Healthcare In the Middle East – Gaps, Challenges, Reforms & Opportunities

Healthcare disparities have been prevalent in the Middle East countries since more than last 2 decades.

Social determinants of health like poor education access and quality, economic instability, neighbourhood & built environment & social and community context leads to healthcare disparities

Conflict in Middle East region has had an additional adverse effect on the health care systems, making solutions even more challenging.

However, recognition of the problems that loom large for various diseases identified and non-identified can provide an opportunity for international collaboration that focuses on providing patient and physician education and identifying strategies to improve access to specialized health care.

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Challenge/s in the Middle East:

Middle East- World's Health Care Professionals

Health care systems, needs, and outcomes in countries of the Arab world (Middle East) are as varied as the countries themselves. Their pre-existing conditions, especially those affected by conflict, political instability, poverty, and corruption, play a large part in a health system's ability to function, particularly as it relates a lot to health workforce migration.

Key Challenges to Healthcare Workforce in the Middle East

Conflict and instability drive health worker shortages in countries like Djibouti, Somalia, Sudan, Yemen, Gaza, and Syria. Bombings kill or displace staff, destroy facilities (e.g., 70% of Syrian workers fled; only 51% of Yemen's facilities functional in 2022), and disrupt training. Even non-conflict areas suffer: Lebanon's economic crisis post-2020 Beirut explosion slashed wages (e.g., doctors earning <50 cents/hour), spurring emigration.

Gulf states like Saudi Arabia face rising demand (240% increase projected; needs 20,000 more doctors by 2030) but lose locally trained staff to the West despite Vision 2030 efforts. Low pay (e.g., $200/month in Egypt), poor conditions, and lack of

supplies push graduates abroad, wasting training investments (e.g., Sudan loses $24M/year).

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Emerging Trends and Solutions

Expand training with incentives: Build medical schools (Saudi Arabia: 5 to 37; Egypt: new colleges; Jordan: private licenses) and offer better wages/job security to retain nationals.

Empower women: Reform laws for training/mobility, add maternal leave to boost female doctors, addressing patient preferences and gender gaps. Policies supporting gender equity, like mobile clinics for women in conservative regions, enhance access without undermining cultural values.

Telehealth growth: Market to expand 26.3% by 2030 amid rising internet use; eases access but doesn't replace physical staff or fix emigration. Example: The UAE's "Doximity-like" online platforms, for instance, link patients with specialists remotely, something that could be replicated in poorer nations with the help of international donors. Investment in digital literacy and broadband infrastructure is paramount to make these technologies universally accessible.

Policy shifts: Reduce expatriate reliance (Gulf region); avoid poaching from fragile states per WHO, invest in retention over recruitment.

A robust local workforce is essential for stability, as global shortages (10M by 2030) and shocks like COVID highlight vulnerabilities.

Partnerships to meet workforce needs:

Scholarships and forgiveness of educational loans can attract doctors and nurses to rural or conflict areas. International medical school partnerships can also improve training quality, as evidenced by Qatar's partnership with Weill Cornell Medicine.

International Collaboration and Aid

Inter-governmental institutions and successful Middle Eastern countries can invest in the **development of healthcare in war zones**. NGOs and the WHO can act as facilitators for the exchange of knowledge, supply chains, and infrastructure rebuilding. Saudi Arabian humanitarian assistance to Yemen, for instance, could be direct investments in reconstruction in healthcare using sustainable systems rather than relief.

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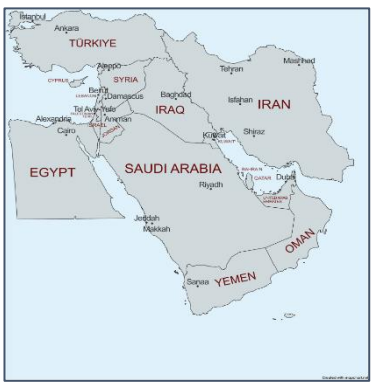
Healthcare Happening / Timeline	Significance
Early 20th Century: Community-based healing practices	Marked the rudimentary start of healthcare, relying on traditional methods before modern infrastructure
1970s-1980s: Formation of Gulf health cooperation (e.g., joint medicine purchasing); Establishment of Arab Board for Medical Specializations (1978) and Masters in Epidemiology (1983)	Promoted regional collaboration, quality medicines at lower costs, and specialized training, improving health standards across Arab countries
2017: UAE launches first national AI strategy	Aimed to reduce non-communicable disease burden and position UAE as AI hub, initiating digital transformation in healthcare
Post-COVID era (2020s): Digitization for disease monitoring, telemedicine (e.g., Okadoc USD10M funding)	Enabled virtual consultations, compliance tracking, and recovery improvements despite oil price constraints; built high-tech medical cities in UAE, Qatar, Saudi Arabia
Vision 2030 (Saudi Arabia) and Dubai Health Investment Guide (ongoing)	Transformed healthcare from cost center to economic asset via FDI, natively digital ecosystems, and platforms like Seha Virtual Hospital; projected regional healthcare IT market at $7.9B by 2028.
Source: https://duphat.ae/evolution-of-healthcare-in-the-middle-east-region/	



Diverse region with a combined population exceeding 500 million, total GDP around $4-5 trillion (GCC alone ~$2.5T), and healthcare expenditure projected at $200B+ annually by late 2020s, heavily led by Gulf states

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Population

- 1)~550 million (2025 est.), with Egypt (~110M), Turkey (~85M), and Iran (~90M) as largest; Gulf states like Saudi Arabia (37M) and UAE (10M) have high per capita wealth
- 2) Growth driven by youth bulges in Levant/Iran and migrant labor in GCC

GDP

- 1)Aggregate GDP: Approximately $4.5 trillion (nominal, 2025), dominated by oil-rich GCC (Saudi ~$1.1T, UAE ~$0.5T, Qatar high per capita)

Healthcare Expenditure

- 1) GCC healthcare spending reached ~$100B+ in 2023, projected to $135B by 2027
- 2) UAE has allocated 3.5 per cent and Saudi Arabia 5.7 per cent of their GDP to healthcare expenditures and are expected to rise further

Disease Patterns

Non-communicable diseases dominate: diabetes projected +96% by 2045, rising CVD/obesity; MERS-CoV persists (19 cases in 2025, mostly KSA). Conflict zones (Syria, Yemen, Iraq) face infectious outbreaks, malnutrition; wealthier states prioritize preventive digital health.

Country Group	Pop (M)	GDP ($T)	Health Exp (%GDP)	Key Diseases
GCC (e.g., Saudi, UAE)	~60	~2.5	3-6%	Diabetes, CVD, obesity
Egypt/Turkey	~195	~1.5	~4-5%	NCDs, hep C
Iran/Iraq	~170	~0.7	~5%	Sanctions-hit NCDs, conflict trauma
Source/s: https://www.worldhealthexpo.com/insights/healthcare-management/me-builds-resilient-healthcare-systems-with-shift-toward-population-health-management				
https://www.oecd.org/en/publications/health-at-a-glance-2025_8f9e3f98-en.html				

	Life expectancy at birth (years)	Adult mortality rate[b] (both sexes)	Infant mortality rate[c] (both sexes)	Hospital beds (per 10,000 population)	Medical doctors (per 10,000	Nursing and midwifery personnel
	(2019)	(2016)	(2020)	(2017)	population)	(per 10,000 population)
Algeria	77.13	95.03	19.46 (18.47–20.52)	19 (2015)	17.19 (2018)	15.48 (2018)
Bahrain	75.81	56.81	5.78 (4.34–7.73)	17.40	9.26 (2015)	24.94 (2015)
Djibouti	65.81	244.50	47.18 (28.17–76.07)	14.00	2.24 (2014)	7.29 (2014)
Egypt, Arab Republic	71.82	164.60	16.65 (11.31–24.23)	14.30	7.46 (2019)	19.26 (2018)
Iran, Islamic Republic	**77.35**	**80.13**	**11.14 (6.53–18.92)**	**15.60**	**15.84 (2018)**	**20.77 (2018)**
Iraq	**72.42**	**173.50**	**21.32 (16.4–27.48)**	**13.20**	**9.66 (2020)**	**23.87 (2020)**
Jordan	77.87	110.50	12.92 (9.35–17.66)	14.70	26.61 (2019)	33.47 (2019)
Kuwait	80.97	79.22	7.58 (7.04–8.16)	20.40	23.42 (2020)	46.83 (2020)
Lebanon	76.44	95.62	5.97 (2.77–12.04)	27.30	22.07 (2019)	16.74 (2018)
Libya	75.78	150.30	9.53 (5.58–16.16)	32.00	20.91 (2017)	65.31 (2017)
Morocco	72.99	69.06	16.02 (11.36–21.85)	10.00	7.31 (2017)	13.89 (2017)
Oman	73.90	96.25	9.45 (8.38–10.68)	14.70	17.74 (2020)	39.38 (2020)
Qatar	77.17	61.76	4.93 (4.42–5.5)	12.50	24.85 (2018)	71.97 (2018)
Saudi Arabia	74.31	89.13	5.99 (4.61–7.94)	22.40	27.38 (2020)	58.17 (2019)
Sudan	69.15	223.90	39.92 (29.96–53.04)	7.40	2.62 (2017)	11.46 (2018)
Syrian Arab Republic	72.67	301.10	18.45 (9.58–24.45)	14.00	12.87 (2016)	15.41 (2016)

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Tunisia	77.04	91.00	14.29 (12.64–16.09)	21.80	13.03 (2017)	25.14 (2017)
United Arab Emirates	76.08	73.95	5.62 (4.95–6.4)	13.80	26.01 (2019)	57.46 (2019)
Yemen, Republic	66.63	221.30	45.71 (23.97–81.09)	7.10	5.25 (2014)	7.85 (2018)
Source/s	• https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2022.1045739/full • WorldHealthOrganization. The Global Health Observatory, Indicators Index. (2022). Geneva: World Health Organization. Available online at: https://www.who.int/data/gho/data/indicators/indicators-index (accessed November 15, 2022) • **b** Adult mortality rate is defined as the probability of dying between 15 and 60 years per 1,000 population. • **c** Infant mortality rate between birth and 11 months per 1,000 live births					

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Emerging Trends: Universal Healthcare coverage - Middle East countries

	GDP US$ per capita (2019)	Current health expenditure (CHE) per capita[b] in US$ (2019)	Current health expenditure (CHE) as % of gross domestic product[c] (GDP) (%) (2019)	Government health spending as % of current health expenditure[d] (CHE) (%) (2019)	Out-of-pocket expenditure as % of current health expenditure[e] (CHE) (%) (2019)	Priority to health (GGHE- D%GGE)[f] (2019)
Algeria	3,976	248.20	6.24	65.00	33.44	10.73
Bahrain	23,443	940.40	4.01	59.20	29.73	7.23
Djibouti	3,437	61.81	1.80	53.70	24.15	4.28
Egypt, Arab Republic	3,161	149.80	4.74	27.80	62.75	4.66
Iran, Islamic Republic	7,010	470.40	6.71	49.50	39.49	21.40
Iraq	5,568	253.30	4.48	49.40	50.10	5.99
Jordan	4,405	334.00	7.58	51.20	30.29	12.80
Kuwait	31,999	1759.00	5.50	87.00	11.79	8.93
Lebanon	7,668	663.10	8.65	49.00	33.54	13.43
Libya	9,337 (2006)	309.90 (2011)	6.05 (2011)	65.40 (2006)	36.67 (2011)	6.42 (2011)
Morocco	3,282	174.20	5.31	39.90	46.81	7.12
Oman	15,343	624.70	4.07	86.40	6.56	7.98
Qatar	62,088	1807.00	2.91	72.80	12.33	6.50
Saudi Arabia	23,140	1316.00	5.69	69.20	16.50	11.05
Sudan	1,026	46.93	4.57	22.70	67.38	5.56
Syrian Arab Republic	1,958 (2012)	69.83 (2012)	3.57 (2012)	45.30 (2012)	53.69 (2012)	4.47 (2012)
Tunisia	3,349	233.10	6.96	57.10	37.94	12.58
United Arab Emirates	43,103	1843.00	4.28	52.30	12.51	7.40
Yemen, Republic	1,446 (2012)	73.18 (2015)	4.25 (2015)	23.90 (2012)	80.96 (2015)	2.23 (2015)

Source/s: https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2022.1045739/full#T1
b Per capita current expenditures on health expressed in respective currency—US dollar.
c The level of current health expenditure expressed as a percentage of GDP.
d The share of governmental health spending of total current health expenditures.
e The share of out-of-pocket payments of total current health expenditures.
f Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%): is the share of general government expenditures funding current health expenditures

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Universal Health care Coverage

Country	Health expenditure (Latest available)	World bank income group	FP index	SCI in 2021 per WHO	UHC index
Algeria	5.53 (2021)	Upper-middle income (UMC)	N/A	74	N/A
Bahrain	4.27 (2021)	HIC	97.5	76	86.1
Djibouti	2.88 (2021)	LMC	98.4	44	65.7
Egypt	4.61 (2021)	LMC	82.3	70	76.0
Iran	5.77 (2021)	UMC	91.9	≥74	82.7
Iraq	5.25 (2021)	UMC	88.8	59	72.1
Jordan	7.29 (2021)	LMC	96.5	65	79.1
Kuwait	5.78 (2021)	HIC	95.9	78	86.4
Lebanon	10.06 (2021)	LMC	79.0	73	75.7
Libya	4.02 (2011)	UMC	72.0	62	66.9
Morocco	5.74 (2021)	LMC	95.5	69	81.4
Oman	4.37 (2021)	HIC	99.7	70	83.5
Qatar	2.89 (2021)	HIC	99.2	76	87.0
Saudi Arabia	5.97 (2021)	HIC	99.1	≥74	85.9
Sudan	2.84 (2021)	Low income (LIC)	90.4	44	62.8
Syria	3.05 (2012)	LIC	96.4	64	78.6
Tunisia	6.97 (2021)	LMC	91.2	67	78.2
United Arab Emirates (UAE)	5.31 (2021)	HIC	99.8	82	90.3
Yemen	4.25 (2015)	LIC	87.2	42	60.9

Sources: [6, 13-15]

Legend for the SCI:

Very high coverage-high coverage (≥80)

High coverage (60–79)

Medium coverage (40–59)

Low coverage (20–39)

Very low coverage (<20)

Table illustrates MENA's countries range of income levels, health expenditure, as well as SCI and FP indexes (https://doi.org/10.1016/j.dialog.2026.100291)

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Methodology & Key takeaways:

1. Analyses progress toward Universal Health Coverage (UHC) in the Middle East and North Africa (MENA) region
2. Comparative case study approach across selected MENA countries (likely including high- and low-income examples like UAE and Somalia based on related works), using the WHO-World Bank UHC monitoring framework to assess service coverage and financial protection indices
3. Reviewers screened publications on UHC components (service coverage, financial protection) post-UN resolutions, resolving discrepancies via consensus
4. UHC in MENA aims for equitable access to quality services without financial hardship, aligning with SDG 3.8, but faces barriers like fragmented financing, high out-of-pocket spending, urban-focused infrastructure, and low primary care coverage. Achieving it requires expanded pooling, fiscal reforms, and multi-sector interventions to reduce inequities, especially in low/middle-income countries where indices average ~75% but service gaps persist. Progress is uneven, with only a few countries (e.g., UAE at 90%) nearing targets, highlighting needs for legislation, PHC expansion, and reduced OOP to boost solidarity and efficiency

Middle East & Africa Pharmaceutical Market Insights

IQVIA Inc.

(Report Release Date: Jun 2024 Analytical Timeframe: MAT Mar 2024)

Market Performance and Growth Trends

- The MEA pharmaceutical market reached $32.6 billion in Q1 2024, growing 7.8% compared to the previous period.
- Value sales increased by 10.5%, while volume sales declined slightly by 0.9%.
- Retail channels dominate with 68.5% of value sales, growing at 11.5% PPG.
- Hospital channel growth is notable, with value increasing by 8.4% but volume decreasing by 2.2%.
- MNCs hold 59.4% of the market, with local companies growing at 10.2% in value.

Regional Market Insights

- Saudi Arabia remains the largest market at $11.6 billion, expanding 9.1% PPG.
- UAE is the second-largest, with $4.1 billion in sales, growing 16.5% PPG, driven by newer antidiabetics.

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Key Market Players and Company Dynamics

- Top multinational companies include Sanofi, Novartis, and GSK; Eli Lilly is the fastest-growing at 82% PPG.
- Local companies like Jamjoom Pharma, Hikma, and SPIMACO are expanding rapidly.
- Local/regional companies contributed 40% of total sales, with Hikma and Tabuk among the largest

Market Forecasts and Future Outlook

- The global pharma market is projected to reach $2.32 trillion by 2028, with MEA expected to reach $64.1 billion.
- MEA's CAGR from 2023-2028 is forecasted at 4.6%, slightly below the global rate.
- The region's growth is driven by local/regional players, with notable expansion in key markets like KSA, UAE, and Kuwait.

Product and Therapy Area Trends

- Alimentary tract treatments are the leading therapy area, accounting for 20% of regional sales.
- Antineoplastic and immunomodulators are the fastest-growing therapy class at 17% PPG.
- Key therapy areas include systemic anti-infectives, nervous system, and cardiovascular systems.
- Growth in specific therapies is driven by market demand, with notable increases in anti-ulcerants and antidiabetics.

Additional Sources:

- https://pubmed.ncbi.nlm.nih.gov/39559798/
- https://insightscaremagazine.com/addressing-healthcare-disparities-in-the-middle-east/
- https://www.iqvia.com/library/podcasts/clinical-trials-landscape-in-the-uae-and-middle-east
- https://www.thelancet.com/journals/langas/article/PIIS2468-1253(25)00346-2/abstract