 2008 and 2012, the ratio of Saudi working power in the MOH health field increased from 48.0% to 58.7%. (Health Statistical Year Book, 2012).

3.2 Structure analysis of the healthcare system

As a major (60% of the total health services) finance provider, the Saudi government supported primary health care (PHC) centers (2037) and hospitals with 33 277 beds (244) that belong to the MOH (Al-Rabeeah, 2003; Health statistical year book.4, 2009;Albejaidi, 2010; Al-Otaibi, 2010; Khaliq, 2012; Yusuf, 2014)**.**MOH had well defined functions and structure that included health policies, strategic planning, supervising and administering delivery programmes of the health services; including preventive, curative and rehabilitative health bodies(Sebai et al., 2001; Al-Yousufet al., 2002; Al-Rabeeah, 2003; Albejaidi, 2010; Al-Otaibi, 2010)**.** The military forces medical services, the security forces medical services the Red Crescent Society, the Ministry of Education school health units, health services of the Royal Commission for Jubail and Yanbu, ARAMCO hospitals, referral hospitals (King Faisal Specialist Hospital and Research Centre), the teaching hospitals of Ministry of Higher Education and the health affairs of the National Guard, are also supported governmental bodies (Almalki et al., 2011). These free and public healthcare provider bodies deliver the primary (healthcare centers), secondary (general hospitals with referrals) and tertiary (with specific tertiary services existing at the third level) healthcare facilities for employees and families(Metz 1992; Al-Yousuf et al., 2002; WHO–EMRO 2006; Walston et al., 2008; Ministry of Health, 2010; Albejaidi, 2010; Khaliq, 2012).Whilst, some of these bodies provide healthcare to employees and their dependents, in case of emergencies and crises, they all offer all residents with health services (Al-Farsy, 1990; Mufti, 2000; Al-Otaibi, 2010).

3.2.1 Primary care health centers

To achieve healthcare for all as a major objective, primary care provision was established in the health care centers and hospitals in the Kingdom, (Al-Ahmadi and Roland, 2005) as a major step (Albejaidi, 2010) with the preference of > 60% of the patients (Al-Ahmadi and Roland, 2005), and about 1,925 centers were attending not more than 8,727 visitors each, in the year 2006. MOH records showed prenatal care success (67% - 95%) and vaccination programs with 83% to 94%success (Al-Teheawy and Foda, 1992;El-Gilanyand Aref, 2000; Al-Ahmadi and Roland, 2005). With this beneficial progress in basic healthcare provision, still, cases of diseases associated with obesity, like diabetes, high blood pressure and cardiovascular diseases were reported, which were majorly attributed to the changing habits and trends in the society. Referral secondary healthcare bodies, with more specialized facilities were made available to receive such cases, whilst, more advanced tertiary healthcare bodies received referral cases with more complicated health situations during the period 2002 to 2010.The number of hospitals in total in the year 2010 stood at 415, since then, advancement in number and quality was observed in the years 2010 – 2015 (Table 2, Statista, 2017).

Table 2. Total number of hospitals in Saudi Arabia 2010-2015 (Statista 2017).	
Year	**Number of hospitals**
2010	415
2011	420
2012	435
2013	445
2014	453
2015	462

3.2.2 Hospitals with secondary care

It was noted that the Saudi healthcare system basically delivered Primary care in centers that refer patients for further treatment in about 244general district hospitals with the appropriate secondary healthcare facilities whilst, 38governmental hospitals and 113, belonging to the private sector, are found in major cities (Table 3, Albejaidi, 2010). With the more available oil financial governmental support and supplies, control by the MOH was made effective, centrally. The trend for foundation of Regional specialist hospitals was to decentralize and spread the delivery of more appropriate healthcare in several varieties of healthcare sectors (between 2008and 2009), which, was brought about by the availability of huge wealth resources in Saudi Arabia(Table 4, Albejaidi, 2010).

Table3. Hospitals in Different Healthcare Sectors in Saudi Arabia (Albejaidi, 2010)		
Sector	**Year**	**Hospitals**
Ministry of Health (General hospitals)	2009	244
Other Governmental Agencies	2008	38
Private sector	2008	113
Total		395

Table 4. Budget appropriations for the Ministry of Health (MOH) in Saudi Arabia in relation to the government budget, 2005–09 (Albejaidi, 2010).			
Year	**Government budget (SRa)**	**MOH budget (SR)**	**%b**
2005	280 000 000	16 870 750	6.0
2006	335 000 000	19 683 700	5.9
2007	380 000 000	22 808 200	6.0
2008	450 000 000	25 220 200	5.6
2009	475 000 000	29 518 700	6.2
a US$ 1 = 3.75 SR; b As a % of the total government budget. SR = Saudi riyals			

3.2.3 Tertiary care specialist hospitals

Patients with chronic diseases that demand more and better developed healthcare services and possible staff medical care excellence are resumed to the tertiary care health services found in 56 modern specialist hospitals (Albejaidi, 2010). They represent two cardiac and renal hospitals, four chest and fever hospitals, four eye and ear nose and throat (ENT) hospitals,9 convalescence, leprosy and rehabilitation hospitals,17psychiatric hospitalsand20 obstetrics and pediatric hospitals (Jannadi et al., 2008; Albejaidi, 2010).There has been further expansions the counts of people and the hospitals that accommodated them, in the years that followed (Table 5 and 6)(Health Statistics Annual Book, 1434).

Table 5. Population by nationality and region, KSA, 2013 (Health Statistics Annual Book, 1434).

Regions	**Saudi**	**Non-Saudi**	**Total**
Riyadh	4,655,845	2,861,114	7,516,959
Makkah	1,152,570	902,053	2,054,623
Jeddah	2,062,236	2,045,920	4,108,156
Ta`if	986,090	242,224	1,228,314
Medinah	1,368,026	594,532	1,962,558
Qaseem	1,006,089	331,474	1,337,563
Eastern	1,838,059	1,103,177	2,941,236
Al-Ahsa	943,335	222,087	1,165,422
Hafr Al-Baten	351,345	75,838	427,183
Aseer	1,411,555	313,499	1,725,054
Bishah	312,247	58,553	370,800
Tabouk	716,409	150,394	866,803
Ha`il	527,922	126,814	654,736
Northern	290,590	60,382	350,972
Jazan	1,197,453	299,924	1,497,377
Najran	436,057	119,072	555,129
Al-Bahah	377,773	72,960	450,733
Al-Jouf	247,364	74,024	321,388
Qurayyat	130,925	30,825	161,750
Qunfudah	259,168	38,348	297,516
Total	20,271,058	9,723,214	29,994,272

3.3 Private sector

The contribution made to health services by the private sector has grown over the last 10 years and it plays a vital role in running several hospitals and clinics in the country (MOFA, 2004). The growing demand for these private sector services by both Saudis and expatriates is reflected in the fact that the government has actively encouraged private sector involvement. The number of patients attending private health facilities increased by about a third in the four-year period from 1994 to 1998**(**Al-Otaibi, 2010).

In large cities and towns, the private sector offered a considerable degree of 125 hospitals health service, aided with 11 833 beds, in addition to dispensaries and clinics (2218)(MOFA, 2004; Ministry of Health, 2008; Health statistical year book.4, 2009;Albejaidi, 2010; Yusuf, 2014), but this contribution was expected to increase with the vision of 2020, with an expected population of 36 million (Schieber, 2001; Yusuf, 2014).

Saudi citizens make up about 75% of the patients who use private health care. At the moment the private sector provides about 20 % of the nation's health care services, and it is expected that there will be further future expansion in the private sector for health services**(**Al-Otaibi, 2010).

Table 6. Rate of MOH hospital beds per 10,000 population by region, KSA, 2013(Health Statistics Annual Book, 1434).			
Regions population	**Population**	**Hospital beds**	**Bed rate per 10,000**
Riyadh	7,516,959	7,737	10.6
Makkah	2,054,623	22522	12.3
Jeddah	4,108,156	22773	7.3
Ta`if	1,228,314	224,5	19.7
Medinah	1,962,558	227,2	14.1
Qaseem	1,337,563	22,4	19.9
Eastern	2,941,236	3205,	10.4
Al-Ahsa	1,165,422	,2555	13.3
Hafr Al-Baten	427,183	,2000	23.4
Aseer	1,725,054	22400	13.9
Bishah	370,800	770	20.8
Tabouk	866,803	,2,70	13.5
Ha`il	654,736	,2,25	17.2
Northern	350,972	,20,0	28.8
Jazan	1,497,377	,2250	12.4
Najran	555,129	,2,00	19.8
Al-Bahah	450,733	,2025	24.1
Al-Jouf	321,388	2,0	26.8
Qurayyat	161,750	470	30.3
Qunfudah	297,516	200	6.7
Total	29,994,272	079,83	13.0

A statistical example of the increase in private health care is the number of hospitals and of beds provided privately in 1994 compared with 2002. In 1994 the percentage of privately run Saudi hospitals was 25.8%, rising to 29.9% by 2002, while the percentage of private hospital beds rose from 15.8% to 19.8%. The private sector now provides health services at primary, secondary and tertiary level (Mufti; 2000; MOEAP, 2003) argues that the sector has been growing rapidly over the past several years. The government policy of encouraging private sector participation in all aspects of the economy has led to a growth in commerce, industry and health, in response to increasing demand for health services and a shortfall in the public sector ability to meet it. For example, waiting lists to access the services of public hospitals may be as long as two years Hassan (2006). Therefore, the Saudi government has approved the provision of NHI by private sector agencies. In addition, Mufti (2000) states that in order to provide health facilities to qualifying individuals and organizations, the government purchases services from the private sector. Some private facilities have beds set aside for government patients. Some of the large private hospitals have all the latest in medical diagnostic equipment and are in direct competition with the public specialist hospitals for provision of highly specialized procedures **(**Al-Otaibi, 2010).Al-Hammadi Hospital, the Saudi German Hospital Group, and Almanac Healthcare Group are ones of the leading hospitals in the private sector healthcare that have a multinational working staff (Aldossary et al., 2008; Almalki et al., 2011; Yusuf, 2014).

Health insurance was introduced as a nationwide change by policy makers in the last recent decade (Khaliq, 2012). Through this trend, the governmental finance role played by the MOH was adjusted to oversee and regulate the health services. This newly adopted approach came into effect in phases that were initiated in phase one (2006) by the Cooperative Health Insurance Act of 2003 (CHIA) stating that all employees are insured by their employers (Alkahtani, 2008). Comprehensive health insurance for the whole employment period was secured for expatriate employees and their dependents and of course Saudi nationals in the private sector (Alkahtani, 2008; Saudi Gazette, 2010). The Council of Cooperative Health Insurance (CCHI) reported appreciable progress in the CHIA implementation where the companies that had already got health

insurance registration were 26 with 8.4 million that included 1.87 million Saudi nationals and 6.47 million expatriates (CCHI, 2010; Khaliq, 2012).Advanced and more recent reports aims to provide and review what has been achieved by the year 2015 compare them with previous years to measure the achievements and progress of the Council's activities and highlights and envision the sector Council strategy for 2020 and future projects and initiatives implemented within the Council that will see the Governors visions and outcomes to comprehensive development including health insurance sector in Saudi Arabia (CCHI, 2015).

All public health sector employees were expected to join the health insurance policy in phase two, when prevention, standardization and supervision were planned to be the major roles of the MOH, whilst, the private sector was recruiting most of the public sector hospitals (Walston et al., 2008). These arrangements about health insurance, being sponsored by employers, were expected to embody some ambiguity and vague images concerning the future of PHCs and public hospitals, with exemption of the armed forces and few other corporations (Khaliq, 2012).

The progress and implementation of this Insurance Act (CHIA) was met by several challenges and some inevitable delays due to insurance cost fluctuations, fraud and weak infrastructure (Alkahtani, 2008;Khaliq, 2012).

Though, health awareness level in the society was increased due to these multichannel health bodies but, duplication of efforts and waste of resources were a direct consequence to loss of coordination and lack of clarity of communication channels in between(Alhusaini, 2006; Albejaidi, 2010). A royal decree was forwarded during 2002, founding the Council of Health Services to overcome these obstacles for the provision of up-to-date and comprehensive health care (Health system profile. Saudi Arabia, 2011). This Council was to correct, coordinate and integrate all the health care services that still demanded further progress and achievement (Alkhazem, 2009; Almalki et al., 2011COHS, 2013).

The Saudi Health Registries was established according to and based on the royal cabinet of ministries resolution No. (11) Dated 12/1/1434H, as part of the national center of health information. It aimed mainly that the Saudi diseases registries department was to be the authorized body for supervision, regulation and to support development of national related events/diseases registries in the Kingdom of Saudi Arabia. It has responsibilities over the current registries and setting standards for creating of new registries. The by-law of diseases registries was approved by Saudi health council resolution NO. (66/7) dated 13/9/1434 H (COHS, 2017). The role of this body is in dispensable in future plans of in the field of e-health in general and e-medicine and Telemedicine in particular. By application and employing these methodologies and advanced electronic systems services of excellence could be elicited in collaboration with national and international organizations in delivering and provision of training programs for the staff to ensure secure, confidential and high quality data standards.

With respect to the future challenges that really face Saudi Arabia, as per public healthcare and privatization, there are key players in the private healthcare sectors. Those key players, namely Al-Hammadi Hospital, the Saudi German Hospital Group, and the Almanac Healthcare Group offer quite advanced services, but these services are only localized in some large towns and cities (Yusuf, 2014), still this private business is expanding fast.

4. CONCLUSIONS

The wealthy and healthy economic status of the Kingdom encouraged the Saudi government to invest heavily and develop its health sectors and make it modern by attracting expatriate medical personnel from abroad. Thus, the backing of the Saudi government to the Saudi health services had a great effect in its advancement over recent decades in all levels which, was appreciably a lot in primary, secondary and tertiary aspects of care. By creating the central body, (MOH) has introduced several reforms in these services implemented, namely the PHC. Sectors in the public health services, despite these achievements, are still facing several challenges. These include: establishment and popularization of an efficient, specialized, national health systems of information and the introduction of e-health; development of practical policies for national crises; problems of effective management of chronic diseases; advanced and specialized training developments in human resource with competent and efficient saudization; privatization of public hospital services and financial sources diversification; by enhancing the cooperative health insurance, improving and developing of the multiple roles MOH. To address these challenges, empowerment and coordination of all the efforts scheduled to implement and ensure the success of the strategies of the MOH and other related sectors of the Saudi health care systems should continue improvement in all aspects,.

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