Saudi Arabia: Obesity Health System

Economic classification

High Income[1]

Health system summary

Saudi Arabia has a national health care system that is provided and financed by the Ministry of Health. Full and free at point of service care is available to all citizens (as well as expats working within the public sector), with services provided for at primary, secondary and tertiary level. Free healthcare is also provided to the approximately 2 million pilgrims visiting the holy cities (Mecca & Medina), putting an immense strain on the healthcare budget. This public system also struggles with staffing, with most health professionals being expatriates. In response, the Ministry of Health has committed to doubling the number of professionals training by 2020.

To complement the national system, there is cooperative health insurance provided by private employers and the government (for public workers only). This is compulsory for all working non-Saudi nationals and Saudi nationals who work in the private sector. Citizens also have the choice to have private health insurance schemes to enter the private healthcare system.

Where is Saudi Arabia's government in the journey towards defining 'Obesity as a disease'? 

Where is Saudi Arabia's healthcare provider in the journey towards defining 'Obesity as a disease'? 

In practice, how is obesity treatment largely funded? 

(🟢: Government, 🟠: Insurance, 🔴: Out of pocket expense, ⚪: Unknown)

Have any taxes or subsidies been put in place to protect/assist/inform the population around obesity? 

Is there specialist training available dedicated to the training of health professionals to prevent, diagnose, treat and manage obesity? 

Bariatric only

Are there any obesity-specific treatment recommendations or guidelines published for adults? 

Are there adequate numbers of trained health professionals in specialties relevant to obesity in urban areas? 

Are there any obesity-specific treatment recommendations or guidelines published for children? 

Are there adequate numbers of trained health professionals in specialties relevant to obesity in rural areas? 

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Obesity prevalence

33.5% Women	24.1% Men
18.0% Girls	18.4% Boys

Overweight prevalence

28.0% Women	33.4% Men
14.2% Girls	12.0% Boys

Key prevention policies

⇒ Mandatory calorie labels on menus

⇒ Tax on carbonated and energy drinks

Summary of stakeholder feedback*

Stakeholders reported that a lot of work have been in obesity prevention and control in recent years, with obesity being recognised as a disease by many.

There is said to be a range of treatment options available that are government funded. Demand, however, is high in the public sector and so many of those seeking treatment obtain support via the private system as an out of pocket expense. Demand in the public system is said to be so high that people only get treatment when there have comorbidities, and even then, it is on a case by case basis. Bariatric surgery and obesity medication is also covered by the cooperative health insurance for those that meet the criteria (BMI ≥45 kg/m² for surgery) but this is a recent change.

It was generally agreed that one of the main ways in which people enter the system is via referral when they have comorbidities and their obesity is affecting their health. However, treatments are more readily available in urban areas, with patients in rural areas commonly referred to the cities.

Stakeholders noted that government and association guidelines exist but suggested that these are not yet fully implemented within the health system and at times they did not match insurance criteria. For example, government guidelines recommended surgical intervention for those with a BMI≥ 35 kg/m² with comorbidities, but cooperative health insurance only covers surgery when BMI≥ 45 kg/m².

It was reported that there is limited specialist obesity training available. There appears to be a focus on bariatric surgery, with trainees funded to train. Away from this, there is one bariatric surgery fellowship program and a bariatric medicine fellowship program, but they are both located in Riyadh. Stakeholders called for more training that encouraged multidisciplinary working.

**Based on interviews/survey returns from 6 stakeholders*

Perceived barriers to treatment

- Lack of political will and interest
- Lack of treatment facilities
- Lack of training for healthcare professionals
- Lack of treatment guidelines and/or pathway
- Poor availability of pharmaceuticals
- Cultural norms and traditions
- Lack of knowledge of treatment options
- Lack of opportunity for physical activity

References

1. https://blogs.worldbank.org/opendata/new-country-classifications-income-level-2019-2020 (last accessed 29.08.2019)

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