Health Equity Lens Embedded in the Public Health Policies of Saudi Arabia: A Qualitative Document Analysis

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Abstract
In the Kingdom of Saudi Arabia (KSA), no studies have been documented to analyze the equity aspects of public health policies. The aims of the study were to identify policy documents in the KSA relevant to public health and to explore whether these include an equity approach. Twenty health-related documents were identified from various ministries’ websites and analyzed through directed content analysis. The results showed that the term “equity” was neither defined nor explained in the documents and suggestions on how to tackle health inequities were lacking. None of the suggested measures communicated an explicit focus on promoting health equity or the social gradient. Several upstream, midstream, and downstream measures were suggested to improve justice and public health for the people. The study reveals that there is a need for an in-depth assessment of the policy measures across sectors and their influence on health equity to inform future health policy development and action in the KSA.

Keywords
health equity, policy analysis, Saudi Arabia, qualitative research

Introduction
In 2013, the Human Development Report (Malik, 2013) identified equity as one of the key areas for sustainable development. The recent Report (United Nations Development Program, 2019) confirms the importance of equity and focuses on understanding the dimensions of inequality by exploring their causes and consequences. Equity in health implies that everyone can attain their full health potential and that no one should be disadvantaged from achieving this potential due to their social position or other socially determined factors (Whitehead & Dahlgren, 2006). Inequities in health exist all over the world and highlight systematic differences in health status between different socioeconomic groups (Marmot, 2005); the Arab world is not an exception to this problem (Bibi & Nabli, 2010). Healthy public policies (i.e., integrating health perspectives in all sector policies) address inequities in health and are means by which governments show their will and commitment to promote equity (Kickbusch et al., 2008; Milio, 2001; World Health Organization [WHO], 1988).

In 2005, the WHO established a Commission on Social Determinants of Health to tackle these inequities through actions that reduce health disparities and focus on the social determinants of health (WHO, 2008). WHO, Regional Office for the Eastern Mediterranean (EMRO; Khadr et al., 2012; WHO, EMRO, 2008) reviewed available evidence collected from seven countries of the Eastern Mediterranean Region (Egypt, Iran, Jordan, Morocco, Oman, Pakistan, and Palestine) on the linkages between social determinants and health equity. According to the report (WHO, EMRO, 2008), health inequities in the region emerge from differences in terms of household living standards, workplace conditions, education, employment, job security, access to health care services, and other social differences between the most and least advantaged groups in society. Therefore, to achieve health equity, it is important to take action and involve other actors and sectors of society as an essential part of public policy and practice.
In recent years, progress has been made toward achieving the sustainable development goals worldwide. Evidence shows that poverty and hunger are declining, more children are attending the primary education, child mortality has been significantly reduced, and fighting against HIV/AIDS, malaria, tuberculosis, and other diseases has increased life expectancy (WHO, 2015). In the Arab region, the most significant progress is related to health and education. However, social equity, gender equality, and women’s economic and political participation have been limited (Abdellatif et al., 2019; UN and League of Arab States, 2015). Therefore, future development focuses on approaches to equity and emphasizes the importance of identifying populations that are the most disadvantaged and suffer from multiple disparities.

To investigate the equity aspects in the Arab region, it is also important to take into consideration that this region is diverse in terms of incomes, health indicators, and epidemiological transitions (Jabbour et al., 2012). Countries located in this region comprise high-, middle-, and low-income countries, and they differ from one another based on income, health indicators, and the epidemiological transition (WHO, EMRO, 2008). For example, compared with low-income countries, high-income (Saudi Arabia, United Arab Emirates, Kuwait, Oman, Qatar, and Bahrain) and middle-income (Egypt, Iran, Iraq, Jordan, Lebanon, Morocco, and Tunisia) countries have better health indications regarding newborns with a birth weight of at least 2.5 kg, children with acceptable weight-for-age rate, infant mortality rate, maternal mortality, and life expectancy at birth.

Inadequate access to health care is one of the determinants of social inequities in health (Whitehead & Dahlgren, 2006). Part of the inadequate access can be explained by the burden of payments for health services (Ziglio et al., 2003), particularly for socially vulnerable groups, the availability and access of health services in different parts of a country, and cultural access (meaning that some population groups might experience less respect and dignity or language barriers when visiting health services or dealing with health professionals). In the Kingdom of Saudi Arabia (KSA), through the National Transformation Program 2020, the government is attempting to effect radical changes in the structure and function of its health care system to achieve quality and effective service delivery and equality in health care access (Alharbi, 2018). These changes include fighting against the population growth rate (current annual population growth rate: 2.3%), high burden of noncommunicable diseases, and emerging infectious diseases (e.g., Middle East Respiratory Syndrome; Elachola & Memish, 2016; Memish et al., 2014).

Despite all the governmental efforts, Almalki et al. (2011) have identified several challenges in the health care system in the KSA, such as a shortage of Saudi health professionals, high health care demands resulting from free services, poor accessibility to some health care facilities, and the underutilization of the potential of electronic health services. El Beheraoui et al. (2015) also highlighted the importance of individual characteristics in health care seeking practices in the KSA. In recent years, there have been increased opportunities for women to access education and employment and to participate in decision-making in the KSA (see Alsaleh, 2009); however, as Mobaraki and Söderfeldt (2010) pointed out, social norms and conservative religious beliefs still have a powerful effect on women’s lives and gender equity in health in the KSA (Al-Hazzaa, 2018; Al-Nozha et al., 2005). A recent study shows that, for example, obesity is still more prevalent among women than men in Saudi Arabia and that Saudi females are disproportionately less physically active than males mainly due to lack of social support, time, and resources (Al-Hazzaa, 2018; Samara et al., 2019).

According to the WHO (WHO, EMRO, 2008), there is a paucity of research on health equity and social determinants in the Eastern Mediterranean Region. This is mainly due to lack of knowledge within the field of social sciences in relation to health and the absence of an institutional basis for social scientists with a specific interest in health. Most studies in this region are based on reviews of published and non-published literature; however, research on health equity and social determinants of health is scarce (Gilson & Raphaely, 2008; Khadr et al., 2012). Salem (2009), based on a review of web-published health strategies and plans, found that health equity was acknowledged by almost all Arab countries as a major concern among policy makers. Salem (2009) concluded, however, that equity concerns were not translated into concrete, detailed measures to overcome the prevailing inequities or their social determinants in the assessed countries. The KSA is one of the Arab countries that reports health equity as part of its mission statement (Khadr et al., 2012; Ministry of Health, 2019). However, an analysis of the equity aspects of public health and social policies has not yet been performed in the KSA. Therefore, this study aimed to identify the main strategies and policy documents in the KSA that are relevant to public health and, through a deductive content analysis (Hsieh & Shannon, 2005), to explore whether the documents include an equity perspective and whether the suggested measures communicate a clear focus on promoting equity and addressing the social gradient.

**Conceptualization and Dimensions of Equity in Health Policy**

Health inequity refers to health inequalities that are avoidable and unnecessary, that is, socially produced conditions that are regarded in a specific context as unfair and thus changeable (Whitehead & Dahlgren, 2006). In a health context, inequity is known as the absence of social justice in health or unfair health disparities (Braveman & Gruskin, 2003). According to Braveman and Gruskin, comparing health and its social determinants between more and less advantaged social groups is crucial for assessing health equity. These comparisons are essential to determine whether
national and international policies are leading toward or away from greater health equity in a society. Health inequity has a serious impact on life expectancy and quality of life. Due to health inequities, people who belong to socially disadvantaged groups experience a heavier burden of disease and disability. Inequities in health are associated with inequities in social status and are referred to as the social gradient in health (Whitehead & Dahlgren, 2006). The term “social gradient” indicates that health improves with increased income throughout the income distribution. The evidence shows that if the socioeconomic position of an individual decreases, their health status will decrease correspondingly. Povlsen et al. (2014) pointed out that even though both upstream (structural factors) and downstream (behavioral, social, and psychological factors) measures are important to reduce social inequalities in health, special awareness of and focus on the structural determinants of health (such as socioeconomic context, health systems governance, policy, and cultural norms and values) are crucial (Khadr et al., 2012; Whitehead & Popay, 2010).

Overwhelming evidence witnesses that behavioral forms of health promotion are inadequate for addressing social inequities in health and changing the health gradient (Baum & Fisher, 2014; Popay et al., 2010). One of the most important barriers for progress in broad action on the social determinants of health is the “lifestyle drift” (Hunter et al., 2009). The concept refers to the tendency for policy to start off recognizing the need for action on upstream social determinants of health inequalities but then drift downstream to focus mainly on individual lifestyle factors (Carey et al., 2017; Popay et al., 2010). Baum and Fisher (2014) promoted strategies addressing social determinants that are likely to reduce health inequities, concluding that evidence alone will not result in health policies aimed at equity and that political values and will, and the pressure of civil society, are also crucial.

The concept of equity should be investigated within the context of a specific country, a region, or across countries as the differences in articulating and communicating equity are related to history, values, and the political, social, and economic structures of each country (Milio, 2001; Starfield, 2001). Vallgårda (2011) found clear variations in national public health policies and programs and argued that differences exist in the way politicians and governments, as a result of their political ideologies, perceive themselves as having a responsibility for the population’s health. For example, a study on the health equity aspects communicated in the Nordic public health policies (Denmark, Finland, Norway, and Sweden) showed that although most of the policies that addressed social inequalities in health were similar in these countries, there were differences in terms of clarity in communicating the social gradient and addressing the social determinants (Povlsen et al., 2014).

In social policy, equity refers generally to a fair distribution of economic and social resources and burdens by guaranteeing minimum living standards for all, reducing inequality, and promoting social integration (Österle, 2002). August Österle (2002) has proposed a framework for the systematic analysis of equity in social policy, which is based on the equity objectives and how equity concerns are translated into social policy practice. The framework consists of three dimensions of equity in social policy: the resources or burdens to be shared or reallocated, the recipients of these resources, and the principles according to which the allocation takes place. The approach is goal-focused to reveal the range of equity concerns in social policy. What is actually allocated through social policies is the use of, access to, and choice between specific resources. It includes regulating care provision, in-kind services, and intermediated resources such as money. The recipients may be individuals, groups of individuals, families, households, geographical areas or public, or nonprofit organizations. The allocation principles determine the target groups of the social policy and the extent to which the resources are shared; the need-related principle entails that “need” is the respect to which individuals are unequal and to which differentiation among individuals is made. In this perspective, age, gender, and income do not matter; rather, “need” refers to required support arising from social risk. Egalitarian principles suggest that every citizen must receive the same amount of resources to be shared without considering their different needs, for example, level of disability. Time-related principles are often seen as indicators of the intensity of the need, for example, waiting lists as a basis for allocating places in health care institutions or queuing for a doctor’s appointment. Time-related principles are also used in insurance or social benefits models defining the duration of time when contributions are paid (e.g., maternity benefits). Status-related principles refer to the use of age, gender, and civil-, family-, residence-, or occupational status as a basis in the targeting of social policies. Economic-related principles refer to income, savings, or other assets that are considered a basis for allocating resources or targeting policies. Principles are mixed when several of the approaches mentioned above are used in combination. Principles may also be implicit (e.g., political power or informal connections, the role of lobbies) and not explicitly stated in the policies.

We used Österle’s (2002) framework as a tool in the deductive, structured content analysis of the selected policy documents and in formulating the coding scheme of the study.

Materials and Method
This study opted for a qualitative document analysis method (Bowen, 2009), which is a systematic procedure for reviewing and evaluating written texts that have been recorded without researchers’ intervention to elicit meaning, gain understanding, and develop knowledge. Document analysis, in line with any other qualitative method, requires data to be
explored and interpreted by researchers for identifying meanings relevant for the study aims and, through systematic coding, developing understanding about the phenomena under interest (Bowen, 2009). A deductive, directed content analysis was applied in the data analysis (Hsieh & Shannon, 2005).

**Data Search and Selection of Documents**

In this study, the data consisted of public health-related policy documents and papers, strategic plans, goals, objectives, program reports, study reports, or other gray literatures (e.g., websites) that provided specific information about the plans, policies, or implementation strategies relating to health, or which mentioned health or health care as active components. To identify and include the documents and papers (concerning the years between 2008 and 2018), official websites of various ministries of Saudi Arabia were checked. Altogether, 20 relevant documents were identified from the government website and the ministries of health, economy and planning, labor, and higher education.

The type and characteristics of the documents are listed in the Table 1. Nine documents were in Arabic and 11 in English.

**Data Extraction and Analysis**

The data extraction and analytic process (during 2017–2018) entailed identifying, selecting, making sense of, coding, and narratively synthesizing data contained in the included documents (Greenhalgh, 2016). During this process, the coding and the selection of text extractions to be included were continuously discussed, agreed in Skype meetings, and confirmed in writing through email among the coders. The native Arabic speaking researcher reviewed the Arabic documents and coded the text material, whereas the documents that were available in English were reviewed and coded by the English-speaking researchers. The extracted data in Arabic were translated into English to be able to discuss and verify the accuracy of the coding together with the entire study group. The analytic coding process was supervised by two senior researchers. The included document texts were saved in word program to allow coding with color highlighting.

The data extraction and analysis were informed by the following research questions that were formulated in accordance with the main aim of the study:

**Research Question 1:** Is the term “equity” used or applied and communicated in the selected texts and documents? (Or, is the term used or expressed in some other way?)

**Research Question 2:** What strategies and measures are suggested to reach health equity in the KSA?

**Research Question 3:** Do the measures suggested for addressing social inequalities in health communicate a clear focus on promoting equity and/or on addressing the social gradient?

Furthermore, regarding the strategies and suggested measures, we extracted and analyzed the data on the three key dimensions of equity in social policy described by Österle (2002) as the main coding categories to answer the following questions:

- What resources or burdens were suggested to be shared or reallocated?
- Who would be the recipients of these burdens and resources?
- What principles were applied in the allocation?

During the coding process, the texts were first read several times before words or (parts of) sentences were identified and highlighted to be included in the predetermined codes. The included passages of texts were then copied and inserted to a coding template, including the predetermined categories and codes. Any text that could not be coded with the initial coding scheme was given a new code. The initial codes, along with the data excerpts, quotations, or entire passages, were then organized under the key questions through directed content analysis technique as described by Hsieh and Shannon (2005). According to Hsieh and Shannon, the directed content analysis is guided by a structured process where the predetermined key concepts and initial coding categories are formulated based on existing theory—in our case, it is equity in social policy framework by Österle (2002). The findings of the directed content analysis are to offer supporting and non-supporting evidence for an existing theory (Hsieh & Shannon, 2005).

In the last stage of analysis, the researchers moved beyond the manifest content (i.e., beyond the surface and easily observable, particular words in a written text) and analyzed also the latent content underlying the elements of the surface of a message (Potter & Levine-Donnerstein, 1999). This required the coders’ interpretations of the meaning of the content. To interpret, understand, and judge the meaning in the contents, the coders constantly accessed their predetermined coding scheme, including the operationalization of the key codes and categories. For instance, the coding scheme, based on the theory of health equity (Österle, 2002; Whitehead & Dahlgren, 2006), consisted of operationalization of the key concepts that helped the coders to put their observations into the corresponding data categories as uniformly as possible and to ensure the validity of their judgments.

**Results**

The term “equity” was not explicitly used in the identified documents (Table 1), but the idea of equity was implicitly communicated by addressing objectives for tackling poverty
and guaranteeing that all social groups share the benefits of growth and improvement of quality of life. The state’s role to protect health and provide health care to every citizen was emphasized.

**How the Term “Equity” Was Communicated**

Out of the 20 documents and texts analyzed, only a few documents mentioned the term “equity.” However, the term was neither defined nor explained. The texts most often referred to the human rights perspective, for example: “to promote national unity, to guarantee human rights, and to maintain social stability (Doc 1). Justice, charity, equality, and human rights were mentioned as core principles of Islamic teaching (Docs. 2, 3, and 8), as a general principle of the policy (Doc 18) or as the way of working, including additional principles of professionalism, quality, honesty, and transparency (Doc 19). The Health Strategy (Doc 3) in particular mentioned that the promotion and preservation of public health requires improvements of the quality and performance of health services and systems and geographic justice in the distribution of services in various regions of the Kingdom (Doc 3). The principle of equity was implicit in the vision of the KSA (expressed at the website) as follows: “Carrying health conditions or health status of Saudi inhabitants to the best and highest possible level, in terms of justice and equality in providing health care, and in terms of effectiveness and the possibility of incurring the financial burden of the treatment and health care (Doc 5).”

**Measures Suggested**

Several upstream measures (referring to policy actions that shape the economic, social, and physical environments; Sacks et al., 2009) were suggested to improve justice and the public health of the people: improving standards of living...
and quality of life of citizens, minimizing unemployment, developing laws and regulations to improve health systems governance, monitoring the performance of the public health sector, providing accessible and appropriate health services, improving the capacity of hospitals and health care centers, and enhancing the quality of preventive and therapeutic health care services (Docs. 1, 3, and 8). The public sector was suggested to focus on the planning, regulatory, and supervisory roles of health care (Doc 8). Use of existing evidence and scientific research were proposed to be utilized better to ensure best practices in the health care sector (Docs. 9, 10, 15, and 19). Although the importance of focusing on measures for needy groups, such as children, youth, and women, was emphasized (Docs. 1, 6, 8, 9, 10, and 13), ensuring medical care provision to every citizen was also clearly expressed (Doc 16). Primary care, in particular, was noted to have a responsibility to identify and prioritize people in need of mental health services (Docs. 14, 15, and 20).

Midstream measures (referring to policy actions that directly influence behavior and lifestyle; Sacks et al., 2009) were to support and develop participation of youth and women in social development (Docs. 1 and 9) by organizing, for example, youth consultation workshops in different regions of the KSA (Doc 6), increasing awareness and training on family safety, child maltreatment, and domestic violence (Docs. 9 and 10), and encouraging citizens and residents to participate regularly in sports and athletic activities (Doc 8).

Key performance indicators (KPIs) included strengthening the principles of equality among all categories of the society (Doc 2). KPIs mandated pursuing achievement of targets and verifying rates completed over the 5-year period covered by the plan (Doc 2). These indicators have been used for the first time in development plans according to the concept of the personal and operational performance dashboard to the development goals, consistent with the national transformation program, which holds promising hopes in creating a hoped-for development boom (Doc 2).

Downstream measures (i.e., policy actions that support health systems and public health services; Sacks et al., 2009) included providing health care at all levels, promoting public health and disease prevention (Doc 3), and the development of laws and regulations governing the public health sector and monitoring its performance, with interest in research and academic training and health investment areas (Doc 3). Furthermore, the measures included ensuring that patients have access to primary health care services 24/7 (Doc 3), optimizing and better utilizing the capacity of hospitals and health care centers, and enhancing the quality of preventive and therapeutic health care services (Doc 8). Developing private medical insurance was seen as a tool to improve access to medical services and reduce waiting times for appointments with health specialists (Doc 8).

**How the Equity Aspects and Social Gradient Were Addressed**

The suggested measures did not focus explicitly on promoting health equity but indicated a tendency to move away from action to address the social gradient toward activities targeted at the most disadvantaged. There were some expressions that the measures should support people with special needs (e.g., children who are displaced or have suffered from war; Doc 13) and that there should be no disparity in health services provided to members of the community based on social and economic considerations (Docs. 1, 3, and 6). Although disadvantaged groups, women, children, and youth were mentioned as special focuses of health promotion, these target groups were not further described or divided into subgroups. One of the main suggested activities was to undertake studies and surveys of youth in all regions. Presumably, based on the data, the needs and resources of youth according to income, age, education, family backgrounds, and so on, would provide more specific evidence on the needs related to this subgroup.

**Resources of Burdens That Were Suggested to Be Shared or Reallocated**

Health services were suggested to be provided at supportive prices. The data included suggestions on strategies aimed at achieving a qualitative and quantitative expansion of education and vocational training; giving priority in employment of the national workforce although the strategies were not described in concrete measures and the agency responsible for implementation of the strategies was not explicitly mentioned. Inputs from international, national, and regional consultants and experts would be used to ensure the achievement of the policy goals (Docs. 4 and 5). Management costs were proposed to be reduced, quality of services improved, and business agility and resilience enabled (Doc 6). A patient-centered health care system would be able to meet patients’ health needs in the right place at the right time (Doc 6). Adopting a public and national strategy that focuses on the main morbidity burdens, including noncommunicable diseases, nutrition, reproductive health, smoking, AIDS, traffic accidents, and injuries (Doc 6), was viewed as important. The Vision 2030 (Docs. 8 and 12) emphasized working toward developing a private medical insurance to improve access to medical services and reducing waiting times for appointments as important measures for improving health equity.

**The Recipients**

The recipients of reallocated burdens and resources would include—according to approximately half of the documents—all citizens (Docs. 3, 4, 5, 12, 15, 16, 17, 19, and 20). However, disadvantaged groups with special health needs, such as
The Underlying Principles for Allocation

The reallocation or share of burdens in the suggested measures were related to the egalitarian principle, which was explicitly mentioned in less than half of the documents but more often implicitly mentioned. The message of these policies was that resources must be shared equally among all people: . . . strengthening the principles of justice and equality among all categories of the society . . . (Doc 2); . . . There should be no disparity in the quality of health services provided to members of the community based on geographic disparities, social, economic, or any other considerations . . . (Doc 3); . . . concerned with public health and the provision of health care to every citizen . . . (Doc 7); . . . equal access to health care for all (Docs. 12 and 19) without any geographical, physical, social, cultural, or linguistic obstacles (Doc 19); . . . regardless of his or her religion, sex, race, or nationality (Doc 16).

Internal migration from rural areas into large cities in the KSA has caused population escalation in some major cities. This has further resulted in a growing pressure for public health services and infrastructure (Doc 1). The suggestion to reduce development disparities among regions (Doc 1) was related to the economic principle (Österle, 2002) but could also be related to a demand for good health systems governance (Siddiqi et al., 2009). These principles may be implicit in the suggestions of management and performance control in the public and private health sector through the setting of laws, systems, and decisions aimed at achieving quality and excellence in health care that is to be transparent, clear, fair, and accountable for, clean from corruption and concealment of facts (Doc 3), and by optimizing and better utilizing the hospitals’ and health centers’ service capacity and enhancing the quality of care (Docs. 4, 5, 8, and 19). In the area of health care specifically, good governance was mentioned as essential for ensuring that policies are implemented in a systematic manner and that procedures are applied according to quality standards (Doc 3). Better collaboration and integration between health and social care was also suggested (Doc 8). Time-related principles were embedded in suggestions to reduce waiting times and improve access to medical (Doc 8) and social care (Doc 19).

Needs-related suggestions were articulated, for example, by ensuring that the most vulnerable citizens are provided tailored care and support (Doc 8) and that the services provided are patient-centered (Docs. 4, 5, 14, 17, and 19). Status-related principles may be observed in policies that emphasized measures particularly for children, youth, and women (Docs. 1, 6, 9, and 10), and for other vulnerable groups such as the unemployed (Docs. 1 and 8).

The idea of enhancing community participation was suggested explicitly in three of the analyzed documents (Docs. 1, 6, and 8). The Tenth Development Plan (Doc 2) suggested improving the educational, health, and economic conditions of Saudi women. This would require deepening the orientation of the policy measures toward women empowerment (Doc 2).

Discussion

The data of the study indicate that the policy documents from the KSA are guided by the principles of Islamic teaching, including “justice,” “charity,” “equality,” and “human rights.” It is generally understood that equity is an ethical principle, which is consonant with or closely related to human rights principles (Braveman & Gruskin, 2003). However, the term “equity” was not explicitly defined on any of the policy documents, and some of the documents referred to a human rights perspective by expressions such as “to promote national unity, to guarantee human rights and to maintain social stability.” As Whitehead and Dahlgren (2006) concluded, health (system) policies and the measures suggested by these should be built on principles for tackling inequities in health. However, in this study, the equity approach did not come explicitly across as one of the common themes when synthesizing the included documents. The documents had mainly adopted the rhetoric connected to the ideology of equity, but none of the documents detailed the processes or strategies to tackle issues of inequity in health. This is in line with an earlier analysis of the existence of an equity lens in health policies in Arab countries by Salem (2009) who also found that equity had just remained as lip service in the policies without suggestions on how to tackle health inequities in the included countries, which also may be an indication of a tendency to “life-style” drift (Hunter et al., 2009; Popay et al., 2010) in their health policy making. Furthermore, there was a lack of systematic conceptualization of “equity” in the documents. Österle (2002) pointed out that this is a general deficit across many areas of social policy.

Evidence suggests that universalistic policies are more efficient in poverty reduction and fighting against income inequalities than those targeted at the worse off only (Jacques & Noël, 2018; Korpi & Palme, 1998; Whitehead, 2007). Evidence on effective policies and interventions that benefit a large segment of the population has been rather limited and fragmented in the context of the KSA (Al-Sharqi & Abdullah, 2013). Our analysis revealed that most of the policy documents did not include all population groups residing in the KSA as the recipients of the reallocation of burdens and resources. For example, approximately half of the policy documents (Docs. 3, 4, 5, 7, 12, 15, 16, 17, 19, and 20) mentioned “all citizens,” and a few documents also referred to
adolescent girls, women, and older adults, there are still special attention should be paid to the needy groups, such as the policy documents of the present study emphasized that their legal status (Alkabba et al., 2012). Although some of fever, should have access to free management independent of with some serious diseases, such as tuberculosis and dengue particularly among Saudis and non-Saudis. Only patients distribution of health resources in the Saudi health care system, wide inequities in the provision of health care and in the dis-

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According to Whitehead and Dahlgren’s Principles of Policy Action, policies should strive to bring up the level of health of the groups of people who are worse off to that of the groups who are better off; narrowing the health divide and reducing social inequalities should be conducted throughout the entire population (Whitehead & Dahlgren, 2006). A survey conducted by Saeed (1999) found that 83.6% of the clinicians working in different regions in the KSA believed that health care and resources should be made accessible to all the patient groups regardless of the legal status (Saeed, 1999). However, Alkabba et al. (2012) noted that there are wide inequities in the provision of health care and in the distribution of health resources in the Saudi health care system, particularly among Saudis and non-Saudis. Only patients with some serious diseases, such as tuberculosis and dengue fever, should have access to free management independent of their legal status (Alkabba et al., 2012). Although some of the policy documents of the present study emphasized that special attention should be paid to the needy groups, such as adolescent girls, women, and older adults, there are still some population groups that may not have access to the social and health services provided by the government.

Alyaemni et al. (2013) suggested that improving women’s health would require improving gender equity in society across both the private sphere (including family and cultural norms) and public sphere (including employment rights and spatial mobility). The government of Saudi Arabia has achieved remarkable progress in the status of gender equality in education, employment, and health (Alsaleh, 2009). Efforts have been made to promote improvements in the status of women and in enabling them to participate in economic, health, and social development. Examples of these efforts would include giving women the right to vote, the right to run in future municipal elections, the right to drive, the right to education, and an access to government services such as education and health care without the need of consent from a guardian (Alsaleh, 2009). Despite these major reforms, gender inequality entwined in patriarchy, traditional social norms, and Islamic laws persists. For example, in rural areas in particular, a male relative may prevent a woman from being treated by a male gynecologist or obstetrician, even in an emergency (Mobaraki & Söderfeldt, 2010). Furthermore, high fertility, abortion being forbidden, and strict regulations with regard to family planning and sterilization methods could explain the high burden of women’s health issues in the KSA (Mobaraki & Söderfeldt, 2010).

Alyaemni et al. (2013) showed that there are distinguished processes and structures that shape the daily lives and health of women and men in the KSA. According to Alyaemni et al., most Saudi women perceived their health to be worse than men’s and attributed this to their childbearing, domestic and caregiving roles, restrictions on their mobility, poverty, and psychological stress related to their responsibilities for children and the extent of marital support and harmony. This supports the suggestion by Whitehead and Dahlgren (2006) that social inequities in health should be described and analyzed separately for men and women; this difference should be taken into consideration while developing strategies to combat health inequities. Although measures to improve the education, health, and economic conditions of Saudi women were emphasized in some policy documents (Doc 2), gender equity was not a health policy priority, and women’s health issues were overlooked in most of the policy documents; as a result, the problem of gender inequality in health and health care access remains.

Our study found that although some disadvantaged groups, for example, women, children, and youth, were mentioned as special target groups for health promotion in the policy documents, these target groups were not further described as specific focuses of interventions or services, and there were no specific suggestions on how to overcome difficulties in access to health care. It seemed obvious that the policies were not informed by recent evidence: Alkabba et al. (2012) noted that Saudi patients in many peripheral areas have various cultural and language barrier problems in accessing health care. Richard et al. (2016) explicitly stated that improving access to primary health care for all population groups is important for achieving health equity, yet this remains a challenge in the KSA. Fadaak (2010) pointed out that due to the lack of an officially defined poverty line in the KSA and the lack of laws that grant Saudi citizens the right to a minimum standard of living through the government social security system, the citizens at risk of poverty—for example, female-headed households (widows, divorced, or abandoned)—remain dependent on their family or charity support.

Österle (2002) pointed out that the first set of considerations with regard to equity refers to the decision of which resources should be shared to prevent a decrease in the availability of services or to guarantee a minimum level of resources. The document data did not give a clear picture of measures regarding this type of choice. The Saudi Vision 2030 (Docs. 8 and 12), however, emphasized work toward promoting private medical insurance systems as an
important measure for improving health care quality and health equity. Simultaneously, this policy encourages private sector investment in health care, which may lead to the introduction of user fees (Al-Hanawi et al., 2018; Howard, 2014). Referring to the evidence by Al-Hanawi et al. (2018), quality improvement would be a key incentive to motivate the Saudi people to contribute to financing the health care system through user fees. Walston et al. (2008) have noted that a greater reliance on the private sector to address rapidly escalating health care costs and deteriorating quality may produce other consequences. For example, people who are insured by private insurance may instead seek health/medical services at private hospitals, followed by underutilization of the MOH network of hospitals and primary health care centers, which altogether have been the largest providers of health care services in the Kingdom (more than 62% of inpatient care; Price, 1988; Walston et al., 2008). As most (private/public) hospitals in the KSA are centralized in larger cities, the increased privatization of health care could further encourage centralization of health care. Thus far, it is challenging to address the health equity gaps in health service access, particularly in rural and remote regions where nearly 20% of the total population resides, and bring all the population groups under a proper comprehensive insurance coverage (Al-Sharqi & Abdullah, 2013).

However, there are substantial income disparities between people with respect to gender, age, race, religion, and legal status. The introduction of taxation and user fees in health care, which is perceived as the best strategy to increase health care quality, could also exacerbate the preexisting disparities in income and health care access in the Kingdom (Al-Hanawi et al., 2018; Mufti, 2000). User fees may also deter the poor from seeking care (WHO, EMRO, 2008). Nevertheless, knowledge about the cost barrier to health care access among vulnerable and marginalized subpopulations is very limited (Alshamsan et al., 2017). Unlike the privatization of health care, alternative strategies are proposed to be sought to ensure that health policies have provisions for the equitable distribution of resources to help achieve health and health justice for all and meet health-related targets set by the Sustainable Development Goals (Valentine et al., 2016).

**Conclusion**

This is the first study to analyze the equity aspects of public health and social policies in the KSA. The results highlight the equity gaps in the main public health strategies and policy documents that inform appropriate policy measures to promote equity in health and/or on addressing the social gradient influencing health care access.

The analysis showed that although some documents mention the term “equity,” the term was neither defined nor explained. The texts mostly referred to the human rights perspective, which was expressed as essential to maintain social stability in the KSA. Apart from the basic communication of the human rights perspective as a principle in the policy documents, the suggested measures did not communicate an explicit focus on promoting health equity or the social gradient. Österle (2002) has pointed out a common lack of precise definitions of equity in policy making and evaluation in the social- and public health policy fields, but in general, equity objectives stress the importance of fair distribution of resources and burdens in a society. Österle (2002; based on Badelt et al., 2001; Wilson & Wilson, 2018) summarized four sets of equity objectives—guaranteeing minimum standards, supporting living standards, reducing inequality, and promoting social integration.

Several upstream measures were suggested to improve justice and public health for the people, including minimizing unemployment (e.g., through the expansion of education and vocational training and giving priority to employment in the national workforce), developing laws and regulations to improve health systems governance, and the quality of the public health sector, for example, by providing accessible and appropriate health services. Midstream measures (referring to policy actions that directly influence behavior and lifestyle) include supporting and developing the participation of youth and women in social development. The KSA will organize training and campaigns to increase awareness on family safety, child maltreatment, and domestic violence. Citizens and residents were encouraged to regularly participate in sports and athletic activities and to tackle obesity and lifestyle-related noncommunicable diseases. Downstream measures included providing health care at all levels at supportive prices and promoting public health and disease prevention. The KSA emphasizes a patient-centered health care system that would enable meeting patients’ health needs in the right place at the right time. Management costs were proposed to be reduced. Management and performance of both the public and private health sectors would be controlled through setting laws, systems, and regulations to ensure transparent, clear, fair, and accountable services. Good health system governance (see, for example, Siddiqi et al., 2009) was mentioned as essential for ensuring that policies are implemented in a systematic manner and that health services would perform according to high-quality standards. There was no detailed description of what these standards would entail.

The reallocation or share of burdens in the suggested measures were related to the egalitarian principle: The message of these policies was that resources must be shared equally among all people although the importance of focusing measures on needy groups, such as children, youth, women, and the unemployed, was emphasized. However, the measures to these specific target groups were not described in detail. Reducing health disparities between regions in the KSA was also viewed as crucial. The idea of enhancing community participation was suggested explicitly in a few documents. However, the participatory *methodological* approach that is necessary to make the marginalized people’s voices...
heard and coproduce the evidence for policy making (Greenhalgh, 2018; Popay et al., 2007) was absent from the documents. Improving the educational, health, and economic conditions of Saudi women, as explicitly suggested by the data, would require deepening the orientation of the policy measures toward women empowerment.

The study reinforces the view of earlier studies (e.g., Petticrew et al., 2004; Whitehead et al., 2004) that the health equity evidence base is limited and that there is a need for an in-depth analysis on concrete policy measures that address health equity in the KSA. Analyzing existing policies for their positive and negative impacts on the life chances of different groups in the population (Whitehead & Popay, 2010) would be crucial for addressing the social determinants of health and health equity.

**Limitations**

Several limitations inherent to a document analysis are potential flaws of our study: The included documents were produced for some purpose other than research; consequently, they did not provide sufficient detail to answer the research questions (sometimes, the information was lacking from the documents). Another limitation was the fact that some documents were not retrievable and access to some documents was deliberately blocked. Thus, the difficulty of accessing documents resulted in an incomplete collection of data. This may have caused a “biased selectivity” (Yin, 1994). According to Yin (1994), in an organizational context, the available documents are likely to be aligned with corporate policies and procedures and with the agenda of the organization’s principles. This way, the documents that are available may also reflect the emphasis of the particular organization that handles this record-keeping and public availability (Bowen, 2009).

Moreover, the use of the qualitative narrative method (Greenhalgh, 2016) to synthesize the text of the policy documents overlooks the papers describing individual experiences and the interaction of multiple structural influences, which could have been important for an equity analysis (Greenhalgh, 2018). Such a comprehensive approach, for example, by Baum et al. (2018), suggests that document analysis should be complemented with an analysis of case studies of policies to demonstrate good practices to address social determinants of health and promote equity across sectors. Finally, our analysis would not truly implicate the performance of the health system from an equity perspective in terms of the prevention and management of different health conditions (Dover & Belon, 2019) or policy-making levels (Harris et al., 2015), which were beyond the scope of this study. Harris-Roxas et al. (2011), for example, have demonstrated that an overall system-focused consideration of health equity in the policy-making processes and implementation may be enhanced by equity-focused health impact assessment.

**Acknowledgments**

We thank Dr. Tamader Al Rammah for assistance in obtaining the ethical clearance from the ethical committee of the King Saud University for the study.

**Author Contributions**

A, the principal investigator of the research, was responsible for the design, data collection, and methodology of the study and was the main author of the article. A, B, and C performed the data collection. The initial coding of the data, written in English, was performed by B and C coded the materials that were in Arabic. A contributed in the further analysis process and the validation discussion of the analysis and coding. D and E participated in the analysis and the writing of the article.

**Declaration of Conflicting Interests**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

**Funding**

The author(s) received no financial support for the research, authorship, and/or publication of this article.

**Ethics Approval**

The ethical clearance for this study was obtained from the King Saud University, College of Medicine’s Institutional Review Board (IRB), in March 2017.

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