Industry Report

Healthcare

Saudi Arabia

August 2011

Economist Intelligence Unit
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Economist Intelligence Unit

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Symbols for tables
"0 or 0.0" means nil or negligible; "n/a" means not available; "–" means not applicable

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Industry Reports from the Economist Intelligence Unit

Industry Reports provide the Economist Intelligence Unit's five-year forecasts for six key industries along with relevant market analysis. They focus on sectoral and sub-sectoral demand in each of 60 countries, and are updated quarterly, semi-annually, or annually depending on the country.

The Industry Reports are driven by the country-based macroeconomic forecasts for which the Economist Intelligence Unit is renowned. An Economist Intelligence Unit country expert examines our forecasts for the key indicators in each industry, taking into account economic and political developments, global and regional trends, and market- or competitor-specific factors that are likely to have an impact on the sector over the next five years. The analyst then provides commentary to outline the implications of these trends for companies in the industry.

The Economist Intelligence Unit's country and industry analysis draws on the expertise of 100 in-house editors and economists, including industry specialists, and a global network of more than 600 contributors. The historical industry data on which our forecasts are based come from a variety of sources. As with all the Economist Intelligence Unit's analysis, we select the most dependable and up-to-date sources available.

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Market data at a glance

Healthcare at a glance

	2006[a]	2007[a]	2008[a]	2009[b]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Life expectancy, average (years)	75.7	75.9	76.1	73.6	73.9	74.1	74.4	74.6	74.8	75.1
Life expectancy, male (years)	71.0	71.2	71.5	71.7	71.9	72.2	72.4	72.6	72.8	73.0
Life expectancy, female (years)	74.8	75.1	75.3	75.6	75.9	76.2	76.4	76.7	76.9	77.2
Infant mortality rate (per 1,000 live births)	19.3	18.6	18.0	17.3	16.7	16.2	15.6	15.1	14.6	14.1
Healthcare spending (SR bn)	45.4	60.6	75.0	67.1	75.0	101.6	100.9	126.1	130.9	138.5
Healthcare spending (% of GDP)	3.4	4.2	4.2	4.8	4.6	4.8	4.8	5.8	5.8	5.8
Healthcare spending (US$ m)	12,125	16,160	20,005	17,888	19,995	27,097	26,908	33,632	34,897	36,944
Healthcare spending (US$ per head)	506	654	784	680	737	968	931	1,128	1,134	1,164
Healthcare (consumer expenditure; US$ m)	1,895	2,341	2,781	2,877	3,139	3,550	3,940	4,282	4,643	4,769

[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.

Market opportunities

	2006[a]	2007[a]	2008[a]	2009[a]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Population (m)	24.0	24.7	25.5	26.3	27.1	28.0	28.9	29.8	30.8	31.8
GDP (US$ bn at market exchange rates)	356.6	384.9	476.3	372.7	434.7	564.5	560.6	579.9	601.7	637.0
GDP per head (US$ at market exchange rates)	14,878	15,568	18,675	14,165	16,017	20,158	19,396	19,442	19,550	20,061
GDP (US$ bn at PPP)	523.0	549.2	584.9	593.9	619.3	670.5	724.2	777.9	839.2	901.8
GDP per head (US$ at PPP)	21,816	22,212	22,935	22,574	22,822	23,943	25,058	26,082	27,267	28,403
Personal disposable income (US$ bn)	99.8	118.0	136.3	136.7[b]	146.0	161.8	177.0	190.8	208.3	227.9
Household consumption (US$ bn)	94.8	112.4	132.5	136.8	148.3	165.5	182.3	198.0	217.0	238.1
Household consumption per head (US$)	3,954	4,546	5,196	5,199	5,465	5,908	6,306	6,637	7,050	7,499
Exports of goods & services (% change)	3.4	2.7	-4.2[b]	-10.0[b]	1.7	7.3	0.5	1.2	2.9	2.2
Imports of goods & services (% change)	25.2	22.2	9.7[b]	1.8[b]	3.3	10.0	6.6	5.3	5.1	4.7

[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.

Key indicators

	2006[a]	2007[a]	2008[a]	2009[a]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Real GDP growth (%)	3.2	2.0	4.2	0.6	3.3[a]	6.7	5.3	4.9	5.1	4.8
Consumer price inflation (av; %)	2.3	4.1	9.9	5.1	5.4	5.6	4.3	3.4	4.3	4.5
Budget balance (% of GDP)	21.0	12.2	32.5	-6.2	7.0	14.4	3.5	-1.8	-6.0	-8.0
Current-account balance (% of GDP)	27.8	24.3	27.8	5.7	16.1	26.1	17.5	13.1	8.5	5.7
Lending rate (av; %)	9.0[b]	8.8[b]	6.9[b]	7.2[b]	7.3	7.2	7.1	6.6	7.7	7.8
Exchange rate SR:US$ (av)	3.75	3.75	3.75	3.75	3.75[a]	3.75	3.75	3.75	3.75	3.75

[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.

Healthcare report

(Forecast closing date: July 27th 2011)

Healthcare spending, international comparison
(% of GDP)

	2006[a]	2007[a]	2008[a]	2009[b]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Saudi Arabia	3.4	4.2	4.2	4.8	4.6	4.8	4.8	5.8	5.8	5.8
US	15.8	16.0	16.1	16.3	16.0	16.2	16.2	16.2	16.2	16.2
Japan	6.5	6.7	6.8	7.0	7.2	7.3	7.5	7.7	7.9	7.9
China	4.5	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7
Germany	10.5	10.4	10.6	10.6	10.6	10.6	10.6	10.6	10.6	10.6

[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.

Healthcare spending *Five-year forecast*

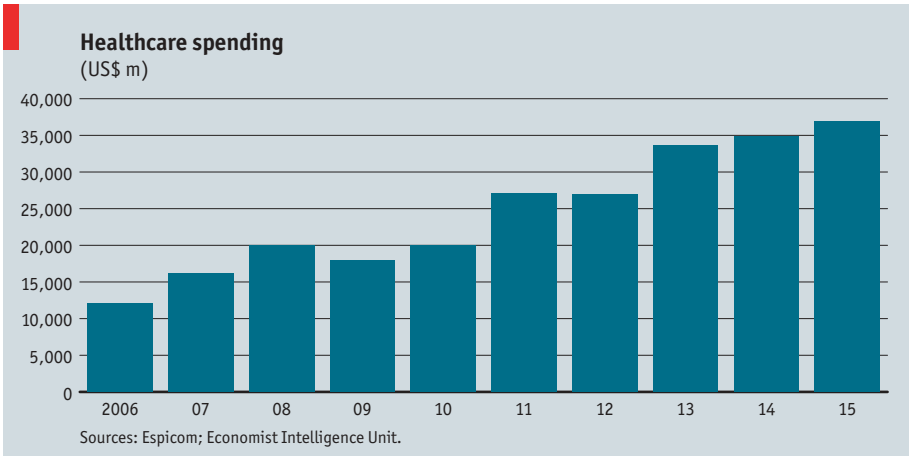
- Saudi Arabia spent an estimated 4.6% of its GDP on healthcare provision in 2010, which is similar to other Gulf Co-operation Council (GCC) states but low in comparison with most developed countries.
- Total spending per head in Saudi Arabia is catching up with some of the other oil-rich Gulf states, following strong increases in recent years. This trend of growth is expected to continue during 2011-15, driven mainly by government spending but also by rising demand for private healthcare. We expect spending to rise by an average of 9.6% a year between 2010 and 2015.
- Given the state's overweening desire to ensure stability in the kingdom in the wake of the Arab Spring, total spending on the country's healthcare sector—including the construction of 110 new hospitals—will continue to rise strongly over the forecast period, reaching 5.8% of GDP in 2015.
- Although the fiscal account is set to move into deficit from 2013, a very low public debt stock and large financial reserves mean that the government is well placed to maintain strong state spending levels over the forecast period.
- Some efforts are under way to increase the role of the private sector in public-private partnerships, with the aim of improving efficiency and overcoming the management problems in some public hospitals. Purely private healthcare is also likely to expand further, although its expansion will be constrained by the local political culture: most Saudis see free public healthcare as a right.

Income and demographics

	2006[a]	2007[a]	2008[a]	2009[a]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Nominal GDP (US$ bn)	356.6	384.9	476.3	372.7	434.7	564.5	560.6	579.9	601.7	637.0
Population (m)	24.0	24.7	25.5	26.3	27.1	28.0	28.9	29.8	30.8	31.8
GDP per head (US$ at PPP)	21,816	22,212	22,935	22,574	22,822	23,943	25,058	26,082	27,267	28,403
Private consumption per head (US$)	3,954	4,546	5,196	5,199	5,465	5,908	6,306	6,637	7,050	7,499
No. of households ('000)	4,270	4,410	4,550	4,630[b]	4,711	4,818	4,931	5,048	5,168	5,291

[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.



Funding sources

- Around two-thirds of all healthcare spending is financed by the central government. The government funds healthcare both directly and indirectly through subsidies to private-sector institutions. Recurrent costs (such as salaries and pharmaceuticals) will continue to account for the vast majority of government healthcare spending.
- The health and social services allocation in the budget more than doubled between 2005 and 2010, boosted by booming oil revenue, and, despite the global recession, it has since nearly doubled again. The 2011 budget allocation for healthcare has risen by 12% to SR68.7bn (US$18bn), or 11.8% of total spending.
- In early 2011 King Abdullah bin Abdel-Aziz al-Saud announced a raft of new spending measures, worth US$130bn, designed to forestall social unrest. As part of these plans, the state health sector will receive an extra US$4.3bn to expedite the upgrading of the country's medical facilities, although there was no mention over what time period the money will be disbursed.
- Bureaucratic bottlenecks have hindered implementation of the government's ambitious hospital expansion plans and, aware of this, the government is seeking to encourage private-sector involvement in the sector. With this in mind, in March 2011 the king announced that the loan limit (provided by the Ministry of Finance) for private hospitals will be raised from SR50m (US$13m) to SR200m.
- The most important factor shaping healthcare demand is population growth of 3% a year. Saudi nationals make up slightly less than three-quarters of the population and are entitled to free healthcare. Free healthcare is also available to religious pilgrims, with the Red Crescent Society, the Ministry of the Interior and the armed forces all providing treatments and facilities.

Healthcare: key indicators

	2006[a]	2007[a]	2008[a]	2009[b]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Life expectancy, average (years)	75.7	75.9	76.1	73.6	73.9	74.1	74.4	74.6	74.8	75.1
Life expectancy, male (years)	71.0	71.2	71.5	71.7	71.9	72.2	72.4	72.6	72.8	73.0
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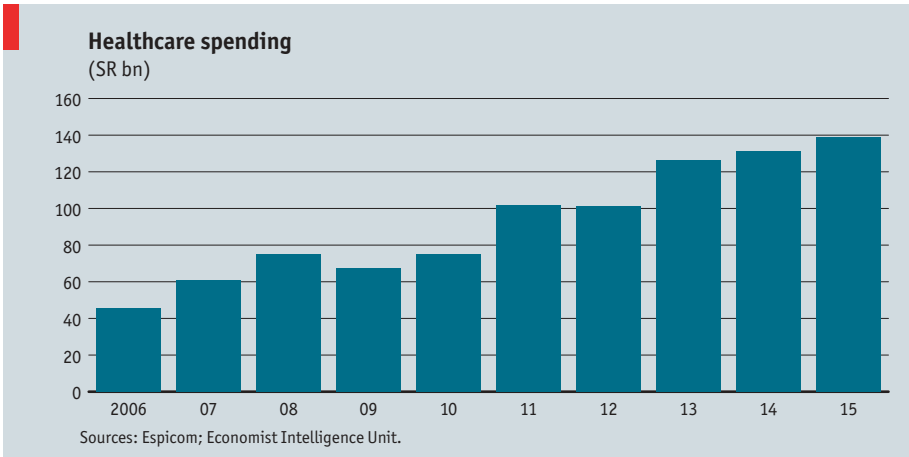
Healthcare (consumer expenditure; US$ m)	1,895	2,341	2,781	2,877	3,139	3,550	3,940	4,282	4,643	4,769
Doctors (per 1,000 people)	1.9	1.9	1.8	1.8	1.8	1.8	1.8	1.8	1.8	1.8
Hospital beds (per 1,000 people)	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3

[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.



Private health insurance

- Private spending typically accounts for one-quarter of total healthcare spending.
- The growth in private health insurance has been largely led by the requirement, phased in since 2001, for expatriates to have medical insurance coverage, which they need to renew their residence and work permits. Companies are mandated to provide the insurance premium, from a minimum of SR1,000 per employee to a maximum of SR250,000.
- According to the Co-operative Health Insurance Council (the health insurance regulator), total private health insurance premiums reached US$1.3bn in 2009, and, as of May 2008 (the latest data available), there were 23 insurance firms and 989 businesses included in the scheme, covering 3.4m non-Saudis and 332,000 Saudis.
- Although the expatriate population will continue to increase, growth in private health insurance over the forecast period will increasingly be driven by Saudi nationals, despite the government's continued commitment to state healthcare. This will probably be assisted by government lending and other forms of support.

- Having initially rolled out mandatory health insurance for foreign employees in 2001, in 2009 it was announced that a health insurance scheme would be introduced for 1.5m Saudi nationals (and their families) employed by small and medium-sized private-sector companies. The law became mandatory in 2011.
- In the medium term, officials have suggested that the government may introduce a national health insurance scheme for all Saudi citizens, which would be publicly funded and would finance healthcare for nationals at either public-sector or private-sector hospitals. However, this is likely to be some years away.

Healthcare provision

Healthcare recruitment

- The doctor/patient ratio is 1.8 per 1,000 people, which is low compared with most OECD countries. Although the government has invested in medical training, the health system remains heavily reliant on expatriate doctors and nurses, who make up a large majority of the total working in the kingdom.
- According to the latest Ministry of Health data, 21.9% of physicians, including dentists, were Saudi nationals at end-2009, but a much higher 46.9% of nurses were Saudi.
- The healthcare sector's ability to recruit is limited by "Saudiisation" quotas, which require firms to employ a certain proportion of Saudi nationals. A new quota system, Nitaqat, will be introduced in November 2011.
- Nitaqat will be akin to a traffic light system: foreign workers at "red" companies will lose their permits, while qualifying "green" companies will be able to recruit from "yellow" and "red" companies. Companies in the "yellow" category will be unable to renew their workers' visas after six years.

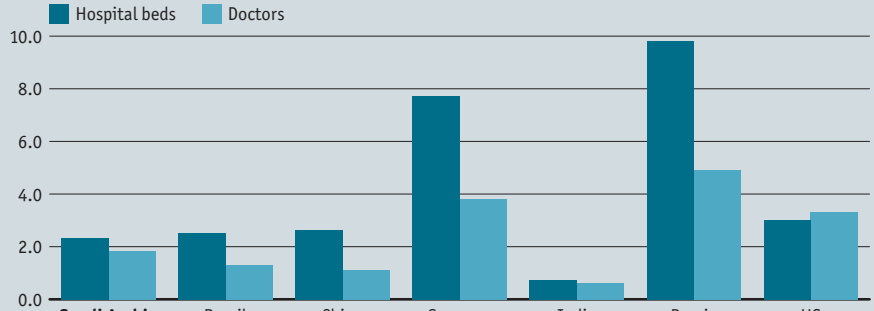
Saudiisation quotas for health services under the Nitaqat system

Less than ten employees:
Red: 0%
Yellow: 0%
Green: 0%
Excellent 0%
10-49 employees:
Red: 0-4%
Yellow: 5-13%
Green: 14-29
Excellent: 30%+
50-499 employees:
Red: 0-9%
Yellow: 10-15%
Green: 16-29%
Excellent: 30%+

500-2,999 employees
Red: 0-9%
Yellow: 10-19%
Green: 20-34%
Excellent: 35%+
3,000 or more
Red: 0-9%
Yellow: 10-19%
Green: 20-34%
Excellent: 35%+

- The government plans to invest in training more nationals in medicine, and aims to establish five new medical schools, although the timeline is not clear. The Princess Nora bint Abdulrahman University, the largest women-only university in the world, was expanded in May 2011, and now includes a 700-bed teaching hospital.
- Although the availability of Saudi nationals will increase, the supply of trained Saudi health workers will struggle to keep pace with the mass of new hospitals coming on stream. As a result, the influx of expatriate health workers will continue.
- The lack of foreign workers' rights will occasionally cause tensions with their home countries. Nevertheless, although most recently Saudi Arabia has banned domestic workers from Indonesia and the Philippines (after strong criticism from those countries over the treatment of their nationals), it is notable that this restriction does not cover health workers.

Hospital beds and doctors, international comparison, 2010
(per 1,000 population)



Sources: Espicom; Economist Intelligence Unit.

Hospitals and clinics

- The government is currently pursuing an extremely ambitious hospital construction programme, which will eventually increase the total number of hospitals operated by the health ministry to 354, up from 244 in 2009.
- It is doubtful that the government will fulfil all of its spending plans, as its construction programme has typically lagged behind schedule. The tough

local financing environment will also restrain the construction programme by limiting the involvement of the private sector.

- Most public hospitals are run by the Ministry of Health. Several other public-sector institutions operate hospitals for their employees, including the Ministry of Defence, the Ministry of the Interior, the National Guard, Saudi Aramco (the state-owned energy monopoly), the Royal Commission for Jubail and Yanbu (Marafiq), Saudi Airlines and some universities. (The number of university hospitals is set to increase significantly, funded from the education budget.)
- The standard of public hospital facilities can be extremely high, although some are now in need of modernisation. Equally, with multiple stakeholders and weak co-operation between departments, there is a lack of cohesion in national health strategy. In an effort to address this, a new Supreme Health Services Council was established in 2010 to co-ordinate healthcare policy.
- There were over 400 hospitals at the end of 2009—244 under the health ministry, 39 under other government agencies (2008 figure) and 125 private hospitals. There were 1.7 public-sector hospital beds (out of a total of 2.3 beds) per 1,000 people at end-2008, according to the latest available figures from the central bank, compared with 2.6 beds per 1,000 people in 1986.
- Overcrowding is far worse in urban areas, where the ratio of beds to people is usually lower, since rapid population growth in major cities has tended to outstrip the pace of new hospital construction. Besides hospitals, there are also 2,037 smaller health clinics across the country, with over half of these including a dental surgery.
- A government-commissioned study by Booz & Company, a US management consulting firm, in 2008, envisaged demand for hospital beds leaping from 51,000 in 2007 to 70,000 in 2016. However, problems with public-sector management of hospitals and bureaucratic delays are leading policymakers to advocate a greater role for the private sector in constructing and operating hospitals.
- As of 2009 there were 125 private hospitals—almost half located in Riyadh and Jeddah—accounting for around 30% of hospitals and providing 21.2% of total hospital beds. Private extensions have also been built to some state hospitals, and there could be an increasing trend of hospitals offering private services (for instance to expatriates) to diversify their revenue streams.
- It will prove particularly difficult to attract sufficient private investment into more impoverished areas, however, which means that the government will need to bear a large part of the costs involved in extending health services to the kingdom's large rural population.
- Privatisation of over 200 public-sector hospitals has been discussed since at least 2002, but not much progress has been made. With the government keen to avoid any domestic tensions in the wake of the Arab Spring, a mass privatisation programme is unlikely. However, rather than being sold, hospitals may instead increasingly be leased out under a management contract.

- There is a well-established private hospital-management sector in Saudi Arabia, with some 100 facilities currently run by the likes of Saudi German Hospital Group, Kingdom Holding and the Saad Group. Dr Mazen Fakeeh, director-general of Dr Soliman Fakeeh Hospital, says that the private sector needs to invest US$20bn in Saudi healthcare in the next 20 years.
- Providers will increasingly offer low-cost options, or offerings that include a credit package. One provider, Salam Home Health Care, launched examination and treatment services in 2009 that are offered at patients' homes in some regions of the country, presenting a lower-cost alternative.
- As the domestic healthcare sector develops, fewer nationals will travel abroad for treatment. Before the 1990s, patients requiring specialist medical services routinely travelled to Europe or the US for treatment, which was paid for by the government. However, it is noteworthy that senior members of the royal family continue to prefer treatment in US or European hospitals.
- An increasing number of foreigners are also seeking medical treatment in Saudi Arabia. The Supreme Commission for Tourism and Antiquities (SCTA) issued a report in early 2010, which stated that medical tourism in 2007 amounted to SR800m (US$213m).

Pharma and biotech

International comparison

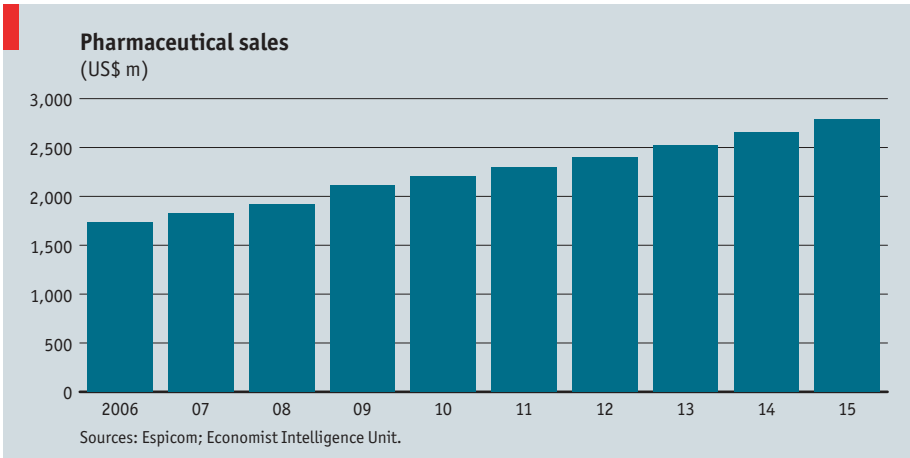
- The pharmaceutical market was worth a relatively modest US$2.2bn in 2010, compared with US$4.7bn in Egypt, for example. Nevertheless, the Saudi pharmaceutical market remains the largest in the Gulf Arab states.
- The government has sought to stimulate domestic production through various measures, including subsidies and bulk drug purchases by the government, but overall this sector has not been a priority for the traditionally state-directed economy.

Pharmaceutical sales

	2006[a]	2007[a]	2008[a]	2009[b]	2010[b]	2011[c]	2012[c]	2013[c]	2014[c]	2015[c]
Pharmaceutical sales (US$ m)	1,734	1,823	1,916	2,109	2,199	2,295	2,399	2,521	2,649	2,783

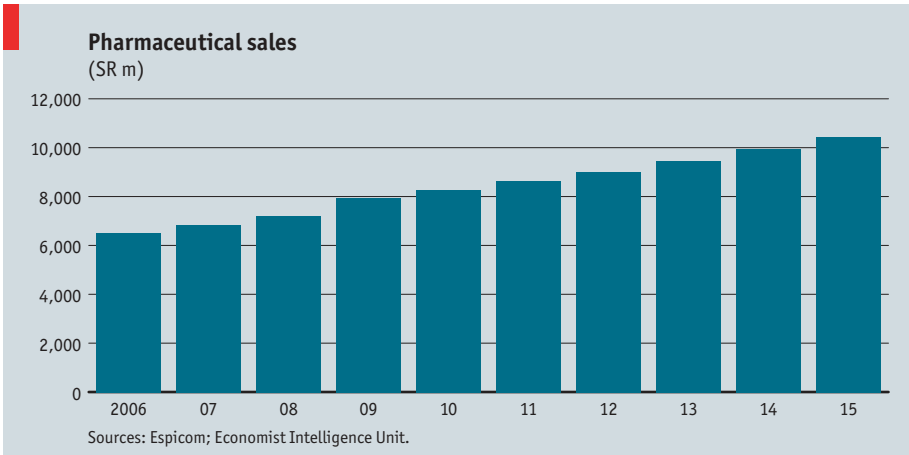
[a] Actual. [b] Economist Intelligence Unit estimates. [c] Economist Intelligence Unit forecasts.

Source: Economist Intelligence Unit.



Five-year forecast

- The Saudi pharmaceutical market is forecast to expand by some 4.8% per year over the forecast period, to reach US$2.8bn by 2015. This is equivalent to US$90 per head in 2015. Branded products are more popular than generics, but this situation should begin to shift over the forecast period as the government seeks to contain costs by increasing its purchase of generic drugs.
- Precise data are lacking but it is believed that around 35% of pharmaceuticals by value are purchased by the government, with the remaining 65% bought by the private sector (private healthcare facilities and out-of-pocket purchases by individuals).
- At present the two major purchasers of pharmaceuticals are the health ministry and the Secretariat-General of Health (SGH). The health ministry is the single largest buyer of pharmaceuticals in the country, buying about US$200m per year. With an ever growing budget, it will be well placed to increase pharmaceutical purchases over the forecast period.
- The SGH is also the executive arm of the Health Ministers' Council of the GCC. It holds a large annual tender for medicines and other goods for distribution to hospitals around the Gulf.
- Up to 85% of total pharmaceutical sales come from abroad, of which the private sector typically purchases around two-thirds. The country is also an exporter of pharmaceuticals, although sales have fluctuated markedly in recent years.



Pricing

- In 2007 the government set up a public-sector company, the National Unified Procurement Company for Medical Supplies (Nupco) to be the sole supplier of medicines and medical appliances to Saudi government institutions. This is intended to help to reduce prices, which have been driven up by inefficiencies in procurement.
- The kingdom's existing medical import and distribution firms, however, have complained that Nupco is driving them out of business, as they cannot

compete on scale. There are ten medical importers who are reported to have invested SR5bn (US$1.3bn) in cold-storage vehicles, warehouses and offices.

- Price controls are an issue for exporters into Saudi Arabia. Since July 2009 responsibility for setting the local retail prices for all imported drugs has been the job of the Saudi Food and Drug Authority (SFDA).
- According to PhRMA, a US-based body that represents the interests of multinational pharmaceutical firms, the health ministry typically bases its prices on the lowest prices found elsewhere, and that the comparison countries selected are not genuinely comparable to Saudi Arabia in terms of income levels or drug-consumption patterns.
- A range of price reductions ordered in 2008 led to complaints that they will reduce incentives for the introduction of innovative new drugs to the local market. Despite the government's aim to attract increased foreign investment in domestic drug manufacturing, ad hoc interference with medicine prices will remain a feature of government regulation in the forecast period.

Item	Price (US$)	% of monthly personal disposable income	Affordability rank
Aspirins, 100 tablets (supermarket)	5.40	1.27	26 out of 55
Routine check-up at family doctor (av)	42.67	10.06	28 out of 55
One X-ray at doctor's office or hospital (av)	33.33	7.86	25 out of 56
Visit to dentist, one X-ray and one filling (av)	213	50.29	43 out of 56

Note. Affordability rank: for each country the price of an item as a percentage of monthly personal disposable income is calculated. Countries are ranked according to these percentages. The most affordable country will have the lowest percentage and be ranked first.

Generics

- Generics are estimated to account for around 15% of the Saudi pharmaceutical market, which is dominated by branded imports. Generics are mostly produced locally, and local firms concentrate on generic production, sometimes exporting to other Middle Eastern countries.
- As part of its strategy to reduce spiralling health costs, the government aims to promote the use of generics, especially in the public sector. The government is also trying to encourage domestic generics production, in a bid to create jobs. These efforts have had limited success, as consumers continue to opt for more expensive, branded medicines (although insurers will prefer affordable drugs).

Pharma and biotech supply dynamics

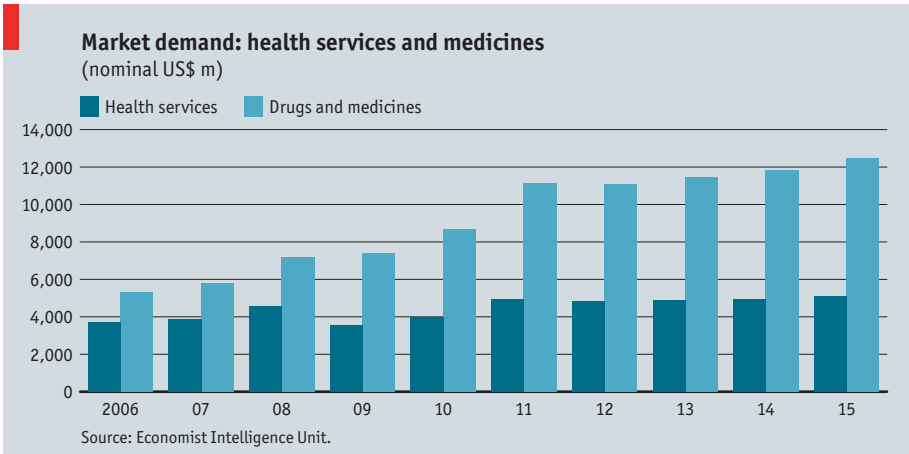
- The local pharmaceutical industry is relatively small and supplies only around 15% of the market. Local firms mainly produce generic products, and original research and development (R&D) is limited. However, the government is enthusiastically seeking to encourage R&D in the country, with a number of laboratory research centres opened in Jeddah and Riyadh.
- In terms of imports, the principal overseas suppliers are European medicine manufacturers from the UK, Germany, Switzerland, Liechtenstein and France,

as well as the US. According to the latest data available, in 2008 Saudi Arabia imported some US$2.27bn of pharmaceuticals. However, there may be rising demand for low-cost generics from emerging markets owing to price competitiveness.

- Although heavily dependent on imports, Saudi Arabia is also a small exporter of, predominately, retail medicaments. In 2008 total pharmaceutical exports reached US$145m. The leading export destination was Sudan, followed by the UAE, Egypt and Jordan.
- There are currently at least nine domestic pharmaceutical manufacturers, operating 27 factories. Four multinationals also have local production facilities.
- The leading local pharmaceutical firm is GlaxoSmithKline of the UK, which operates a joint venture with Banaja Saudi Import Company, which has a 51% stake in Glaxo Saudi Arabia and is both a manufacturer and a distributor. The joint venture is the largest pharmaceutical company in Saudi Arabia in terms of sales, with a market share of around 10%.
- The largest Saudi-owned manufacturer is the Saudi Pharmaceutical Industries & Medical Appliances Corporation (Spimaco). Spimaco accounts for 72% of private-sector drug sales in the domestic market, which equates to US$139m. Spimaco has operations across North Africa and the Middle East, and has recently expanded into Europe.
- The second-largest all-Saudi pharmaceutical manufacturer is the Tabuk Pharmaceutical Manufacturing Company, which makes generics for the local market and some export markets. According to Tabuk, some of its products are approved for use in European countries including France and Denmark. The company is a subsidiary of the Arab Supply and Trading Company.
- Another leading manufacturer is the Saudi Japanese Pharmaceutical Company, a joint venture between the local Tamer Group, a medical importer and distributor, and two Japanese firms, Astellas and Daiichi-Sankyo, which produces a mixture of generics and licensed products.
- Domestic pharmaceutical manufacturing is set to expand during the forecast period, in part encouraged by regulatory changes (including a change in the law that allows overseas pharmaceutical companies to build facilities from scratch and to manufacture drugs in the country with 100% ownership).
- Recent investors include Sanofi-Aventis of France, which has signed an agreement with Emaar the Economic City (EEC) to build a plant in King Abdullah Economic City, north of Jeddah, to manufacture a range of branded products, starting with oral anti-diabetic and cardiovascular medicines.
- A Swiss drug manufacturer, Novartis, announced in late 2010 that it had struck a deal with a local vaccine manufacturer, Arabio, to build a new facility that will produce three of Novartis's commonly-used vaccines. Novartis is hoping to challenge Glaxo as the leading supplier of vaccines in the country.
- In March 2011 it was announced that Shamla Pharmaceuticals Industries (a partnership that includes a Saudi firm, Zimmo Trading, as well as an Egyptian and Syrian partner) will build a plant in King Abdullah Economic City

(KAEC), with production set to begin in 2012. The plant will serve both the domestic and overseas market.

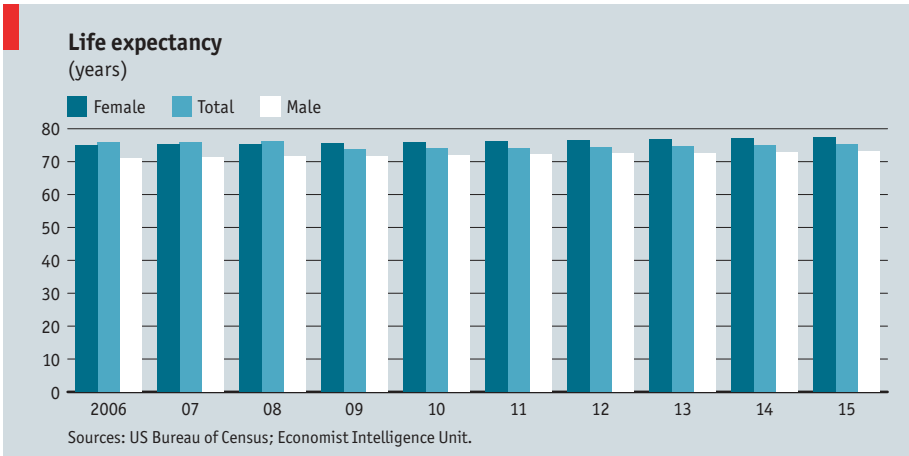
- It is also now possible for foreign firms to operate pharmacies in the country. Taking advantage of this, a Dubai-based chain, Planet Pharmacy, has expanded into Saudi Arabia, trading under the name Zahrat al-Rawdah.
- The government is also looking to encourage investment in biotechnology, and, with that in mind, the Jeddah BioCity complex (located in King Abdulaziz University) has been created. Among several high-profile deals, Jeddah BioCity has invested US$15m in US-based Genway, which will allow it to transfer Genway's antibody manufacturing expertise to Saudi Arabia.
- Despite the kingdom's increasing success in attracting outside investment, development of the domestic pharmaceutical industry will continue to be constrained by the kingdom's weak copyright protection and extensive counterfeiting.
- In 2010 the US Trade Representative removed Saudi Arabia from its Priority Watch List, after advice from the International Intellectual Property Alliance (IIPA) year later. However, in February 2011, the IIPA recommended that Saudi Arabia go back on the list, owing to what the IIPA deemed unacceptably high piracy rates, and a general lack of deterrent enforcement actions.
- Development will also be constrained by the cumbersome approvals process. Before importing a pharmaceutical product into Saudi Arabia, a company needs to be registered with the health ministry and its drug product must have been approved. It can take two to three years for such approval to be granted, as the ministry requires local tests to be carried out.



Disease trends

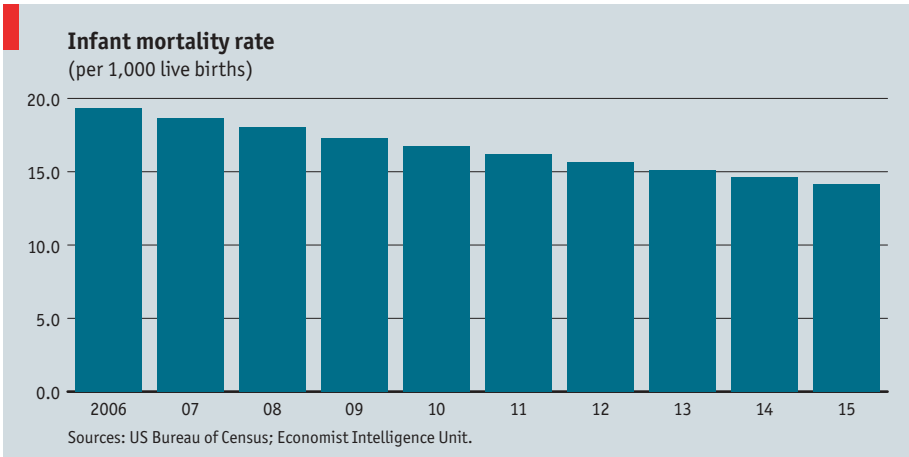
Population health

- This expansion of healthcare has greatly improved health indicators in the country. Life expectancy in Saudi Arabia averaged an estimated 73.9 years in 2010 (compared with 63.9 years in 1989)—although this remains far way below the 81 years seen in Sweden—and the rate of infant mortality has fallen from 26 per 1,000 live births in the early 1990s to 16.7 per 1,000 live births in 2010.



Demographic trends

- Population growth is forecast to average 3.2% a year in 2011-15, marginally higher than in 2006-10, as inward migration offsets the impact of a slow and gradual decline in the national fertility rate. Most of the population is under 25 and around one-third is under 15.
- Saudi Arabia has a very small proportion of over 65s—just 2.4% of the total in 2010, compared with 5.4% in Egypt and a global high of 21.6% in Japan. With the share of over-65s expected to rise only slightly in Saudi Arabia, to 2.6% in 2015, the burden on healthcare resulting from an ageing population (a feature of many Western states) will not be much of an issue in the kingdom.
- The heavy reliance on imported labour, together with the social and cultural factors that support the dominance of men in the private-sector workforce, creates a gender imbalance whereby Saudi women make up just over one-third of the population, with expatriate men making up nearly 30%.



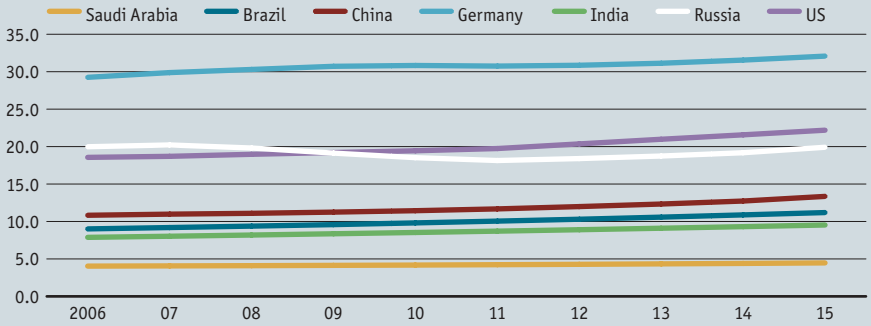
Major disease trends

- As in many developed countries, non-communicable diseases such as cancer and cardiovascular disease are now the main causes of death. Nonetheless,

Saudi Arabia still has infectious diseases more commonly associated with developing countries, such as malaria and tuberculosis.

- Low levels of exercise, widespread consumption of fatty and salty foods and a high level of obesity will take their toll on the general standard of health. Cardiovascular illnesses and diabetes are likely to remain particular problems.
- As of 2008 a staggering 20% of nationals over the age of 20 suffer from type-2 diabetes, brought on by poor diet and sedentary lifestyles. This is one of the highest rates in the world, although on a par with levels in the UAE. The World Health Organisation (WHO) predicts that by 2030 there will be 2.5m diabetes sufferers in Saudi Arabia.
- The region's diabetes epidemic may have been a factor behind the decision of a German company, Linde Engineering, to participate in a project to build a plant in Saudi Arabia to manufacture insulin.
- In addition, there are concerns about the spread of AIDS; the social stigma attached to the disease suggests that the real incidence of AIDS and HIV is almost certainly higher than the official estimate of some 15,213 (a cumulative figure since 1984). According to the health ministry, over 70% of those diagnosed are expatriates.

Old-age dependency ratio, international comparison
(%)



Sources: US Bureau of Census; Economist Intelligence Unit.

Risk factors

- Despite having only the 46th largest population in the world, Saudi Arabia is the 23rd biggest consumer of cigarettes. Although the government has launched a series of anti-smoking campaigns in recent years, they have achieved little. A law to ban smoking in airports was passed in October 2010, but it is routinely flouted (including by airport officials).
- With some 19% of teenagers being smokers, smoking-related diseases are set to remain a major feature of the ill-health in the kingdom. However, alcohol is illegal in the kingdom, and as such the country does not suffer from the host of alcohol-related health problems evident in many Western countries.
- In recent years, the government has launched AIDS awareness campaigns and has begun to provide free and confidential anti-retroviral treatment for

nationals, but expatriates found to have the disease are typically jailed and then deported.

- In March 2011, the health ministry launched its Salamat campaign. The programme includes sending medical experts to travel around the country teaching youngsters about preventative healthcare.
- According to the WHO, Saudi Arabia has the world's highest traffic fatality rate. Although the government has launched road safety campaigns (with slogans on plastic bags, for example), the prevalence of dangerous, young Saudi drivers is set to remain a feature of life in the kingdom as long as severe restrictions on their social interaction remain in place.