

Investing in quality Healthcare in the UAE

A report by The Economist Intelligence Unit



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About this research

Investing in quality: Healthcare in the UAE is an Economist Intelligence Unit report. The findings are based on desk research and interviews with a range of experts from government and business, conducted by The Economist Intelligence Unit. This research was commissioned by Waha Capital.

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Executive summary

As part of the government's national strategy, the United Arab Emirates is seeking to raise the quality of healthcare to international best-practice standards by 2021. What are the main quality gaps to be overcome in this period? How are changes such as mandatory insurance laws, management outsourcing of public facilities, regulatory devolution and increased rates of accreditation and data collection influencing quality of care?

This study, based on extensive desk research and interviews with leading experts from government and business, identifies the key healthcare quality challenges and the implications of changes in the health system for service quality.

The key findings are as follows:

Staff and skills are the main capacity gaps.

Hospitals and clinics are not at full capacity, suggesting that physical infrastructure is keeping up with demand. Human capital challenges are more pressing. Expatriate workers dominate the sector but are transient, causing high levels of churn in the system. Financial and non-financial incentives could encourage them to lengthen their stay, bringing stability and greater continuity of care, while mobile health technologies could reduce the numbers of staff needed to meet demand.

Growing private participation brings benefits and risks for service quality.

The private sector is taking on a bigger role in health provision, providing more beds, doctors and nurses. Management outsourcing of public hospitals has attracted international healthcare providers bringing best-practice standards, while healthcare free zones place higher service-quality requirements on companies. At the same time, a rush of investment poses a threat if inexperienced investors are not well versed in the unique dynamics of the healthcare sector.

Regulatory devolution allows each Emirate autonomy over a number of policies, but can fragment the system.

Abu Dhabi, Dubai and Sharjah have been taking a larger share of responsibility for health policies. However, the development of differing protocols and standards can impede service quality and make it harder to attain scale across the UAE, increasing transaction costs of operating across emirates. Relocating staff can become difficult owing to differing licensing processes, for example. Authorities must strike the right balance between local autonomy and a harmonised system.

Increased rates of accreditation to global patient safety standards, and greater data collection on patient outcomes, will provide

the first comprehensive picture of the UAE's real quality-of-care standards. Data on service quality have historically been scant. This means limited information to guide patients on where to seek treatment or to help regulators or payers (insurance companies) oversee quality of service. Perceptions of low quality may have been the result of insufficient data rather than facts. Increased accreditation to global standards, such as those of the Joint Commission International,

and increased data collection of patient safety outcomes are now gathering pace, especially in Abu Dhabi, followed by Dubai. With plans to collect and publish more of these critical data over 2015-16, patients will be able to make informed decisions about local treatment, and governments and payers can use such data as leverage in remuneration policies, pricing and licensing.

1

Reaching the 2021 goal

As part of the government's national strategy, the UAE seeks to raise the quality of healthcare services to international best practice by 2021, requiring significant efforts by both public and private actors.

Historically, healthcare in the UAE—and across the Gulf—has been perceived as being of lower quality than in many developed countries. Residents typically use the local system for diagnosis and routine services. For major surgery or the treatment of serious conditions, such as cancer, expatriates often return to their home countries, and many Emiratis choose to travel to the West for treatment (particularly to Germany, Switzerland and the US), even if the procedures are available in the UAE. A Gallup survey in 2012 showed that two in five Emiratis had a preference for treatment abroad.¹

These high rates of outward medical tourism may be down to common perceptions of low quality, rather than objective data. A 2012 survey by the Dubai Health Authority found that almost 10% of those who travelled abroad for treatment did not even attempt to seek local medical advice before leaving. "The community still has trust in the quality of the services being provided outside

of the country, so they will need time to build up trust in their own healthcare providers. That relies on what governments are going to do in the coming years to enhance and improve the services being provided," says Laila Al Jassmi, former CEO of the Health Policy and Strategy Sector, Dubai Health Authority.

Reasons for the perceived quality shortfall in the UAE relative to developed-country peers include the small population, which limits the exposure of doctors to uncommon conditions or surgeries, and the fact that the development of their skills in comparison with countries with larger caseloads is limited. It is also the result of poor outliers undermining the sector's reputation. David Hadley, CEO of Mediclinic Middle East, compares the situation to the Costa Concordia cruise ship disaster in Italy in 2012: "One captain crashes a boat and suddenly everybody is cancelling their cruise trips. The same happens here in healthcare. One hospital or provider makes a mistake, and everybody tarnishes the healthcare service in the UAE as being of a low quality, which is not true." Lack of data on quality of service in hospitals and clinics leads patients to rely on word of mouth to guide their decisions.

¹ "Evidence from the national health account: the case of Dubai", *Risk Management and Healthcare Policy* (2014), Vol. 7, pp. 163-175. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4181628/#b17-rmhp-7-163>

What is quality healthcare?

The most influential framework for discussing quality in healthcare delivery is the Donabedian Model, named after the physician and medical researcher who developed it at the University of Michigan.² The model looks at three aspects of healthcare delivery: structure, process and outcomes, all of which can be quantified with a wide range of metrics.

Structure looks at the context within which healthcare is delivered, such as the number of hospitals, the kind of equipment they use, the numbers and skills of their staff. Metrics related to this category include figures such as the number of beds or doctors relative to the size of the population served, or the average years of experience of the doctors.

Process looks at the way healthcare is delivered, such as the stages of a patient's journey—through consultation, diagnosis and treatment—as well as the manner in which it is delivered through the relationships between medical staff and patients. Metrics related to this category include the number of tests conducted, waiting times and the average length of stay in hospital.

Finally, **outcomes** are the end-result of the healthcare delivered, including changes in patients' health—improvements, errors, complications and mortality rates—as well as patients' subjective opinions of the quality of care they have received.

The three categories are closely interrelated and often correlated, although it is possible

that individual metrics may give contradictory indications of care quality. For example, while a low ratio of hospital beds to population numbers and long waiting times are negative indicators of quality, highly skilled doctors might still be able to produce good health outcomes despite such limitations.

According to our research, hospitals and clinics are operating at relatively moderate occupancy levels in the UAE, suggesting there is no overall capacity gap, although there are gaps in specialised areas. This paradox could be explained by the fact that people are travelling abroad for treatment; it may also be that there are large numbers of uninsured low-income workers who fail to seek treatment for financial reasons. Lastly, interviewees for this report believe that the market may have overheated, with potentially too many new private providers overlapping in areas where economies of scale (in terms of the fuller utilisation of skills and technologies) might be preferable, such as heart surgery. Some infrastructure capacity gaps are, however, evident. The Health Authority Abu Dhabi (HAAD) notes that the most severe shortages in Abu Dhabi are found in intensive care, followed (in no particular order) by emergency care, neonatology, paediatrics, oncology, orthopaedics, rehabilitation, psychiatry and some surgical specialties (especially oncology, neurosurgery and plastic surgery).³ Its 2012 data showed that occupancy levels in intensive care units, at well above 75%, were too high, exerting particular pressure on paediatric intensive care.

² Donabedian, Avedis (1988), "The quality of care: How can it be assessed?", *Journal of the American Medical Association*, 121 (11): 1,145-1,150.

³ <https://www.haad.ae/haad/tabid/816/Default.aspx>

2 Human capital

With the UAE’s health infrastructure at a relatively advanced level, the priority area is to improve staffing—both numbers and skill sets. After a period of decline in the early part of the last decade, the numbers of doctors and nurses have been growing since 2007. The share of doctors in the private sector grew by 15% between 2007 and 2012, while in the public sector their share fell from 47% to 32%. The trend applies to beds as well, with the private sector share growing from 21% to 33%, compared with a fall in the public sector from 79% to 67%. Private-sector growth in overall capacity was particularly marked in 2012, with 37% annual growth in hospital beds (as seven new hospitals opened), a 42% increase in doctors, a 48% increase in nurses and a 67% increase in the number of dentists (an area where the private sector has an 85% share).⁴

However, the government’s staffing goals for 2021—a 50% increase in the number of doctors and nurses per capita—necessitates a continuing upward curve at steeper rates than is currently the case. In addition to raw numbers, there are also skills gaps; a 2013 report identified a shortage of specialist physicians in histopathology, oncology, occupational medicine and infectious diseases.⁵ Given that it takes at least six years to train a doctor, these goals suggest that expatriates will continue to represent a major component of service delivery.

Increasing the number of medical personnel and attracting highly skilled expatriates depends in part on the working environment, and the UAE is a strong performer on many liveability indicators. The increased inflow of workers since 2009 suggests that the UAE is an attractive location,

⁴ The number of hospital beds in the public sector fell slightly between 2007 and 2012, while growing at an annualised rate of 12% in the private sector, increasing from 21% to 33% of total beds. There are a number of large public hospitals under development (such as Al Jalila Children’s Speciality Hospital in Dubai), and when these open, the public sector’s share will rebound somewhat.

⁵ T Loney et al., “An analysis of the health status of the United Arab Emirates: the ‘Big 4’ public health issues”, (2013), *Global Health Action* 2013, 6:20100.

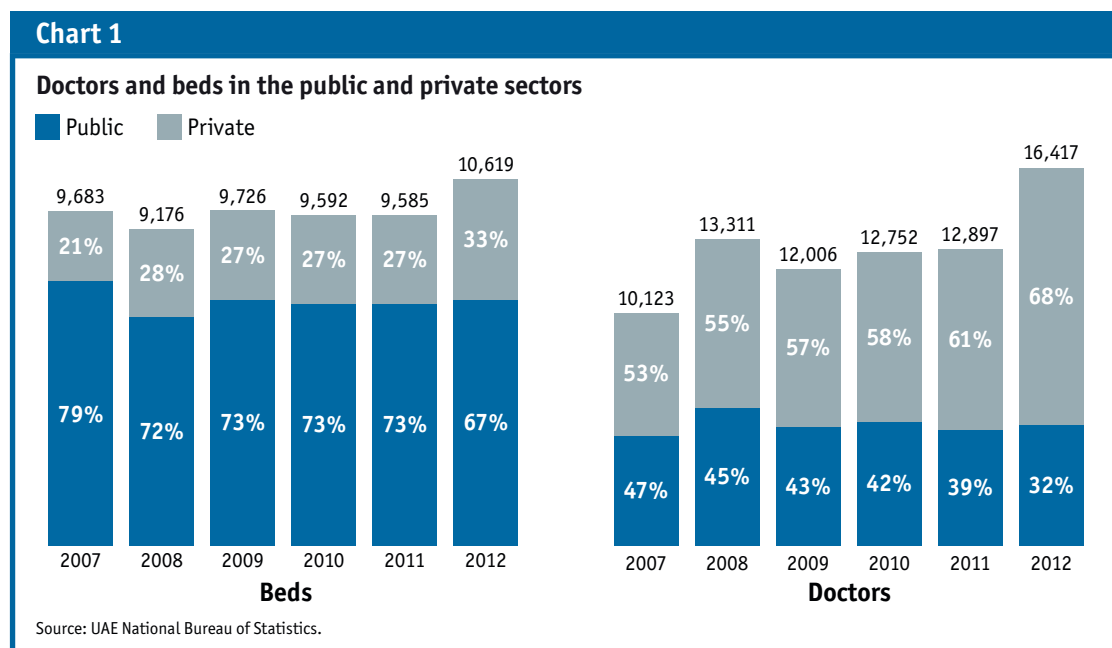
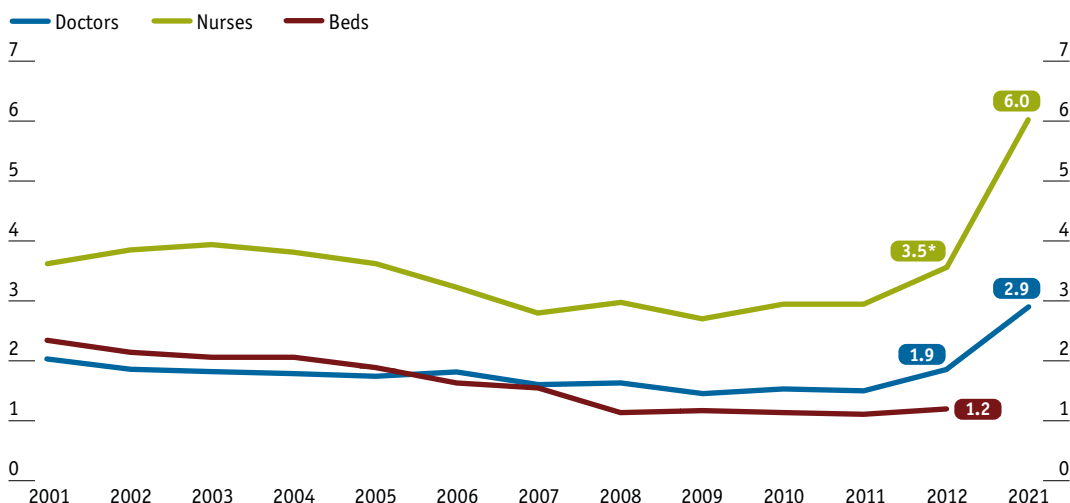


Chart 2

Doctors, nurses and beds

(per 1,000 people)



* The WHO gives an average of 4.1 nurses in 2006-13, probably because of a different definition to the NBS (e.g. including paramedics).
Source: National Bureau of Statistics; National Agenda targets for 2021 shown.

thanks to its developed infrastructure, liveability, public services, stability and liberal environment. However, expatriates need additional motivations to stay in the country, rather than pursue opportunities in other countries where local citizens form the majority of the health workforce.

The transience of healthcare workers hinders care quality, increasing disruptive churn in the system, adding administrative burdens in managing inflows and outflows of staff, and reducing continuity of care and the embedding of locally relevant skills and cultural sensitivities. “While in the future the emerging ‘eHealth’ agenda might partially replace direct patient interactions, healthcare provision today still centres on repeat personal contact,” says Dr Julia Sperling, principal at the consultancy McKinsey & Company. “This contact happens when the patient meets the person who treats them, be it a doctor or a nurse or an allied healthcare professional, and with this dependence on an international workforce to provide a lot of these services [in the UAE], you have the problem of a workforce in flux, a high turnover, patients going back and not being under the care of the same

doctor or perhaps not even the same institution for long periods of time.”

To tackle this issue, expatriate medical workers need sufficient incentives to stay for longer periods. Financial incentivisation policies could be considered, such as offering new staff bonuses tied to longer-term stints. In addition to financial incentives, there are other measures that could help improve incentives for skilled health workers to move to smaller emirates, including fast-track residency and permission for 100% ownership of a health practice through a “free zone”-style policy tool.

To increase the length of time expatriate staff spend in the UAE, consideration will also need to be given to the quality of their working life. One survey of nurses in the UAE compared with nurses in Europe found higher levels of burnout (50% vs 32%) and a greater desire to leave their jobs (53% vs 36%).⁶ The desire to leave is partly because of working conditions and partly because working in the UAE is often seen as “a period of transition before emigrating to Europe, the US, Australia and Canada”, according to Laila Al Jassmi.

⁶ Ghada Sherry, “Nurse & Patient Satisfaction and Quality of Care in the UAE Hospitals. A Cross-Sectional Study of 24 Hospitals”, UAE Nursing and Midwifery Council, March 2013.

A further staffing challenge to be overcome by 2021 is the distribution of skills throughout the UAE, where Dubai and Abu Dhabi are more attractive than the smaller emirates. According to Hans Kedzierski, former CEO of the Sheikh Khalifa General Hospital in Umm Al Quwain, public hospitals in the northern emirates face challenges recruiting staff because the Ministry of Health “believes that when you live in less populated emirates, the package should be substantially lower than salaries offered in Dubai”. Yet well-educated doctors would expect better packages to work in more remote locations.

Recent co-ordination between the UAE’s three main healthcare regulators, which are easing the movement of staff between emirates, should help networks to deploy staff more flexibly, but it brings with it the risk that health workers will come en masse to Dubai and Abu Dhabi, where salaries are higher and the infrastructure is more developed. Financial compensation mechanisms are one potential lever to avoid a clustering of talent in Abu Dhabi and Dubai, but the costs involved would be correspondingly higher.

3

Sector reforms and service quality

The second factor shaping healthcare quality in the UAE is the systemic change occurring in the sector overall—specifically, the growth of the private sector’s share of healthcare delivery and regulatory fragmentation. Both trends are influencing the quality of care in complex and important ways.

Bringing in the private sector

In previous decades, private-sector providers were typically small, stand-alone hospitals and clinics, resulting in a fragmented sector of variable quality. The role of the private sector in UAE health delivery has grown considerably in response to the tripling of the population since 2000, a broadening in medical needs, and efforts to shift the cost burden away from the public sector. Growing demand is driving expansion and consolidation within and between emirates. Some providers have grown from a single long-established location, while others have started chains from scratch or imported internationally recognised brands such as Mediclinic.

This trend looks set to continue. HAAD calls for a sector in which “providers are predominantly private”, while Dubai seeks a 70% private-sector share.⁷ According to the UAE Bureau of Statistics, the private sector’s role is currently larger in Dubai than in Abu Dhabi or the northern emirates. In 2012 its share of outpatients was 71% in Dubai compared with 61% in Abu Dhabi, and for inpatients the ratio was 61% to 41%. This is partly a consequence of the UAE’s unique demography, as expatriates tend to favour private providers. Because it has a larger local population, Abu Dhabi’s public health sector

takes up a larger proportion of the overall provision.

Increased private provision can boost quality of service. Some major chains span multiple levels, from pharmacies and clinics to laboratories and major hospitals, and have the resources to boost quality and ensure consistency in service delivery. International brands taking on outsourced facilities bring best practices from their home regions to the UAE. Abu Dhabi led the management outsourcing of public hospitals approach with the first contract in 2006 with Johns Hopkins, a US teaching hospital, for the management of Tawam Hospital in Al Ain. Johns Hopkins appoints the senior management of the hospital, provides advice and training and helps to attract high-quality medical staff. Currently five hospitals in Abu Dhabi have outsourced management contracts. Dr Mohaymen Abdelghany, CEO of the Al Zahra Hospital, says the opening of the Cleveland Clinic Abu Dhabi in 2015 will raise the bar in terms of quality further: “It’s going to put some pressure on other providers to improve their performance.”⁸

Management outsourcing can also improve quality if the government uses service quality indicators such as readmission rates or waiting times to guide remuneration in a pay-for-performance system, rewarding providers which perform well. In line with government requirements, private operators are already submitting more detailed data on service quality.

However, there are also risks to a pay-for-performance system. In an environment where quality is lacking, pay-for-performance may lead

⁷ <http://gulftoday.ae/portal/a7800343-e4df-47d0-8e69-39e813f2b8e8.aspx>

⁸ Management contracts have also been used in other emirates. For example, since its opening in 2012 the Sheikh Khalifa General Hospital in Umm al Quwain has been managed by NMC Healthcare, a local firm, and Interhealth Canada manages the trauma centre at Rashid Hospital in Dubai.

to a reduction in the number of financially viable providers. The government may then need to channel funding or subsidisation to providers which are near the threshold, as has been the case in several developed health markets. Pay-for-performance incentives need to be balanced against the need to maintain service provisions across areas.

The second channel through which private participation affects quality relates to licensing. To set up in one of the UAE healthcare free zones, providers must meet standards as rigorous as any found in developed markets. Dubai Healthcare City (DHC), launched in 2002, was the UAE's first such healthcare free zone. It is now home to two hospitals and over 120 clinics and laboratories, staffed by about 4,000 medical professionals receiving a million patient visits in 2013. Sharjah Healthcare City is being developed along similar lines and begins leasing land for the construction of the first facilities in late 2014. Free zones permit 100% foreign ownership, zero taxes and full repatriation of profits, but also demand a high standard of service from companies located there. At the same time, there can be a risk to increased private participation outside the free zones, for instance, if there is a rush from investors seeking to enter this space without background or expertise. Mr Hadley of Mediclinic Middle East warns that investors in the healthcare space must possess a deep understanding of the sector's distinctive dynamics.

Fragmented regulation

The second structural change influencing quality of care is regulatory architecture. While the presence of large private healthcare brands can raise quality by bringing in global best practice and generating economies of scale, that is only possible when the market size is large enough to attract significant private investment. However, the recent trend has been towards a fragmentation of regulations across emirates, which could fragment the market.

The first step towards devolution was when Abu Dhabi, the largest emirate, took direct responsibility for its own healthcare in 2001 with the formation of its General Authority for Health Services. In 2007 this split into two bodies: the Health Authority Abu Dhabi (HAAD), responsible for the regulation of the public and private sectors, and the Abu Dhabi Health Services Company (SEHA), in charge of service provision. Meanwhile, in Dubai, in 2007 regulatory responsibility was devolved to the Dubai Health Authority (DHA), which also inherited responsibility for public service delivery. In addition, the Dubai Healthcare City Authority regulates the emirate's healthcare free zone. In the five northern emirates, the UAE Ministry of Health continues to provide both services and regulatory oversight (it also has a small residual presence in Dubai). The Ministry of Health retains certain nationwide responsibilities, such as licensing and controlling the prices of drugs and medical devices. Sharjah, which is the largest of the northern emirates, launched the Sharjah Health Authority in 2010, although it has not replaced the functions of the federal ministry in the emirate.

While this devolution can help avoid a "one size fits all" approach and allows targeted approaches for each emirate, it can also pose a challenge to companies wanting to operate across multiple emirates. Regulatory fragmentation imposes burdens on pan-UAE healthcare providers as they have to function under different regimes and deal with distinctive insurance schemes and pricing systems (see diagram).

The logistical burdens of operating across emirates may mean that providers choose to stick to the largest two emirates by population and income—Abu Dhabi and Dubai. This would increase the disparity of provision between these two and the northern emirates.

Both markets also have challenging rules governing health insurance. When HAAD rolled out its mandatory insurance scheme, it

established a publicly owned company, Daman, to provide subsidised insurance to citizens and low-income workers, as well as to compete in the rest of the market (where it is by far the largest player with one-third of the “enhanced” policies for expatriates). As a result, Daman pays out about 73% of insurance claims by value, giving it the bargaining power of a near-monopoly with providers. The rest of the insurance market is so fragmented that only two other insurers pay more than 2% of claims.⁹ By contrast, in the US, the top five insurers have market shares ranging from 5% to 12%.¹⁰

Although Dubai has not established an equivalent to Daman, it provides health insurance through the DHA to nationals and through the Eyana scheme for government employees. Moreover, the DHA has introduced a new system of capping increases in provider charges. Providers had to request increases in their price list for 2015 capped at 4.2%, justifying them by meeting certain criteria, including in relation to capital investment and quality of service.¹¹ If approved by the DHA, the providers then have to negotiate separately with insurers to accept the new prices. If mandatory insurance is introduced in the northern emirates, then the Ministry of Health may introduce another price-control system.

The combination of a high level of public-sector control over pricing, combined with geographical fragmentation, is an unusual mixture and means that a national chain could end up with different charges for the same service in neighbouring emirates, making it harder to ensure consistency

and limiting the appeal of building a pan-UAE business.

While efforts at price control are understandable given the high rate of healthcare inflation, they could stymie private-sector expansion. Capping price increases may prevent healthcare providers from hiring and retaining the most highly skilled staff, for instance, whose salaries are a major contributor to the health inflation that price caps are intended to moderate.

Finally, fragmentation of rules and regulations, such as those governing the hiring of staff and licensing procedures, are another burden that will complicate administrative procedures for companies wishing to operate in multiple emirates. Relocating staff between emirates becomes more difficult owing to differing licensing processes. This is improving, following an October 2014 agreement between the regulators to establish a unified UAE medical licence. While there is room for differences between emirates, the National Health Council—established in 2008 to co-ordinate between public bodies and the private sector—can play a stronger role in harmonising licensing and standards (such as patient medical records).

The challenge for both private and public entities is to strike the right balance, allowing a nuanced regulatory approach to the unique needs of each emirate while not introducing too many problems for private-sector providers to build scale and achieve the synergies that come from increased resources.

⁹ HAAD, *2013 Statistics Report*, November 2014

¹⁰ National Association of Insurance Commissioners, *2013 Market Share Report*, 2014. These figures relate to market share by premium, but the share by claims paid is likely to be similar

¹¹ <http://www.thenational.ae/business/economy/dubai-healthcare-costs-to-be-kept-in-check-with-inflation>

Seeking a sustainable insurance model for the UAE

Private health-insurance schemes have been available in the UAE for many years, mainly provided by companies as a benefit to higher-income expatriates and their families. The proportion of the population covered grew as the UAE's economy attracted a growing number of middle- to high-income expatriates. However, the recent introduction of mandatory insurance requirements has driven a rapid increase in the insurance market, and subsequently in demand for services.

Abu Dhabi rolled out a mandatory insurance scheme between 2006 and 2008 that provides coverage for various categories of residents. UAE nationals are issued with Thiqa—insurance cards issued by Daman, the public-sector insurance agency. Low-income expatriates receive a basic and partly subsidised insurance policy through Daman. Finally, companies purchase enhanced insurance policies for higher-income employees from a wide range of options offered by licenced insurers.¹²

In Dubai, mandatory insurance is now being rolled out under a February 2014 law. Companies with over 1,000 employees are already required to comply, and all firms will be included by June 2016, as well as dependants and domestic workers. The scheme is being implemented in phases to give providers time to respond to the increased demand placed on them. Before the roll-out, only about one-third of the 3m residents were estimated to be insured.

The northern emirates are likely to be next: a federal law on mandatory insurance was drafted in 2013, but it is unclear when it will be signed

off (similar drafts were considered in 2004 and 2007 but not passed). In the meantime, there is partial insurance coverage in these emirates by some companies and public-sector bodies, including for all employees of the Sharjah government and their dependants, under a scheme launched in 2013.

Mandatory health insurance is critical to equitable access to health. By giving lower-income residents the opportunity to receive medical treatment, it inevitably increases the utilisation of the health system. Insurers receive increased numbers of claims and must manage cost inflation from providers, which pass on costs such as increasing wage bills for doctors and workers. Negotiations between regulators, employers, insurers and healthcare providers determine the level of financial resources deployed by the private sector, and thereby influence the quality of care available to those at the different insurance policy levels.

Sami Alom, CSO at the Al Noor Hospitals Group, points out that the average enhanced premium is about one-fifth of the cost of private health insurance cover in Europe. Given that the cost of providing care in the UAE is not significantly lower than in Europe, raising quality will ultimately require higher premiums. However, the increase may be moderate, because the demographics of expatriate workers in the UAE (predominantly men, mainly aged 20-40 and healthy enough to travel abroad for work) mean that their demands for healthcare, and hence the premiums required for quality care, will be considerably less than they would be among the average population. ■

¹² The policies differ considerably as regards co-payment deductibles, annual coverage limits, the range of providers included and special features included or excluded (such as maternity, dental, optical, pre-existing and chronic conditions, vaccinations, repatriation).

4

Harnessing data

The final factor influencing service quality concerns data and certifications—their use and their impact. Aligning with international quality standards, publishing data on patient service outcomes and using data to drive accountability are all powerful mechanisms for raising standards.

The UAE's push for the accreditation of providers to global standards escalated in 2006, with some hospitals now having completed three accreditation "cycles". The most popular standard is that awarded by the Joint Commission International (JCI), a US-based non-profit organisation. So far, 58 hospitals and 39 other medical programmes in the UAE have received a JCI Gold Seal, representing 14% of the JCI's global accreditations across 63 countries; this compares with just one accreditation before 2006. The JCI has also assisted HAAD in developing its standards for licensing hospitals.

Accreditation is becoming compulsory. Dubai requires all hospitals to be accredited by the JCI or another member of the International Society for Quality in Health Care (ISQua) within two years of opening. The 2014 National Agenda has set a target for all hospitals across the UAE to be accredited by 2021, up from 41% in 2012. As well as boosting standards, the process of accreditation and periodic reviews also provides a quantitative measure of quality. However, while JCI accreditation is a crucial step, Sami Alom, CSO at the Al Noor Hospitals Group, argues that "it only measures process not outcomes ... and should be viewed as a minimum standard; hospitals that will stand out in the

pay-for-performance environment are those that incorporate outcomes into everything they do."

Collecting and acting on data is the second part of the equation. As Mr Alom implies, adherence to best-practice process is a big step in strengthening the quality of healthcare. But collating data on the quality of outcomes is just as important. Data are improving, thanks to the roll-out of mandatory insurance schemes that generate information on the performance of healthcare facilities, incidence rates and patients' journeys through consultations, tests and treatment. These data are helpful for assessing the quality and efficiency of service delivery and identifying capacity gaps.

HAAD has begun using information from its electronic insurance claims system to develop disease progression models in Abu Dhabi, in order to improve planning for the roll-out of new capacity. HAAD is also looking at real-time data monitoring to identify emerging problems such as a temporary shortfall in staff at a hospital. A shift towards paperless administration¹³ also catalyses data collection, while consistent electronic records facilitate communication between healthcare facilities and with patients, all of which can help improve quality of care.

Improved data on the quality of services are not just helpful for the government to monitor the sector; they also empower service users to make informed decisions about where to seek treatment. The transparency of quality scores is also important to advance the education of the public and insurers based on quality

¹³ Dubai launched its "Smart Healthcare Model" in 2013, which is aiming for full usage of electronic patient records and hospital information systems (HIS). At end-2013, 22% of Dubai hospitals had reached level 5 out of 7 on the Electronic Medical Record Adoption Model (EMRAM) scale, up from 0 in 2011. The Ministry of Health has launched a similar initiative in its hospitals with the Wareed programme, an electronic patient record system.

performance, according to Ben Frank, CEO of the Cleveland Clinic Foundation. When regulators start publicising quality-of-care data, stronger performers—which currently rely on word-of-mouth and qualitative assessments, will thrive, while those that perform weakly will suffer.

HAAD is developing an Abu Dhabi Healthcare Quality Index, which the public could use when making decisions about service providers.¹⁴ HAAD intends to collect data on around 200 metrics. It began in July 2014 by requiring hospitals to report monthly on waiting times using metrics, each of which has a 90% target, ranging from minutes waiting for an outpatient appointment (within 60 minutes) to outpatient appointment scheduling (within 48 hours) and days from decision to admission for elective treatment (within 28 days).

The next stage is requiring hospitals to report on a quarterly basis which commenced in the third quarter of 2014, on ten surgical outcome measures, such as infection rates following hysterectomies and hip and knee prosthesis surgery, and readmission rates for urinary tract infections. HAAD will combine this information with waiting-time data, mortality rates (which are already being tracked) and patient satisfaction, to be assessed using the 32-question Hospital Consumer Assessment of Healthcare Providers and Systems survey developed by the US government.

Maha Barakat, HAAD's director general has said publicly that when this information is available, "the public can see first-hand which are the providers with the best quality and which are the providers with the weakest quality."¹⁵ Poor-quality performance could also trigger inspections and even the suspension of hospitals' licences. Outcomes data are also being used as a guide for remuneration packages for private providers in the northern emirates that have received management outsourcing contracts, according to Mr Kedzierski.

Yet the decision on which quality-related data to share publicly, and how, must be taken carefully. According to Robin Ali, a health-funding consultant to the Dubai Health Authority, 136 clinical service quality indicators have so far been identified in Dubai, including "readmission rates, patient satisfaction, clinical outcomes and the extent to which they abide by clinical guidelines". However, "if we went ahead and published them, the public wouldn't understand it, so we will be drip-feeding over a period to make sure there is sufficient time for the public to understand the meaning, as we don't want confusion in the marketplace."

Dubai's quality indicators are expected to be published in early 2015, and Haidar Al Yousuf, CEO of Health Funding at the Dubai Health Authority, expects that DHA will be publishing a more extensive set of metrics by the end of 2015. DHA is also looking to aggregate quality data into a five-star grading system by 2016, to help guide medical tourists as well as residents. Again, like the proposed Healthcare Quality Index in Abu Dhabi, this would be an attempt to present complex data in such a way that they can be easily understood by healthcare consumers.

Unifying these various initiatives across the emirate-level is a set of quantified medium-term quality targets laid out in the National Agenda,¹⁶ unveiled in January 2014. There are ten healthcare indicators, half of which are outcome-related, including (but not limited to) reducing the relative number of deaths from cardiovascular disease by 25% and cancer by 18%; cutting diabetes prevalence to 16.3% (from 19%); cutting childhood obesity to 12% (from 14.4%); and increasing average healthy life expectancy by six years to 73 years.

A second challenge regarding data concerns evaluation and performance assessment, given the absence of straightforward comparison benchmarks for the UAE. The demographic structure of the UAE is unique in that the local population forms a small fraction of the overall

¹⁴ If this combined different metrics together to provide a single quality measurement, it would go beyond systems of quality reporting in other countries, such as the US Medicare's Hospital Compare tool, which provides hundreds of separate indicators related to patient experiences, timely and effective care for various conditions and readmission/complications/death rates, all compared against regional and national averages.

¹⁵ <http://www.thenational.ae/uae/health/health-authority-abu-dhabi-plans-quality-tests-for-every-hospital>

¹⁶ <http://www.vision2021.ae/en/national-priority-areas/world-class-healthcare>

population. This leads to unusual characteristics, as a high proportion of the population is in active employment, many expatriate workers do not bring their families or do not remain with their families for the full childhood period, and very few expatriates retire in the emirates. Thus the population will be less heavily reliant on the health system than in a more normal

demographic, where the proportion of non-working people (children and the elderly) as a share of the total population is higher. It is perhaps more important for the UAE to develop its own data and track performance over time than comparing current data with its high-income peers.



Conclusion

The UAE government has ambitious plans to improve healthcare service quality by 2021. Significant progress has already been made over the last decade, including greater diversity of providers and the arrival of major international healthcare brands; higher rates of accreditation to global quality standards; improved access to healthcare through mandatory insurance; increases in the number of doctors, nurses and beds; more comprehensive data collation; and regulatory sophistication to deal with emerging health needs.

A number of interventions and policies could build on this progress and help the UAE achieve its 2021 targets. The health system as a whole is currently adapting to the changing needs of the country through new institutions and new ways of dividing responsibilities between each emirate, but this can bring fragmentation. Greater integration and harmonisation across emirates could support efficiency and thereby allow providers to attain scale and leverage synergies.

There are emerging differences in the regulatory and institutional architecture of each emirate, increasing the logistical burden of building a pan-UAE presence because providers must navigate different regulatory systems in what is already a relatively small market. This may

cause a loss of economies of scale and synergies. While some variation is natural given the federal structure of the UAE, some frictions could be eliminated. Minimum standards for licensing and harmonised processes for registering staff are two examples of measures that improve harmonisation without impinging on the autonomy of each authority. The National Health Council could play a more prominent role in ensuring greater harmonisation of licensing in other areas, such as patient medical records.

Turning to staffing and skills, several tools can help attain the 2021 targets. To encourage more expatriate workers to come to the UAE and lengthen their stay, the government and health providers may wish to explore targeted incentives, including financial compensation and perks to reward length of service, but also going beyond this to consider benefits such as speed of immigration processes and the possibility of full ownership of a medical practice. While the UAE scores well on liveability indicators, such initiatives could help it ascend the global league tables further as an expatriate destination for healthcare professionals.

To address potential staffing inequities between the largest emirates of Dubai and Abu Dhabi and the other emirates, the government may consider similar policies to increase the attractiveness

of employment in smaller emirates. There may also be a case for the introduction of regulations requiring incoming health workers to remain for a minimum period of employment in smaller emirates, although these have to be balanced against the need to ease the immigration process to keep migration numbers sufficiently high.

Technology can also help to distribute skills across the country, making the number of health professionals “go further”. The labour-saving power of mobile health could reduce the total number of medical staff needed to deliver high-quality services. Mobile-enabled technologies can deliver accessible healthcare information to smartphones and wearable diagnostic sensors, while telemedicine helps healthcare professionals to cover greater geographies and improve patient-data sharing. Telemedicine—the use of information and communications technologies to deliver healthcare from a distance—offers significant opportunities for the sharing of expertise between health workers, which can also distribute knowledge and skills over larger geographies and may tackle regional inequities.

Finally, only through data can the country truly assess, monitor and improve the quality of its health system. There has been an improvement in the provision of data on service quality, especially in 2014 and into 2015. After years of scant information, which led many patients to seek treatment abroad because of their lack of faith in domestic services, the UAE (and especially Dubai and Abu Dhabi) is now collecting

more information than ever before. The planned publication of comprehensive patient service quality data over 2015 and 2016 will for the first time provide an objective rather than anecdotal picture of the region’s service quality.

Looking forward, global data benchmarks for health service quality are of less use for the UAE owing to the country’s unique demographic structure. By 2021 the UAE could aim to have a robust, comprehensive and longitudinal five-year health-service quality data set that will allow it to track performance and highlight gaps. These data can be used by governments to incentivise the private sector through rewards, spanning remuneration and bidding decisions for outsourced services, as well as to weed out poor performers. They should also be publicly digestible, so that consumers can make informed choices about treatment. Those considering medical treatment in the UAE need access to data on metrics such as medical error, hospital infections or readmission rates so that they can make informed decisions. As more patients rely on the local system rather than going abroad, trust in the system will grow, utilisation rates will increase and more private investment will be encouraged, creating a positive feedback loop.

Achieving these milestones by 2021 would greatly strengthen the quality of the UAE health system, contributing to the economic and social health of the country, its attractiveness as a destination in which to live and work, and its long-term wellbeing and prosperity.

While every effort has been taken to verify the accuracy of this information, The Economist Intelligence Unit Ltd. cannot accept any responsibility or liability for reliance by any person on this report or any of the information, opinions or conclusions set out in this report.

About Waha Capital

Waha Capital is an Abu Dhabi-listed investment company, whose aim is to deliver attractive and sustainable returns to its shareholders by deploying and managing capital in areas where the company sees opportunity and can add value. Waha Capital is active in Principal Investments, Capital Markets and Industrial Real Estate. The company's portfolio consists of direct investments across various sectors which include aircraft leasing, healthcare, consumer finance, energy, infrastructure and industrial real estate. Waha Capital operates at the heart of a strong business network in the UAE and the broader MENA region, and enjoys a close affiliation with some of Abu Dhabi's most prominent investment and financial institutions. For more information, please visit www.wahacapital.ae

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